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	07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel Mooresville	550 Glenwood Drive Mooresville, NC 28115

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on record review, resident, family, and staff interview the facility failed to treat a resident in a dignified manner by not responding to a call light and meeting the resident's request which led to the resident's brief and bed being wet with urine requiring an entire bed change. The resident stated this made her feel unwanted, belittled, and uncared for by everyone except her family or 1 of 2 residents reviewed for dignity (Resident #72). The findings included: Resident #72 was readmitted to the facility on [DATE] with diagnoses of Guillain Baree syndrome and dementia and was discharged from the facility on 07/09/22. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #72 was cognitively intact and required extensive assistance of one staff member for toileting and was always incontinent of bladder. Review of the facility daily assignment sheet for 07/09/22 for 3:00 PM to 11:00 PM revealed that Nurse Aide (NA) #3, NA #10, and NA #11 were assigned on the unit where Resident #72 resided. An interview was conducted with Resident #72's family member on 07/11/22 at 1:58 PM who stated on 07/09/22 she received a video call from Resident #72 at 9:08 PM. She stated that Resident #72's call light was on, and she needed to be changed. She stated that Resident #72 stated that she had turned the call light about 20 minutes prior to calling the family member and had reported that the last time she had received incontinent care was at 1:30 PM. The family member stated that while on the video call with Resident #72 a staff member who she could not recall their name came in and when Resident #72 stated she needed to be changed the staff member stated that she was not assigned to Resident #72 that shift and then exited the room. The family member stated that about 10 minutes later another staff member came into the room to provide incontinent care but by that time Resident #72, her brief, and bed were all wet and needed to be changed. (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Resident #72 was interviewed via video call on 07/11/22 at 2:25 PM and stated on 07/09/22 she had remained in bed all day. She stated that the staff had woken her up at 5:30 AM to provide incontinent care and then again at 1:30 PM. Resident #72 stated that she did not see the staff again until around 9:15 PM when a staff member came in to answer her call light that had been a while but when she told the staff member, she needed to be changed the staff member stated that she was not assigned to take care of Resident #72 that shift and then left the room. Resident #72 stated that about 10 minutes later a new staff member came in to provide incontinent care to her. She stated by that time she was wet and so was her bed and everything had to be changed which made her feel unwanted and uncared for except for her family. Resident #72 stated that it was quite belittling for the staff to have to change not only her but her entire bed as well. NA #4 was interviewed on 07/11/22 at 5:57 PM and confirmed that she had cared for Resident #72 on first shift (7:00 AM to 3:00 PM) on 07/09/22. She stated that when she arrived for her shift, she checked Resident #72 who was dry and then she checked her again around 11:00 AM and she was still dry. NA #4 stated that she provided incontinent care to Resident #72 around 1:30 PM before she left for the day. She added she was slightly wet, but her bed was dry so, she only had to change her brief. Nurse Aide (NA) #3 was interviewed on 07/12/22 at 2:33 PM and reported she was working on 07/09/22 from 3:00 PM to 11:00 PM and had answered Resident #72 ' s call light because her assigned NA was on break. NA #3 state that she answered the call light at approximately 9:30 PM and was not sure who was assigned to care for Resident #72 because that was her first day in the facility in 2 years. NA #3 stated that when she answered her call light Resident #72 was on the phone with her family member and was wet and needed to be changed. She stated that her bed was also wet and needed to be changed, they were not saturated but I did not want to leave them soiled. NA #3 did not know which staff member had previously answer Resident #72's call light or how long the call light had been on. NA #10 was interviewed on 07/13/22 at 11:02 AM and confirmed that she worked 07/09/22 from 3:00 PM to 11:00 PM on the unit where Resident #72 resided but stated she did not provide any care to her. She stated she answered her call light around dinner time, and she wanted a cup of ice and that was given to her, she did not mention needing incontinent care at that time. NA #11 was interviewed on 07/13/22 at 1:19 PM and confirmed she worked on 07/09/22from 3:00 PM to 11:00 PM on the unit where Resident #72 resided. She stated she was assigned to sit with another resident on that unit and did not provide any care to Resident #72 during that shift. The Regional Nurse Consultant was interviewed on 07/15/22 at 1:18 PM. She stated that the facility staff were to round on each resident before and after meals, at bedtime and as needed. She stated that Resident #72 should have been checked before and after her evening meal and again at bedtime and if her call light was on then as requested.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 42090 Based on Resident Council Meeting Minutes, resident and staff interviews, the facility failed to resolve dietary grievances that were reported in the Resident Council meetings (1/14/2022, 1/17/2022, 3/10/2022, and 3/31/2022). a. Review of the 01/14/22 Resident Council (RC) Minutes revealed the following dietary concerns: The RC commented on the Dietary Department no longer taking food orders (preferences). Additionally, the kitchen had stopped ordering lactose free milk. The response to the concern was that due to the kitchen staff's old process of taking orders each day was being held and was not signed until 2/8/22.The secondary response was that the kitchen was unable to get the milk in due to shipping issues and they will get to working on it. b. Review of the 01/17/22 RC Minutes revealed the following dietary concerns: The RC commented on the Dietary Department not following their preferences and request that dietary preferences be competed again. The response to the concern was that the new Dietary Manager would complete preferences on start and was not signed until 2/8/22. c. Review of the 03/10/22 RC Minutes stated that menu options are not being taken. The response to the concern was the Dietary Department is planning on reopening the dining room and putting tickets back on the meal trays and was signed on 03/17/22. d. Review of the 03/31/22 RC Minutes stated that food preferences needed to be taken and honored again. Additionally, the RC Minutes reflected the kitchen not having lactose free milk. Thirdly, condiments were not being served on meal trays. Fourthly, RC commented silverware was not provided on some trays. The response to the concern was the Corporate Regional Dietary Manager visited residents individually for likes and dislikes on 04/06/22-04/7/22. The response to the secondary concern was to build a par of 4 cases per order of the milk. The response to the tertiary concern was packets were being distributed by the nurse aide staff and would be changed to have culinary to build trays fully in the kitchen. The fourth response was acknowledgement that silverware was missed on some trays and dietary staff should be more careful. A RC meeting was held on 07/12/22 at 2:18-4:00 PM with 9 members of the RC present. The RC reported continuing to have food concerns with preferences, not getting condiments and silverware consistently. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interviews with the Activity Director (AD) and Assistant Activity Director (AAD) on 07/12/22 at 4:05 PM revealed one or both staff members attend all Resident Council meetings and write up all RC concerns and provide them to the Social Worker/administrative team which discussed them during morning clinical meeting and were distributed to the appropriate departments to handle the concern. They each acknowledged that dietary concerns were always a major discussion in RC meetings. The AAD stated that it seemed they would report a concern at the meeting and preferences and lack of items seemed to reappear often. She stated if they seemed to resolve the topic for one resident it was always a concern for another attending, or it would come back up later. The AAD stated activities was provided responses by the Dietary Department but they were often delayed but she would report and read them back to the members at the next meeting following her receiving a resolution response to the concern. An interview was conducted with the Regional Dietary Manager on 07/13/22 at 1:15 PM. She indicated all resident preferences were taken and should be entered into the electronic medical record system and the tray card system. She also indicated she had not attended RC meetings before, but she was aware there had been concerns voiced regarding the Dietary Department not honoring dietary preferences, missing silverware, and not having the appropriate condiments on meal trays. She indicated she had spoken to Resident #68 regarding his preference concerns earlier on this date and believed they would be corrected, and his meal trays should reflect the preferences voiced. A follow-up interview was conducted with Resident #3 on 07/15/22 at 8:30 AM revealed she attended Resident Council frequently and continued to have concerns with food preferences not being honored and her meal ticket not matching what she was served. A follow-up interview was conducted with Resident #57 on 07/15/22 at 9:05 AM revealed she attended Resident Council frequently and continued to have concerns with food preferences not being honored and her meal ticket not matching what she was served An interview was conducted with Resident #68 with the Dietary Manager present at bedside on 07/15/22 at 9:30 AM. The Dietary Manager indicated he had not attended RC meetings but was aware there were concerns with meal choices not being honored. He indicated he thought the issue had been corrected after the Regional Dietary Manager had spoken to Resident #68 on 07/13/22. However, the Dietary Manager had met with Resident #68 again on 07/14/22 and continued concerns were voiced. Additionally, after the observation of the meal served and the meal ticket for breakfast on 07/15/22, he acknowledged the concerns identified with preferences in RC were still an ongoing issue that needed further resolutions put into place for correction A follow-up interview was conducted with Resident #68 on 07/15/22 at 9:45 AM revealed he attended Resident Council frequently and continued to have concerns with food preferences not being honored and his meal ticket almost never matched what he was served nor what he had identified to be his likes or dislikes. The Director of Nursing was interviewed on 07/15/22 at 2:30 PM. She indicated all departments handling grievances should have a resolution returned to the person filing the grievance within a timely manner which she had recently been taught was 72 hours. The RC grievances should be returned to the Activity Department for them to be read at the next meeting. She stated most grievances should be handled by either her, the social worker, or the Administrator. The Grievance Coordinator should make sure an investigation has been completed regarding the concern and ensure a proper resolution with follow up is provided. