STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family interview, and staff interview, the facility failed to inform Resident #11 ' s Responsible Party of a change in the resident's planned admission placement to a private room with a 14-day quarantine to a semi-private room with a roommate and no quarantine. This occurred during the COVID-19 pandemic and was for 1 of 8 residents reviewed for the right to be fully informed. The findings included: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Electronic correspondence on 3/19/20 between Resident #11 ' s Responsible Party (RP), the facility ' s Business Office Manager (BOM), and the former Admissions Director (AD) revealed the following: -At 8:40 AM Resident #11 ' s RP asked the BOM what the facility ' s protocol was for admitting new residents during the COVID-19 pandemic. -At 8:59 AM the BOM responded, We are still admitting people, we are just admitting them to a private room for a few days to make sure they aren't exhibiting symptoms (with the understanding that they will have to come out of the private room). But at this time we aren't allowing any visitors . The facility ' s census record indicated Resident #11 was admitted on [DATE] to a semi-private room with a roommate (Resident #26). He remained in this same room with the same roommate throughout his stay. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #11 had moderately impaired cognition and required supervision only for locomotion on the unit and was independent for locomotion off the unit. He utilized either a walker or wheelchair for locomotion. A phone interview was conducted with Resident #11 ' s RP on 5/6/20 at 8:15 AM. She reported that prior to his admission she was informed by the BOM or AD that Resident #11 would be admitted to a private room and quarantined for 14 days prior to being integrated into the general population. She stated that she was informed this was a precaution related to the COVID-19 pandemic. She indicated that on the date of admission (3/31/20) she was not able to enter the facility with Resident #11 as visitors were restricted as a precaution related to COVID-19. She stated she was not made aware on this date, 3/31/20, that he was going to be admitted to a semi-private room with a roommate and not quarantined for any period of time. The RP reported that on 4/4/20 she went to visit Resident #11 at the facility, but that due to visiting restrictions she had to visit him through the glass windows in the lobby area. She reported that Resident #11 had no mask on during this visit, which had concerned her as she thought he was going to be under quarantine. Resident #11 ' s RP indicated that she was not sure when she found out for certain that Resident #11 was not in a private room, but that she had multiple communications with the Medical Director who allowed her to see Resident #11 via video call which confirmed he was not in a private room. The RP stated that if she had been fully informed of the changes in planned placement from a private room with quarantine to a semi-private room with no quarantine that she would have reconsidered Resident #11 ' s admission to the facility. A phone interview was conducted with the former Admissions Director (AD) on 5/6/20 at 1:58 PM. She stated that she no longer worked at the facility. She recalled speaking with Resident #11 ' s RP prior to the resident's admission, but she had no recollection of telling them the resident would be in a private room and quarantined for 14 days. She indicated she was unaware of a requirement for quarantining new residents for 14 days when they were admitted related to COVID-19. A phone interview was conducted with the Administrator on 5/6/20 at 3:21 PM. She was asked if Resident #11 was admitted to a private room and quarantined on 3/31/20 and she stated that he was. The census record for Resident #11 that indicated he was admitted to a semi-private room with a roommate was reviewed with the Administrator. She revealed her previous statement was incorrect. She further revealed that Resident #11 was admitted to a semi-private with a roommate on 3/31/20 and was not quarantined. The Administrator was unable to explain why Resident #11 ' s placement plan changed, and she was unable to explain why his RP was not notified of the change. She indicated that prior to admission the RP would have been communicating with the former AD and BOM. A phone interview was conducted with the BOM on 5/6/20 at 4:21 PM. She recalled speaking with Resident #11 ' s RP prior to admission, but she had no recollection of telling them the resident would be in a private room and quarantined for 14 days. The BOM indicated that she could not recall if it was a requirement to admit new residents to a private room and quarantine them from the current residents at the time of Resident #11 ' s admission (3/31/20). She stated that she communicated with his RP via electronic correspondence and she needed to read through that information to see if anything was discussed related to a private room or quarantine. On 5/6/20 at 4:56 PM the BOM forwarded a copy of electronic correspondence that occurred on 3/19/20 at 8:59 AM between herself and Resident #11 ' s RP. This electronic correspondence revealed that she informed Resident #11 ' s RP that he would be admitted into a private room for a few days to make sure he wasn ' t exhibiting symptoms of COVID-19. The BOM provided no explanation as to why this planned placement changed and why it was not communicated to Resident #11 ' s RP prior to or upon admission. A phone interview was conducted with former Unit Manager (UM) #1 on 5/12/20 at 10:26 AM. She confirmed that Resident #11 was admitted to a semi-private room with a roommate on 3/31/20. She stated that upon admission, Resident #11 self-propelled his wheelchair throughout the facility and was not quarantined. A phone interview was conducted with Nursing Assistant #12 on 5/12/20 at 11:15 AM. She stated that Resident #11 was admitted to a semi-private room with a roommate and was not quarantined on admission (3/31/20). She reported that at the time of his admission he was able to self-propel his wheelchair and did so throughout the common areas of the facility. In a follow up interview on 5/21/20 at 11:20 AM the Administrator indicated that Resident #11 ' s RP had a right be fully informed of the change in planned placement from a private room with quarantine to a semi-private room with a roommate and no quarantine. She was unable to explain why this information was not conveyed to his RP.
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, resident, responsible party, staff and physician interviews, the facility failed to notify the resident's responsible party of a resident's death (Resident #2) and failed to promptly notify residents and/or their responsible parties of COVID-19 test results (Residents #7, #24, #18, #17, #30, #20, #28 and #5). This was for 9 of 9 residents reviewed for notification. The findings included: 1) Resident #2 was initially admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Her most recent readmission to the facility was on [DATE] after a hospitalization for gastrointestinal hemorrhage. She returned to the facility under Hospice care. The resident's Clinical Resident Profile revealed a family member was listed as emergency contact #1 and responsible party (RP). The nursing progress notes dated [DATE] at 1:16 PM, revealed Nurse #4 found Resident #2 without a heartbeat and respirations. The resident had expired. The progress note stated Hospice and the funeral home were notified and the funeral home retrieved Resident #2 at 1:30 PM. A phone interview was conducted with Resident #2's RP on [DATE] at 2:00 PM. The RP revealed he was not notified by the

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) facility of the resident's death on [DATE] but rather by the funeral home on [DATE]. A telephone interview occurred with Nurse #4 on [DATE] at 11:35 AM. She was able to recall the resident and events that took place on [DATE]. Nurse #4 explained around 12:00 PM on [DATE] she found Resident #2 without respirations and a heartbeat. She retrieved the acting Director of Nursing (DON- who was the Assistant Director of Nursing at the time) for verification and asked her how the facility handled deaths. She went onto say the acting DON instructed her to call Hospice and Hospice would do the rest of the notifications. Nurse #4 stated she called Hospice and got the phone number for the funeral home. She phoned the funeral home, but she never called the resident's family. On [DATE] at 11:46 AM, the acting DON was interviewed via the telephone and verified instructing Nurse #4 to call Hospice and the funeral home and that Hospice would notify the resident's RP. A phone interview was held with the Hospice Vice President of Compliance and Quality on [DATE] at 1:50 PM. She reviewed hospice documentation for Resident #2 and stated hospice was notified by Nurse #4 on [DATE] relaying Resident #2 expired at 12:15 PM. She added typically the facility staff notified the responsible party regarding a resident's death. The Medical Director was interviewed via the phone on [DATE] at 11:54 AM and confirmed he was notified on [DATE] of Resident #2's death and informed Nurse #4 to call Hospice and when she talked with the family to inquire about the funeral home of choice. The Medical Director stated he was unaware the family had not been notified by the facility and stated it would have been his expectation for the facility to notify the family regarding her death as the nurse would be able to answer any questions they might have had. On [DATE] at 