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was interviewed on 07/15/22 at 2:17 PM. He indicated he had just started at this facility, but he expected meal tickets to match what was on the tray 100% of the time and meal preferences to be honored to include likes and dislikes. He further explained if the facility experienced a shortage with an item on the posted meal, a meal may have to be altered. If this occurred, he expected the dietary department to change the tickets for the day and adjust the menu posted to reflect the changes so the residents can be informed in a respectful, timely manner. If there are preferences that are unavailable but a frequent request that is unable to be gotten on the routine delivery due to back order, there facility has a purchase card and it can be purchased outside the facility and charged back appropriately. He indicated he had begun working on the resolution since he had arrived by meeting with the RC and was in the process of putting new systems into place. He further indicated all grievances to include RC concerns should have a resolution provided within 72 hours. The Administrator indicated he would act as the new Grievance Coordinator in the facility.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on record review and staff interview the facility failed to maintain accurate advance directives throughout the medical record (Resident #47, Resident #131, Resident #22) for 3 of 5 residents reviewed for advance directives. The findings included: 1. Resident #47 was admitted to the facility on [DATE] and most recently readmitted on [DATE]. Review of an active care plan initiated on 09/09/21 read, Advance Directive Do Not Resuscitate Review of a physician order dated 12/04/21 read, Full code. Review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #47 was moderately impaired for daily decision making. Review of the facility's advance directive notebook at the central nurse's station revealed no advance directive information for Resident #47. The Social Worker (SW) was interviewed on 07/12/22 at 4:15 PM. The SW stated she had only been at the facility for a few weeks. She explained that when a resident admitted to the facility, she met with them to determine their code status. Once the code status was determined she let the direct care staff know, completed the required forms, and ensured the medical provider signed them. Once the required forms were signed by the medical provider, she placed the form in the binder at the nurse's station. The SW stated that since she had been at the facility, she had not had the opportunity to go though and audit the current residents advance directives to ensure all the pieces were in place and accurate. She added that the facility did care plan the advance directives, but she had not completed or updated any since she has been at the facility. The SW was unaware that Resident #47's care plan did not match his current order for full code status. She stated she would correct that as soon as possible. The Director of Nursing (DON) was interviewed on 07/15/22 at 12:44 PM. The DON stated that when a resident's advance directives were obtained, they should be entered into the electronic medical record and then placed in the binder at the nurse's station for easy access if the computers were down or in an emergency. The DON stated if there was a care plan in place the SW should update the care plan to reflect the current residents advance directives. 2. Resident #131 was admitted to the facility on [DATE]. Review of a Physician order dated 07/05/22 read, Full code. Review of a Social Services assessment dated [DATE] revealed Resident #131 was cognitively intact. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the advance director binder at the nurse's station revealed a Do Not Resuscitate (DNR) form dated 07/06/22 and a Medical Order for Scope of Treatment (MOST) form that indicated DNR. The Social Worker (SW) was interviewed on 07/12/22 at 4:15 PM. The SW stated she had only been at the facility for a few weeks. She explained that when a resident admitted to the facility, she met with them to determine their code status. Once the code status was determined she let the direct care staff know, completed the required forms, and ensured the medical provider signed them. Once the required forms were signed by the medical provider then she placed the form in the binder at the nurse's station. The SW stated that since she had been at the facility, she had not had the opportunity to go though and audit the current residents advance directives to ensure all the pieces were in place and correct. The SW was unaware that Resident #131's advance directives did not match the current order for full code status. She stated she would correct that as soon as possible. The Director of Nursing (DON) was interviewed on 07/15/22 at 12:44 PM. The DON stated that when a resident's advance directives were obtained, they should be entered into the electronic medical record and then placed in the binder at the nurse's station for easy access if the computers were down or in an emergency. The DON stated that all pieces of the advance directive process should match including the order and MOST form along with the accompanying DNR form if needed. 37280 3. Resident #22 was admitted to the facility on [DATE]. A review of Resident #22's revised care plan dated 07/26/21 revealed the Resident's Advanced Directive was care planned as a Full Code. A review of Resident #22's electronic medical record revealed an Advanced Directive order dated 03/31/22 for a Do Not Resuscitate (DNR). The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #22 was cognitively intact. An interview was conducted with the Social Worker (SW) on 07/12/22 at 4:15 who stated that she had only been employed at the facility for a few weeks. The SW explained that the facility did care plan the Advanced Directives and the care plan should match the desired Advanced Directive. The SW continued to explain that there was an audit for the Advanced Directives, but she had not had an opportunity to conduct the audit. She stated she was not aware of any discrepancies in the Advanced Directive system. During an interview with the Minimum Data Set Nurse #1 on 07/12/22 at 5:59 PM the Nurse stated she had only been employed since January 2022 and explained that she was not sure who was responsible for auditing the Advanced Directives but stated that if the facility care planned the Advanced Directives then both the electronic health record and the care plan should match. An interview was conducted with the Director of Nursing (DON) on 07/15/22 at 12:29 PM. The DON explained that the residents' desired Advanced Directive should match in all areas of the medical record and if the facility chose to care plan the Advanced Directive then it should match as well. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conference with the Administrator, Regional Director of Operations (RDO) and the Director of Nursing on 07/15/22 at 12:42 PM, the RDO explained that the Advanced Directives should be in the computer and should match the care plan if the facility chose to care plan the Advanced Directive. The Administrator indicated the DON would be responsible for auditing the Advanced Directive system and he would ensure compliance.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on record reviews, resident and staff interviews, the facility failed to resolve a grievance for 1 of 1 resident reviewed for grievances (Resident #68). The findings included: Resident #68 was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #68 is cognitively intact. Review of the grievance filed by Resident #68 on 4/11/22 indicated his concern with a lack of a contract for transportation to leave the facility. The response by Administrator #2, who was no longer employed at the facility, was that facility previously had a contract with local transportation company for residents to be able to go into the community to purchase desired items, but she would verify if the contract was current or if each resident required their own contract. Additionally, the form indicated Administrator #2 would have a social worker to assist. Attempts to contact Administrator #2 were unsuccessful during the survey. An interview with Resident #68 was conducted on 07/12/22 at 1:33 PM. Resident #68 reported he was concerned that the facility no longer had a contract with the local transportation company which prevented him from being able to leave the facility to purchase items he would like. He reported that he had not been able to go to the local store to buy items for almost a year and it bothered him because he used to be able to have them pick him up and be able to leave the facility occasionally and Resident #68 said no resolution had been implemented and the ability to use the transportation was still not available to his knowledge. On 07/12/22 at 2:18 PM during a Resident Council meeting, Resident #68 vocalized the concern of not to being able to leave the facility to purchase personal items due to the facility not having a contract with the local transportation company any longer. Other members of the council vocalized they were aware and had been told they could no longer ride the local bus transportation and it was frustrating not to be able to leave the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 07/15/22 at 2:17 PM revealed he had been made aware since his arrival earlier in the week that Resident #68 was concerned with not being able to use the local public transportation and he had been working to locate the reason. He also had reviewed the grievance filed by Resident #68 on 04/11/22 and it did not appear to have a resolution included. He stated the expectation was for grievances to be presented to the social worker as soon as they were completed. The social worker would then bring them before the clinical team during morning meeting and distribute them to the appropriate department which was to handle locating and putting a resolution in place. He stated grievances resolutions should, when possible, have a solution in place within 72 hours of the appropriate department receiving the concern/grievance and a member of the staff should provide a copy of the resolution/solution to the resident or member who voiced the concern. Administrator #1 was unable to confirm whether the facility had a current contract with the transportation company and the response to the 4/11/22 grievance was inaccurate which indicated the facility had a current contract with the local transportation company.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on record review and facility staff interviews, the facility failed to allow a resident to remain in the facility during an active discharge appeal process for 1 of 2 residents (Resident #21) reviewed for discharges. The Findings included: Resident #21 was initially admitted to the facility on [DATE]. Review of Resident #21's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #21 was severely impaired cognitively. The electronic and hard copy medial record for Resident #21 revealed no information about discharge planning. Review of Resident #21's electronic medical record revealed he was discharged from the facility on 05/06/22. Review of the discharge summary dated 05/06/21 revealed Resident #21 was being discharged to a sister facility due to increased wandering and behaviors. Review of the appeal hearing information revealed the hearing officer determined that Resident #21's discharge from the facility was not appropriate, sided with Resident #21, and required the facility to readmit Resident #21. An attempted phone interview was conducted with Resident #21's representative on 07/15/22 at 3:42 PM. They were unable to be reached. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Administrator #2 (who worked at the facility at the time of the discharge) on 07/14/22 at 2:59 PM, she reported she issued Resident #21 a 30-day discharge notice dated 03/30/22 due to increased behaviors and wandering and felt the facility could not meet the needs of Resident #21 and keep him safe. She reported shortly after she issued the discharge notice, she was notified via letter (unable to recall the date of the letter) Resident #21's representative was appealing the discharge. She reported after she received the appeal notice, she was made aware that Resident #21's representative looked for other placement opportunities. Administrator #2 was unable to recall who made her aware of this information. She insisted when she discharged Resident #21 on 05/06/22, she was under the impression that Resident #21's representative was ok with the transfer since Resident #21's representative arrived at the facility to assist with moving Resident #21 to the new facility. She revealed she never spoke with the resident's representative personally to determine if they approved of the discharge to the sister facility. Administrator #2 stated once Resident #21 was discharged to the other facility, she thought the appeal was over, then several weeks later she received a telephone call from the discharge appeal hearing office asking if she was aware she had a discharge appeal hearing scheduled. She reported she immediately contacted Social Worker #2 and they sat in on the hearing and were told the discharge appeal was upheld (meaning Resident #21 would be allowed to remain in the facility). Administrator #2 also reported there was a blue folder in the facility that had information about the discharge planning process that was kept in her office. During an interview with the current Administrator, Administrator #1, on 07/15/22 at 1:02 PM, he reported he had looked for the blue folder Administrator #2 reported having, that held the discharge planning information, but after 3 days of looking, he was unable to locate it. During an interview with Social Worker #2 on 07/14/22 at 2:16PM, she reported she no longer worked at the facility but was present at the time of Resident #21's the discharge. She reported when she arrived at the facility in early April 2022 to begin working as the facility's social worker, the discharge notice had already been provided to Resident #21's representative (03/30/22) and a bed had been secured at a facility that had a secured unit due to Resident #21's increased wandering and behaviors. She stated she never received any communication from Resident #21's representative notifying her that they were appealing the discharge and stated the first time she knew the discharge had been appealed was when she was contacted to be a part of a discharge hearing. During an interview with Director of Nursing #2 (who worked at the facility at the time of discharge) on 07/14/22 at 12:39 PM, she reported they (the administrative team) looked into transferring Resident #21 to a secured memory care unit towards the end of December 2021/early January 2022. She reported they received a bed offer at a sister facility sometime in March 2022 and had included Resident #21's representative in the discharge planning process. She reported she had multiple conversations with Resident #21's representative and insisted they were onboard with the transfer of Resident #21 to the secured unit. She also stated she was not aware that there had been an appeal filed until the hearing date. An interview with the current Director of Nursing on 07/15/22 at 12:40 PM, she reported she was not at the facility at the time of Resident #21's discharge and did not know why the facility continued to discharge Resident #21 with an active appeal. She stated if the Administrator #2 was aware of a filed discharge appeal, then Resident #21 should not have been discharged until the completion of the discharge appeal process. She also reported she had assisted the Administrator #1 and attempted to locate the blue folder that allegedly had the discharge planning information in it with no luck. She reported she was unable to determine if discharge planning had occurred for Resident #21.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on record review, resident, and family interview the facility failed to invite 1 of 1 resident or family to a care plan meeting (Resident #72). The findings included: Resident #72 was readmitted to the facility on [DATE] and was discharged to the hospital on 07/10/22. Review of a quarterly minimum data set (MDS) dated [DATE] revealed that Resident #72 was cognitively intact. Review of Resident #72's medical record revealed no documentation of a recent care plan meeting. Resident #72 was interviewed via phone on 07/11/22 at 2:25 PM. Resident #72 stated that she had been a resident at the facility for years and was currently in the hospital. She stated over the last 6 months to a year she had not been invited or participated in a care plan meeting with the facility. She stated that her family visited the facility almost daily and they were always available to attend the care plan but had not received any notification of one in a long time. Resident #72's family member was interviewed via phone on 07/11/22 at 2:49 PM. The family member stated that while Resident #72 was in the facility he visited almost daily. The family member stated that it had been a good while since he recalled being invited or participated in a care plan meeting. The Social Worker (SW) was interviewed on 07/12/22 at 4:15 PM. The SW explained she had only been at the facility for a few weeks. The SW stated that since she had been at the facility, she had not made it to the point where she was completing care plan meetings with the family or resident. She stated she believed someone else was handling that. The former Director of Nursing (DON) was interviewed via phone on 07/14/22 at 12:19 PM. The former DON stated she was at the facility from February 2022 until the end of June 2022. She stated that when she came to the facility in February 2022, they did not have a SW, and no one was setting up care plan meetings with the resident or family. She explained that when the facility got a SW in April 2022, she and the SW began arranging care plan meeting with the resident and family but stated she was only the member of nursing management, and she could not attend every meeting that was held but did try to attend some of them. The former DON stated she did not recall having a care plan meeting with Resident #72 or her family while she was in the facility. The former SW was interviewed on 07/14/22 at 2:21 PM who confirmed she worked at the facility from April 2022 to July 2022. She stated that she coordinated the care plan meetings at the facility and would invite the resident and family. The former SW stated that she did not have the opportunity to coordinate any care plan meetings for Resident #72 while she was in the facility and was unable to tell me the last time Resident #72 had a care plan meeting with the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS Nurse #2 was interviewed on 07/14/22 at 2:29 PM. She explained that the facility did not have a MDS nurse, and she and a co-worker traveled to the facility every other week to keep the assessments up to date. MDS Nurse #2 stated that they did not handle the care plan meeting with the residents or family and stated the former DON had been working at getting those caught up before she left the facility. The DON was interviewed on 07/15/22 at 1:18 PM. The DON stated that she had only been at the facility for 2-3 weeks and indicated that the SW was coordinating care plan meeting with the resident and family. She stated she had not been involved in a care plan meeting with Resident #72 since she came to work at the facility. The Administrator was interviewed on 07/15/22 at 3:00 PM and stated that he had only been at the facility for 2 days. The Administrator stated that it was best practice to invite resident and families to care plan meetings.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review, staff, resident, and Wound Physician interview the facility failed to transcribe and carry out treatment orders to a non-pressure related wound for 1 of 2 residents reviewed with non-pressure skin issues (Resident #39). The findings included: Resident #39 was readmitted to the facility on [DATE] with diagnoses that included: non-pressure ulcer of buttock and left heel. Review of a quarterly minimum data set (MDS) dated [DATE] revealed that Resident #39 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed that Resident #39 required application of non-surgical dressing other than to feet and no pressure ulcers were noted during the assessment reference period. Review of a physician order dated 07/02/22 read; cleanse right lower leg with wound cleanser, pat dry, apply calcium alginate and dry dressing daily and as needed. Review of a Wound Physician (WP) progress note dated 07/06/22 read in part: Resident #39 has a wound to right distal shin that was full thickness wound. The wound measured 0.8 centimeters (cm) x 0.8 cm with light serous exudate (drainage). The dressing treatment plan read: Leptospermum honey apply once daily for 30 days with gauze or border gauze daily for 30 days. Review of a nurses note dated 07/06/22 at 1:56 PM read, resident seen this am by wound doctor. No new orders at this time. Signed by Nurse #9. Review of the Treatment Administration Record (TAR) for July 2022 revealed the following: Right lower leg cleanse with wound cleanser, pat dry, apply calcium alginate and dry dressing daily and was initialed by staff indicating the dressing had been completed as ordered since 07/02/22. An observation and interview were conducted with Resident #39 on 07/11/22 at 12:02 PM. Resident #39 was resting in bed. He stated that he currently had a wound to his right shin and proceeded to pull the sheet off and revealed a piece of gauze covering the wound with no date noted. Resident #39 stated that he saw the WP every week and he ordered whatever he felt was appropriate for the area but was not sure what he had ordered during his last week visit. An observation and interview were conducted with the WP on 07/13/22 at 11:08 AM. The WP stated he visited the facility weekly and rounded with a staff member. He explained that Resident #39 had several non-pressure related issues including his right shin which he saw last week an ordered Leptospermum honey every day and as needed. The WP removed the dressing that was in place to the right shin and took measurements. The wound measured 0.5 cm x 0.3 cm, and the WP indicated that there was improvement noted. He stated that he dictated his orders in his wound report which were automatically uploaded into the facility's electronic medical record generally the same day as his visit and he expected the staff to enter the order and carry those orders out. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Assistant Director of Nursing (ADON) was interviewed on 07/13/22 at 11:50 AM. The ADON stated that she reviewed the WP reports that were automatically uploaded into the electronic system each week and updated any orders that had been changed. She stated that at times the staff member who rounded with the WP was aware of the order change, would take care of entering those orders. The ADON stated that she was playing catch up and had not a chance to review the reports from last week and was currently working her way through them. Nurse #2 was interviewed on 07/14/22 at 3:13 PM. Nurse #2 confirmed that she had cared for Resident #39 on 07/10/22 and 07/11/22 and had completed his wound treatments as ordered. She could not recall what the specific treatments where but recalled put a dressing on Resident #39's right shin as directed. Nurse #2 stated that the WP usually visited the facility weekly but she did not round with him so she would complete wound treatments per the resident current order on the TAR. An attempt to speak to Nurse #9 who rounded with the WP on 07/06/22 was attempted on 07/15/22 without success. The Director of Nursing (DON) was interviewed on 07/15/22 at 12:57 PM. The DON stated that the ADON was ultimately responsible for reviewing the weekly wound report from the WP and ensuring the orders were entered and carried out. The DON explained that when the WP visited on 07/06/22 he verbally told Nurse #9 no new orders but when his report came in there was new orders. The DON stated that the ADON should have reviewed the WP progress note and ensured the correct order was entered and carried out.

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on record review, resident, family, and staff interviews the facility failed to provide incontinence care before the resident wet through her brief and bed linens (Resident #72) and provide assistance to maintain personal hygiene (Resident #131) for 2 of 5 resident reviewed for activities of daily living. The finding included: Resident #72 was readmitted to the facility on [DATE] with diagnoses of Guillain Baree syndrome and dementia and was discharged from the facility on 07/09/22. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #72 was cognitively intact and required extensive assistance of one staff member for toileting and was always incontinent of bladder. Review of the facility daily assignment sheet for 07/09/22 for 3:00 PM to 11:00 PM revealed that Nurse Aide (NA) #3, NA #10, and NA #11 were assigned on the unit where Resident #72 resided. An interview was conducted with Resident #72's family member on 07/11/22 at 1:58 PM who stated on 07/09/22 she received a video call from Resident #72 at 9:08 PM. She stated that Resident #72's call light was on, and she needed to be changed. She stated that Resident #72 stated that she had turned the call light about 20 minutes prior to calling the family member and had reported that the last time she had received incontinent care was at 1:30 PM. The family member stated that while on the video call with Resident #72 a staff member who she could not recall their name came in and when Resident #72 stated she needed to be changed the staff member stated that she was not assigned to Resident #72 that shift and then exited the room. The family member stated that about 10 minutes later another staff member came into the room to provide incontinent care but by that time Resident #72, her brief, and bed were all wet and needed to be changed (via the video call). Resident #72 was interviewed via video call on 07/11/22 at 2:25 PM and stated on 07/09/22 she had remained in bed all day. She stated that the staff had woken her up at 5:30 AM to provide incontinent care and then again at 1:30 PM. Resident #72 stated that she did not see the staff again until around 9:15 PM (time on her tablet device) when a staff member came in to answer her call light that had been a while but when she told the staff member, she needed to be changed the staff member stated that she was not assigned to take care of Resident #72 that shift and then left the room. Resident #72 stated that about 10 minutes later a new staff member came in to provide incontinent care to her. She stated by that time she was wet and so was her bed and everything had to be changed. NA #4 was interviewed on 07/11/22 at 5:57 PM and confirmed that she had cared for Resident #72 on first shift (7:00 AM to 3:00 PM) on 07/09/22. She stated that when she arrived for her shift, she checked Resident #72 who was dry and then she checked her again around 11:00 AM and she was still dry. NA #4 stated that she provided incontinent care to Resident #72 around 1:30 PM before she left for the day. She added she was slightly wet, but her bed was dry so, she only had to change her brief. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Nurse Aide (NA) #3 was interviewed on 07/12/22 at 2:33 PM and reported she was working on 07/09/22 from 3:00 PM to 11:00 PM and had answered Resident #72's call light because her assigned NA was on break. NA #3 stated that she answered the call light at approximately 9:30 PM and was not sure who was assigned to care for Resident #72 because that was her first day in the facility in 2 years. NA #3 stated that when she answered her call light Resident #72 was on the phone with her family member and was wet and needed to be changed. She stated that her bed was also wet and needed to be changed, they (sheets) were not saturated but I did not want to leave them soiled. NA #3 did not know which staff member had previously answer Resident #72's call light or how long the call light had been on. NA #10 was interviewed on 07/13/22 at 11:02 AM and confirmed that she worked 07/09/22 from 3:00 PM to 11:00 PM on the unit where Resident #72 resided but stated she did not provide any care to her. She stated she answered her call light around dinner time, and she wanted a cup of ice and that was given to her, she did not mention needing incontinent care at that time. NA #11 was interviewed on 07/13/22 at 1:19 PM and confirmed she worked on 07/09/22from 3:00 PM to 11:00 PM on the unit where Resident #72 resided. She stated she was assigned to sit with another resident on that unit and did not provide any care to Resident #72 during that shift. The Regional Nurse Consultant was interviewed on 07/15/22 at 1:18 PM. She stated that the facility staff were to round on each resident before and after meals, at bedtime and as needed. She stated that Resident #72 should have been checked before and after her evening meal and again at bedtime and if her call light was on then as requested. 2. Resident #131 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease. Review of Social Service assessment dated [DATE] revealed Resident #131 was cognitively intact. Review of the facility's shower schedule revealed Resident #131 was scheduled for showers on Wednesday and Friday on first shift. Review of Resident #131's documentation report for bathing dated July 2022 indicated that on first shift on Wednesday 07/06/22 Nurse Aide (NA) #4 documented a partial but did not specify if it was a bed bath or shower and on Friday 07/08/22 NA #5 documented a bed bath. An observation and interview were conducted with Resident #131 on 07/11/22 at 10:28 AM. Resident #131 was resting in bed dressed in a pajama top and bottom. Resident #131's hair was standing up in spots and appeared almost wet with oil and the bottom of her feet were black with dirt. She stated that her showers were scheduled for Wednesday and Friday morning, but she had not had a shower since she admitted on [DATE]. She stated she asked a staff member this morning for a shower, and they told her it was not her shower day, but she did not know who the staff member was. Resident #131 stated she had an appointment on Friday, and she wanted to be sure she had a shower before her appointment. An observation and interview were conducted with Resident #131 on 07/12/22 at 11:08 AM. Resident #131 was resting in bed dressed in a pajama top and bottom. Resident #131's hair was standing up in spots and appeared almost wet with oil and the bottom of her feet were black with dirt. She again stated she had asked for a shower yesterday and did not get it. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	NA #5 was interviewed on 07/13/22 at 7:59 AM and confirmed that she cared for Resident #131 on Wednesday 07/06/22. She stated that Resident #131 had just admitted to the facility the day before and she did not have any clothes with her. She stated she set her up with a wash basin and wash cloth so she could wash her face. NA #5 stated that Resident #131 did not have a shower that day, but she did not know why, she stated maybe there was a shower team or maybe she had not been added to the shower sheet yet but again did not know why Resident #131 did not have a shower that day. NA #5 stated that their assignment sheet indicated who was scheduled for a shower that day and if there was no shower team then the NAs on the hall were responsible for completing the scheduled showers. NA #4 was interviewed on 07/13/22 at 10:28 AM and confirmed that she cared for Resident #131 for the first time on Friday 07/08/22. NA #4 stated that she did not give Resident #131 a shower on Friday 07/08/22 and she was not sure if there was a shower team or not. She stated that recently they have been lucky and had a shower team often but did not recall if they had one on 07/08/22. NA #4 stated that there was a paper at the nurse's station that told them who was scheduled for a shower each day, but she could not recall why Resident #131 did not get one on 07/08/22. NA #1 was interviewed on 07/14/22 at 2:04 PM who confirmed that she cared for Resident #131 on 07/11/22 and 07/12/22. She stated that on 07/11/22 Resident #131 did ask for a shower but it was not her scheduled shower day and was told her that her scheduled shower day was on Wednesday, and she seemed ok with that. The Director of Nursing (DON) was interviewed on 07/15/22 at 12:41 PM. The DON stated that showers were scheduled based upon room or by resident preference and should be given as scheduled. If the resident requested a shower on a non-scheduled shower day, then it should be given by the staff as requested by the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review, resident, family, staff, and Medical Director interviews the facility failed to protect a resident from falling from the bed to the floor during personal care for 1 of 3 resident reviewed for supervision to prevent accidents (Resident #72). The findings included: Resident #72 was readmitted to the facility on [DATE] and was discharged to the hospital on 07/09/22. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #72 was cognitively intact and required one person assistance with bed mobility, toilet use, and personal hygiene. The MDS also indicated Resident #72 had no falls since the previous assessment. Review of a fall care plan updated 06/28/22 read; the resident was at risk for falls related to impaired mobility. The goal stated that resident would be free of falls through the review date. The interventions were: be sure the residents call light was within reach and encourage the resident to use it for assistance as needed (added 06/29/20), follow the fall protocol (added 06/29/20), and when resident was in bed place all necessary personal items within reach (added 06/29/20). Review of an incident report dated 07/09/22 read in part, per Nursing Assistant (NA) #3; she was changing resident's brief and turned to throw the soiled brief in the trash when resident started sliding off her bed on the right side. NA #3 stated she quickly got to resident's side and assisted resident to the floor. Resident was observed by staff lying on her left side on the floor, face down. Resident #72 complained of left arm, left shoulder, and left foot pain. The Medical Doctor (MD) was notified, and resident was transferred to the emergency room (ER) for evaluation per family request. Event occurred around 9:45 PM. Resident description: unable to give description. Immediate action taken: transported to the ER for evaluation and staff educated resident to be 2 person assist with positioning and incontinent care. The report was completed by Nurse #4. Review of a hospital Emergency Department Discharge Report dated 07/11/22 read in part; Discharge Diagnoses: Fall: accidentally fell out of bed after being turned while being changed by nursing home-landed on her left side. X-ray of the tibia, fibula, left femur and pelvis did not show any evidence of acute fracture or dislocation involving the pelvis, left femur, or left leg. Resident #72's family member was interviewed on 07/11/22 at 1:58 PM. The family member stated that on 07/09/22 around 9:00 PM she received a video call from Resident #72. A staff member entered the room and was going to change Resident #72, she took the tablet that was on video call and sat it on the side of the bed. The family member stated that she could hear the interaction between Resident #72 and the staff member who she did not know. The family member stated she heard the staff member tell Resident #72 that this was her first night in the facility and asked Resident #72 to turn onto her side and shortly after she heard Resident #72 say I am sliding I am going to fall and the staff member replied, no honey you're not going to fall your fine and then the family stated we heard Resident #72 fall out of bed to the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview with Resident #72 were conducted on 07/11/22 at 2:25 PM via video conference call. Resident #72 was resting in a hospital bed and was dressed in a gown. Resident #72 was observed to have extensive dark purple bruises to her left hand, wrist, and arm as well as her chest and both breast. Resident #72's left knee was slightly swollen with some faint bruising noted. She recalled the evening of 07/09/22 and stated a new staff member who she had never seen before and did not know her name answered her call light that had been on for a while. When the staff member came into my room, I told her I was wet and had not been changed since 1:30 PM so she proceeded to put both of my side rails down and turned me to one side and then the other and the next thing I know I am screaming I am falling, and the staff member stated no you're not and then I fell to the floor. Resident #72 stated when she fell her left wrist, arm, and knee where hurting but she was mainly uncomfortable being on the hard cold floor. She added that she did not want to return to the facility and the hospital was working on finding her a new place to go. Nurse #4 was interviewed on 07/11/22 at 6:11 PM. Nurse #4 stated that on 07/09/22 she was sitting at the nurse's station when NA #3 came to the desk and reported that she was providing incontinent care to Resident #72, and she turned to throw the soiled brief in the trash can and Resident #72 started sliding off the bed on the right side and she quickly got to her and assisted her to the floor. Nurse #4 stated that Resident #72 generally kept her bed high and when she entered the room the bed was kind of high. Nurse #4 stated she and Nurse #18 entered Resident #72's room she was lying on the floor face down on her left side. One of her legs was bent behind the other and she complained of left arm, shoulder, and foot pain. Her family member was on the phone during this time when she fell . Nurse #4 stated that they put a pillow under her head and covered her with a blanket and called EMS. Resident #72 had no visible injuries at the time. Nurse #4 could not recall if the side rails were up or down but stated that NA #3 was alone in the room with Resident #72 at the time of the fall An observation of Resident #72's room was conducted on 07/12/22 at 2:00 PM. Resident #72's bed was the bed closest to the door Resident #72's bed was a standard pressure reducing mattress. The empty bed on the other side of the room was an air mattress that had been deflated and was not made. No personal effects were noted on that side of the room. Nurse #18 was interviewed on 07/12/22 at 3:37 PM and confirmed he was working on 07/09/22 on the unit where Resident #72 resided but was working the other end of the hall. He stated he was doing treatments on his end of the hall when NA #3 approached him to tell me Resident #72 had fallen out of bed. Nurse #18 stated he entered the room at the same time as Nurse #4 did and found Resident #72 face down on her left side Resident #72 complained of left shoulder pain and left leg pain, and we placed a pillow under head and made her comfortable until EMS arrived. Nurse #18 stated Resident #72 had no visible injuries at the time, but her family was on the phone during this time and was also reassured that we were going to assess Resident #72 and were going to send her to the ER for evaluation. Nurse #17 was interviewed on 07/12/22 at 3:49 PM and confirmed that she was the nurse responsible for Resident #72 on 07/09/22 when she fell . The NA reported that she was providing incontinent care to Resident #72 and she rolled out of bed but she tried to break her fall and lowered her to the floor. Nurse #17 stated when she entered Resident #72's room she found her lying on her left side on the floor, she appeared to be scared and was complaining of left arm and knee pain. Nurse #17 stated that Resident #72 was on the phone with her family at the time of the fall. She stated she tried to assess Resident #72 from the position she was in and did not see any visible injuries, her vital signs were obtained, and we put a pillow under her head and called EMS who was there very quickly and transported Resident #72 to the ER. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NA #3 was interviewed on 07/12/22 at 2:33 PM and confirmed she was working on 07/09/22 when Resident #72 fell . She explained that 07/09/22 was her first time working at the facility since 2020 and first time rendering any care to Resident #72. Resident #72's call light was on, and she answered the light since her assigned NA was on lunch. NA #3 stated that Resident #72 was on the phone with her family at the time, but I proceeded to provide incontinent care to her. She stated that she began to provide care to Resident #72 because her brief was wet and so was her sheets and bed. She added that Resident #72's side rails were up, and she left them up. She started out on Resident #72's right side and turned her towards the left side of bed, NA #3 stated she tucked the bed sheets that were wet, and the soiled brief under Resident #72 and then went to Resident #72's left side and turned her toward the right side of the bed. NA #3 stated she pulled the soiled linen and brief out from under Resident #72 and turned to her left to throw them in the trash can and Resident #72 started to fall out of bed I tried to grab her and could not grab her because she was too far over, and I was not able to catch her so I moved to the other side of the bed and tired to break her fall. NA #3 stated that Resident #72's feet rolled out of the bed first and then her top half which was what she was able to assist to the floor. Resident #72 was screaming to get help and Nurse #17 was the first person in the hallway she came to. Nurse #17 immediately went to the room and NA #3 explained she then went to find Resident #72's nurse. Her family member that was on the phone did not want us to touch her, she wanted EMS called. We were able to obtain vital signs which were stable, and she had no bleeding. Resident #72 was complaining of arm pain but she was scared for the most part. EMS arrived quickly and before she left, she told her family that she would call them once she got to the hospital. The Director of Nursing (DON) was interviewed on 07/15/22 at 1:18 PM. The DON stated that when a resident fell in the facility they were immediately assessed by a nurse. If there is visible injury they would contact the MD before moving the resident. If the resident hit their head, we would not move them. Vital signs were obtained, pain was evaluated, skin assessment including range of motion should all be completed post fall. The staff should be documenting, completing the appropriate paperwork, and notifying the appropriate people. The DON stated that they had looked at Resident #72's fall but not in depth. The goal of the facility was to determine root cause of the fall and implement an intervention to prevent the fall from happening again. The Administrator was interviewed on 07/15/22 at 11:45 AM. The Administrator had been at the facility for 2 days and stated there was no doubt in my mind that she needed two person in that room. The MD was interviewed on 07/15/22 at 10:26 AM. She stated that she had been told that Resident #72 had fallen out of bed. She indicated that Resident #72 had a lot of stiffness and would not be able to react in an appropriate amount of time. The MD stated that educating the staff on how to properly turn a resident and to ensure all supplies were within reach before starting the task were so important to keep the resident safe. She continued to say that Resident #72 did not have behaviors of falling on her own accord and could not get up on her own.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on observations, record reviews, staff, Resident and Physician interviews the facility failed to secure an oxygen tank that was stored upright on the floor in a resident room (Resident #63), failed to provide water humidification for 2 residents (Resident #31 and Resident #39), failed to clean the oxygen concentrator filters for 1 resident (Resident #31) and failed to maintain oxygen tubing in good working condition for 1 resident (Resident #39) for 3 of 4 residents reviewed for respiratory therapy. The findings included: A review of the facility's Oxygen Safety policy dated 11/01/20 revealed it is the policy of this facility to provide a safe environment for residents, staff and the public. *Oxygen Storage #c revealed Cylinders will be properly changed or supported in racks or other fastenings (i. e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty. 1. Resident #63 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease. The quarterly Minimum Data Set assessment dated [DATE] revealed her cognition was moderately intact and required oxygen therapy. On 07/11/22 at 3:55 PM an observation and interview were conducted with Resident #63. An full tank of oxygen was stored between the bedside table and the wall. The oxygen tank was standing up right and was not secured. The Resident wore an oxygen cannula in her nares that delivered between 2.5 to 3 liters of oxygen per minute delivered by the oxygen concentrator in the room. Resident #63 explained that she needed the oxygen because she became too winded when she went out to smoke. The Resident also explained that the free standing oxygen tank had been in her room for as long as she could remember. On 07/12/22 at 9:21 AM an observation of the free standing oxygen tank remained stored unsecured between the bedside table and the wall. The Resident was not in the room. On 07/12/22 at 2:09 PM an observation was made of the free standing oxygen tank stored unsecured in the room. An interview and observation was conducted with Nurse #7 on 07/12/22 at 4:08 PM who confirmed she was generally the nurse for Resident #63. The Nurse explained that Resident #63 wore continuous oxygen at 2 liters per minute because she easily became short of breath on exertion without the oxygen. Nurse #7 was accompanied to Resident #63's room and acknowledged the free standing full oxygen tank stored unsecured in the corner of the Resident's room. The Nurse explained that the oxygen tank should have been taken to the oxygen supply storage room because of the potential for explosion and retrieved a transport cart for the oxygen and returned the oxygen tank to the storage room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/15/22 at 12:29 PM an interview was conducted with the Director of Nursing (DON) who explained that the oxygen tank should not have been stored in the Resident's room and should have been stored in the oxygen supply room until needed. During an interview with the Administrator on 07/15/22 at 2:33 PM he explained that the oxygen tanks should be stored in the oxygen supply room and residents with oxygen should have physician orders to support the use of the oxygen. 2. Resident #31 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease. a. A review of Resident #31's medical record revealed a physician order dated 03/06/22 to change oxygen and nebulizer tubing (label and date tubing), humidification bottle, bag cover and clean filters on concentrator every week on Sunday night shift. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #31 was cognitively intact and required oxygen therapy. On 07/11/22 at 11:08 AM an interview and observation were made of Resident #31. During the interview an observation was made of the condition of the filters on the oxygen concentrator which were gray and were covered with white dust that rippled when touched. The Resident explained that the nurses changed her nasal cannula once a week but did not clean the filters. The Resident stated she cleaned the filters when she felt like it. On 07/11/22 at 1:48 PM an interview was conducted with Nurse #5 who confirmed she was assigned to Resident #31. The Nurse explained that the filters on the oxygen concentrators were cleaned once a week by third shift. She continued to explain that it was every nurses' responsibility to check the oxygen setting, condition of the oxygen tubing, humidification and condition of the filters every time they go into the residents' rooms. The Nurse accompanied the Surveyor to Resident #31's room to view the condition of the oxygen filters. The Nurse acknowledged the dirty filters on each side of the oxygen concentrator and stated, oh no, it shouldn't be like that, it should be cleaned because the dirt could impede the flow of clean oxygen. The Nurse cleaned the oxygen filters. b. On 07/14/22 at 3:11 PM an observation was made of Resident #31's water humidification bottle which was dry and completely void of water. The humidification bottle was dated 05/08/22. The Resident was not in her room. During an interview with Nurse #2 on 07/14/22 at 3:15 PM the Nurse acknowledged that she was the one that changed the water humidifier bottle on 05/08/22 and stated the bottle had been dry all day. The Nurse explained that the facility had been out of water humidification bottles for the oxygen concentrators for a while and she had asked the Central Supply Clerk (CSC) to order them, but he ordered the wrong type. The Nurse accompanied the Surveyor to the medical supply room where there was an ample supply of water humidification bottles, but they were the wrong type of bottles to fit Resident #31's oxygen concentrator. The Nurse stated the CSC was aware of the water humidification bottle shortage. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/14/22 at 3:29 PM an interview was conducted with Resident #31 in the Resident's room. The Resident explained that when she went to bed last night (07/13/22) she only had a little water left in the humidification bottle and when she woke up that day (07/14/22) the water was gone. The Resident continued to explain that she needed the humidification because without it she developed sores in her nose. The Resident stated she did not have sores as of that time, but her nares were dry. The Resident stated the facility was aware that there was no water in the humidification bottle and that the facility had trouble getting the correct water humidification bottles for her concentrator. During an interview with the Central Supply Clerk (CSC) on 07/14/22 at 4:14 PM he stated he had only been the CSC since 05/2022 and received no orientation to ordering the supplies. He explained that in June he realized he was not ordering the oxygen humidification bottles fast enough so he ordered some and realized they were the wrong type than what they needed. The CSC continued to explain that he ordered the correct type that day (07/14/22) and the supply should be delivered on Sunday 07/17/22 or Monday 07/18/22. On 07/15/22 at 8:16 AM an interview was conducted with the Regional Director of Operations (RDO) who explained that the facility conducted an audit and inventory of the water humidification bottles and obtained what was needed from their sister facility as well as ordered more supply. The RDO indicated that when the facility realized they would not have enough supply to get through to the next delivery, they should have obtained the water humidification supply from the sister facility. An interview was conducted with the Medical Director who was Resident #31's Physician on 07/15/22 at 10:53 AM. The Physician explained that the purpose for the water humidification was for comfort and to reduce dryness and sinusitis. She continued to explain that if the resident complained of dryness then they needed the humidification especially if they used oxygen long term which Resident #31 did. The Physician stated she would expect the facility to maintain a supply of water humidification bottles. An interview was conducted with the Director of Nursing (DON) on 07/15/22 at 12:20 PM. The DON explained that the oxygen filters were cleaned once a week and more often when needed. She indicated the nurses should be checking the filters when they go into the residents' room. The DON also explained that it was unacceptable for the facility to run out of water humidification bottles and indicated the facility had retrieved an ample supply from their sister facility. During an interview with the Administrator, Regional Director of Operations (RDO) and the Director of Nursing on 07/15/22 at 12:42 PM the Administrator stated the facility should have utilized all their resources for the water humidification bottles and would do so going forward. He explained that he would educate the staff to call him when they ran out of supplies. 35789 3. Resident #39 was readmitted to the facility on [DATE] with diagnoses that included heart disease. Review of a physician order dated 03/04/22 read; oxygen at 2 liters per minute via nasal canula or to maintain oxygen saturation level above 92%. Change oxygen tubing and humidification bottle every week on Sunday night. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #39 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed Resident #39 had no shortness of breath and used oxygen during the assessment reference period. Review of the MAR dated July 2022 revealed the following: change oxygen tubing and humification bottle every week on Sunday night. On Sunday 07/03/22 Nurse #10 initialed the order indicating the change had occurred and on Sunday 07/10/22 Nurse #11 initialed that she had completed the change. An observation and interview were conducted with Resident #39 on 07/11/22 at 12:04 PM. Resident #39 was resting in bed with an oxygen canula in his nose that was connected to a concentrator sitting beside his bed. The humidification water bottle was attached and was noted to be empty and was dated 05/09/22. Resident #39 stated that they were supposed to change the water bottle and oxygen tubing every week on Sunday night, but it had been months since it had been changed and the tubing was stretched out from taking it on/off and it did not stay in place. The prongs of the oxygen canula were cloudy in color and the loops over Resident #39's ear were loosely in place with one piece of the foam padding missing. The piece of the oxygen canula that was used to secure the tubing under Resident #39's chin would not stay up and when he pulled it tight and let go the piece would fall down on the tubing and the tubing would start lifting from his ears. An observation and interview were conducted with Resident #39 on 07/12/22 at 11:02 AM. Resident #39 was resting in bed with an oxygen canula in his nose that was connected to a concentrator sitting beside his bed. The humidification water bottle was attached and was noted to be empty and was dated 05/09/22. Resident #39 stated that they still had not changed his oxygen canula and the prongs of the canula remained cloudy and the loops over Resident #39's ear were loosely in place with one piece of the foam padding missing. The piece of the oxygen canula that was used to secure the tubing under Resident #39's chin would not stay up and when he pulled it tight and let go the piece would fall down on the tubing and the tubing would start lifting from his ears. Resident #39 stated that he had asked a nurse to please replace the oxygen tubing she obtained the tubing and put it in his drawer of his nightstand but did not change it. Resident #39 did not know who the nurse was. An observation and interview were conducted with Resident #39 on 07/13/22 at 12:00 PM. Resident #39 was in bed with his oxygen canula in his nose, the prongs of the canula remained cloudy and the loops over Resident #39's ear were loosely in place with one piece of the foam padding missing. The piece of the oxygen canula that was used to secure the tubing under Resident #39's chin would not stay up and when he pulled it tight and let go the piece would fall down on the tubing and the tubing would start lifting from his ears. Nurse #2 was interviewed on 07/14/22 at 9:42 AM and confirmed she was responsible for Resident #39. She explained that the oxygen tubing and water bottles were changed weekly on Sunday or as needed. She added that they usually changed the tubing and water bottle on night shift but during her shift she would periodically check the oxygen concentrator. Nurse #2 explained that humidification water bottles were changed when they were empty. Nurse #2 was asked to check Resident #39's humidification water bottle at his bedside which was empty and dated 05/09/22, she stated oh my. Resident #39 stated to Nurse #2 that his oxygen tubing was loose and would not stay in place and the pads of the ear loops were gone as well. Nurse #2 replied that she would get him some new tubing but stated that the facility did not have the correct humification water bottle to change out. Nurse #2 stated that the Central Supply clerk had ordered the wrong bottles. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #10 was interviewed on 07/14/22 at 1:16 PM who stated that she did not work in the facility on 07/03/22. She stated she did not recall ever changing Resident #39's water bottle or oxygen tubing. Nurse #11 was interviewed on 07/15/22 at 9:53 PM who confirmed she had cared for Resident #39 on 07/10/22 but could not recall if she had changed his oxygen tubing or humification water bottle. The Administrator and Director of Nursing (DON) were interviewed on 07/15/22 at 1:00 PM. The DON stated that Resident #39's oxygen tubing should have been changed every Sunday night and the humidification water bottle when it was empty. She stated that a lot of the agency staff were just clicking things off without really checking what they were clicking. The Administrator added that this was their opportunity to fix the issue because the facility had a sister facility within walking distance, and we should have used our resources to get what our residents needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35789 Based on observations, record review, and staff interview the facility failed to remove expired medications from 2 of 3 medication carts (100 hall cart and 200 hall cart) and 2 of 2 medication rooms (front medication room and back medication room). The facility also failed to remove unopened insulin pens for 1 of 3 medications carts (100 hall cart) reviewed. The findings included: Review of the manufacture recommendations for Novolog (insulin) Flex pen read in part; unopened flexpen's should be stored in the refrigerator between 36- and 46-degree Fahrenheit. 1. An observation of 100 hall medication cart was made on 07/14/22 at 10:20 AM with Nurse #2. The observation revealed the following expired medications: -Ondansetron (antiemetic) 4 milligrams (mg) 8 tablets that expired on 04/30/22. -Cogentin (used to treat Parkinson's disease) 1 mg 10 tablets that expired on 06/11/22. -Pantoprazole (used to treat reflux) 2 mg/1milliliter (ml) bottle that contained approximately 200 ml of liquid that expired on 07/06/22. The observation further revealed 5 unopened vials of Novolog Flex pen 100 units/ml that were stored in the medication cart. Nurse #2 was interviewed on 07/14/22 at 10:39 AM. Nurse #2 confirmed that she was responsible for the 100-hall medication cart. She stated that she was not sure if the nursing management staff went through the medication carts looking for expired medications. She stated that the hall nurses were expected to go through the medication carts if they had the time. Nurse #2 stated that she had not had the time to go through the medication cart because she had gotten report late and needed to get started with the medication pass and was unaware of the expired medications. She also stated that the 5 vials of unopened insulin should be kept in the medication room in the refrigerator and that whoever received them from the pharmacy just placed them in the wrong spot. The Director of Nursing (DON) was interviewed on 07/15/22 at 2:12 PM. The DON stated that the nurses should be going through the medication carts weekly to remove any expired medications. She added that the nursing management team and the pharmacy staff also tried to help the hall nurses as much as possible. The DON explained the expired medications should have been removed from the medication cart and returned to the pharmacy and the unopened vials of insulin should have been placed in the refrigerator until opened then it could be left on the medication cart for use. 2. An observation of the 200-hall medication cart was made on 07/14/22 at 3:34 PM with Nurse #8. The observation revealed the following expired medication: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Pramipexole (used to treat Parkinson's disease) 0.5 milligrams (mg) 15 tablets that expired on 06/30/22. -Ibuprofen (pain reliever) 600 mg 12 tablets that expired on 06/14/22. An interview was conducted with Nurse #8 on 07/14/22 at 3:40 PM. Nurse #8 stated that at times she would go through the medication cart and check for expired medications but had not noticed the medications that were expired. She explained that she worked through an agency and worked on a different cart each time she was in the building, and it was hard to keep each medication cart neat and orderly and remove all the expired medications without all of the staff assisting. The Director of Nursing (DON) was interviewed on 07/15/22 at 2:12 PM. The DON stated that the nurses should be going through the medication carts weekly to remove any expired medications. She added that the nursing management team and the pharmacy also tried to help the hall nurses as much as possible. The DON explained the expired medications should have been removed from the medication carts and medication rooms and returned to the pharmacy. The DON added that the pharmacy staff visited the facility the first week of July 2022 and had not discovered the expired medications. 3a. An observation of the front medication room was made on 07/14/22 at 12:47 PM with the Unit Secretary. The observation revealed the following expired medication: -Nicotine Transdermal patch (smoking cessation) 14 patches that expired 01/21. -2 unopened bottles of Multivitamin 100 tablets each that expired 06/22. The Unit Secretary was interviewed on 07/14/22 at 12:52 PM. The Unit Secretary stated that she would take the expired medications and discard them but was unsure who was responsible for checking the medication rooms for expired medications. b. An observation of the back medication room was made on 07/14/22 at 3:38 PM with Nurse #8. The observation revealed the following expired medication: -3 boxes of 100 Bisacodyl (laxative) suppositories that expired 05/22. An interview was conducted with Nurse #8 on 07/14/22 at 3:40 PM. Nurse #8 stated that she did not know what to do with the expired medications, but she would find out. She was also unaware of who was responsible for checking the medication rooms. The Director of Nursing (DON) was interviewed on 07/15/22 at 2:12 PM. The DON stated that the nurses should be going through the medication rooms weekly to remove any expired medications. She added that the nursing management team and the pharmacy staff also tried to help the hall nurses as much as possible. The DON explained the expired medications should have been removed from the medication rooms and returned to the pharmacy. The DON added that the pharmacy staff visited the facility the first week of July 2022 and had not discovered the expired medications.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on record reviews, resident and staff interviews, the facility failed to honor a residents' food choices for 2 of 2 residents reviewed for meal preferences (Resident #68 and Resident #31). The findings included: 1. Resident #68 was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #68 was cognitively intact. An observation and interview with Resident #68 on 07/13/22 at 11:30 AM revealed Resident #68 sitting in his wheelchair which was positioned next to his bed. He had a stack of meal tickets spread out over his bed for review. He shared his concern the facility was no longer providing residents with food item choices and did not listen and abide by his meal preferences when they delivered his trays daily. Resident #68 stated he was often having to return to the dietary department in order to ask for items he had requested to be delivered or ask for an alternate meal when food was delivered which he had vocalized that he did not like. Resident #68 held up a meal ticket dated 07/10/22 with a note hand-written by staff that informed him the staff member responsible for ordering the requested item did not order it and the item was unavailable to him as requested. The meal ticket included 2 pimento cheese sandwiches which he indicated they sent to him on both his lunch and dinner trays daily. Resident #68 stated the dietary department did not deliver the traditional menu items to him on days when they aligned with his food preferences in addition to the pimento cheese sandwiches which caused him to be tired of only eating the same sandwich so often. An observation and interview on 07/13/22 at 1:01 PM revealed Resident #68 had been delivered his meal tray. He provided the meal ticket and his untouched meal tray for comparison. The ticket indicated 2 pimento cheese sandwiches, yellow frosted cake and potato chips. Observation of the meal tray revealed he had not been sent neither the cake nor potato chips and an alternative dessert had been provided that he stated was not a food preference for substitution. An interview with the Regional Dietary Manager on 07/13/22 at 1:15 PM. She indicated all resident preferences were taken and should be entered into the electronic medical record system as well as a separate tray card system for preferences. She indicated she had spoken to Resident #68 regarding his preference concerns earlier on this date and believed they would be corrected, and his meal trays should reflect the preferences voiced. The RDM said the facility had two separate systems each resident's preferences had to be included in and often they were not transcribed into both systems which caused inconsistencies. She explained the Dietary Manager was new in their role and she believed the former Dietary Manager had not been diligent in ensuring the resident preferences were transcribed into both systems. (continued on next page)

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	07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel Mooresville	550 Glenwood Drive Mooresville, NC 28115

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview with the Dietary Manager on 07/15/22 at 9:30 AM were conducted in Resident #68's room. Resident #68 was lying in bed with his breakfast tray setup in front of him on an overbed table. The breakfast tray included bacon and the meal ticket indicated he was to be served sausage. He was also served hot cereal and Resident #68 stated his preference was a named cold cereal. The Dietary Manager indicated he was aware there were concerns with meal choices not being honored. He indicated he thought the issue had been corrected after the Regional Dietary Manager had spoken to Resident #68 on 07/13/22 and he had met with Resident again on 07/14/22, but appeared after the breakfast observation on this date, the concerns identified with preferences in RC were still an ongoing issue that needed further resolutions put into place for correction. A follow-up interview was conducted with Resident #68 on 07/15/22 at 9:45 AM revealed he attended resident council frequently and continued to have concerns with food preferences not being honored and his meal ticket almost never matched what he was served nor what he had identified to be his likes or dislikes. The Administrator was interviewed on 07/15/22 at 2:17 PM. He indicated he had just started at this facility, but he expected meal tickets to match what was on the tray 100% of the time and meal preferences to be honored to include likes and dislikes. He further explained if there was an item on the menu for the day and a meal had to be changed the tickets must be changed and the menu must reflect the changes and be posted so the residents can be informed in a respectful, timely manner. If there were preferences that were not included on the dietary departments routine meal purchase orders such as potato chips or others that the dietary department was unable to be obtained on the routine delivery due to back order, the facility had a purchase card and it could be purchased outside the facility and charged to the purchase card. 37280 2. Resident #31 was admitted to the facility on [DATE]. A review of Resident #31's medical record revealed a physician order dated 09/08/21 for a regular diet, regular texture and regular/thin liquid consistency. The medical record also indicated an allergy to corn products. The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #31 was cognitively intact. An observation and interview were conducted with Resident #31 on 07/11/22 at 11:10 AM. The Resident's untouched breakfast tray was still in the Resident's room which contained a bowl of corn flakes (plastic wrapping intact) and an unopened carton of reduced milk. The breakfast meal ticket indicated the Resident was on a regular diet with no restriction and she was to receive rice krispies and whole milk. The meal ticket also indicated Resident #31 had allergies to corn and corn products. Resident #31 explained that she had voiced her food preference to a dietary staff member several weeks ago that she only wanted rice krispies and milk for breakfast and it did not matter if the milk was whole milk or reduced milk. The Resident continued to explain that she could not eat the corn flakes because she had an allergy to corn products that caused her to have an upset stomach. (continued on next page)

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	07/15/2022

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with Resident #31 on 07/13/22 8:29 AM the Resident's breakfast meal tray was sitting on the bedside table with a bowl of corn flakes which were still wrapped in plastic wrap and an unopened carton of whole milk. The meal ticket on the tray stated the Resident should have received rice krispies. Resident #31 stated that was what they brought her to eat for breakfast and they knew she can't eat corn products. 07/13/22 8:45 AM an interview was conducted with the Dietary Manager (DM) who reviewed Resident #31's breakfast meal ticket and stated she should have received the rice krispies. The DM also indicated he needed to educate the dietary staff about being more careful to read the meal tickets and put what the ticket called for on the meal trays. On 07/13/22 at 8:50 AM an interview was conducted with Dietary Aide #1 who confirmed that she worked on 07/11/22 and 07/13/22 for the breakfast meal preparation. The DA explained that the process was for the DA to call out to the cook what was needed for the meal tray and the cook would put the items on the meal trays. The DA stated she knew Resident #31 liked 2 corn flakes and 2 milks for breakfast and that was what she called out for the cook. The Surveyor showed the DA the 2 breakfast meal tickets for 07/11/22 and 07/13/22 that indicated no corn flakes and the preference for rice krispies. An interview was unable to be obtained from the Cook scheduled for 07/11/22 and 07/13/22. An interview was conducted with the Senior Regional Culinary Manager (SRCM) on 07/13/22 at 10:54 AM. The SRCM explained that she conducted an audit on all the residents in house in June 2022 to obtain their food preferences and stated she specifically remembered obtaining Resident #31's food preference for breakfast. The SRCM indicated that the dietary staff would be reeducated to the meal preparation process which included making sure the items placed on the meal trays matched what was on the meal tickets.