4:25 PM, a phone interview occurred with the Funeral Home Director/Manager and stated when he called the RP on [DATE], the RP stated he was unaware Resident #2 had passed away. On [DATE] at 12:30 PM, a phone interview was conducted with Hospice Nurse #1. She verified Nurse #4 called her on [DATE] to report Resident #2 had expired and had actually called her twice. The first time was to report the time of death for Resident #2. Hospice Nurse #1 went on to say she asked Nurse #4 if there was anything they could do or calls to be made and was told no. A few minutes later Nurse #4 called back and asked it there was a funeral home on record as the facility did not have one listed. The number was provided to Nurse #4. The Hospice Nurse #1 added there was no communication that the family needed to be called and normally the facilities call the RP's. In an interview with the Administrator on [DATE] at 11:15 AM, she indicated the facility should have contacted the RP when Resident #2 passed away. She went onto say that at times the Hospice Nurse would call the families and other times the facility called and felt like caused confusion and breakdown in communication with the families. The Administrator added it was ultimately the responsibility of the facility to notify RP's of any changes to a resident's condition to include death. 2) Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's Clinical Resident Profile revealed a family member was listed as emergency contact #1 and responsible party. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #7 was cognitively intact. A nursing progress note dated [DATE] indicated Resident #7's responsible party (RP) was informed a resident at the facility had tested positive for COVID-19. Resident #7's care plan dated [DATE] read she was positive for COVID-19 with interventions that included notifying the RP of any changes in Resident #7's condition. The resident's nursing progress notes dated [DATE] to [DATE] did not include any documented information that Resident #7's RP was notified of COVID-19 testing or positive results for COVID-19. On [DATE] at 1:47 PM, a phone interview occurred with Resident #7. She confirmed she had been made aware by the facility that she tested positive to COVID-19 but was unable to state the date of notification. A phone interview was conducted with Resident #7's RP on [DATE] at 2:17 PM. He explained he had called the facility on [DATE] to do a wellness check since he wasn't able to visit the facility and was told by the answering nurse that Resident #7 had been tested for COVID-19 on [DATE] and results were received back on [DATE], but was provided no further information to whether she tested positive or negative to [MEDICAL CONDITION]. The RP went on to say he had not received any calls from the facility or corporate level regarding Resident #7's test results for COVID-19 and that prior to the COVID-19 pandemic he was receiving notifications from the facility for any changes in condition for Resident #7. On [DATE] at 10:02 AM, via electronic correspondence with the Administrator, she indicated Resident #7 was tested for COVID-19 on [DATE] with results received on [DATE] revealing she was positive for [MEDICAL CONDITION]. The Administrator further stated Resident #7 was listed on the alert and oriented notification roster which meant the resident was notified of the COVID positive results. In an interview with the Administrator on [DATE] at 11:15 AM, she stated for cognitively intact residents, it was the responsibility of the resident to inform their own RP's of the testing results. She verified Resident #7's RP was not notified that she tested positive for COVID-19 and acknowledged the facility should have followed the regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results. On [DATE] at 11:40 AM, the Medical Director was interviewed via the telephone. He stated he presumed Resident #7's RP knew since she talked frequently on the phone with them. The Medical Director acknowledged the facility should have followed the regulations regarding notification of both the resident and the RP for the significant change of positive COVID-19 results. 3) Resident #24 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Clinical Resident Profile revealed a family member was listed as the resident's emergency contact #1 and responsible party. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #24 had moderately impaired cognition. A nursing progress note dated [DATE] at 11:39 AM, indicated Resident #24's responsible party (RP) was informed visitors were not allowed due to the COVID-19 pandemic. Resident #24's care plan dated [DATE] read he was positive for COVID-19 with interventions that included notifying the RP of any changes in Resident #24's condition. Resident #24's nursing progress notes dated [DATE] to [DATE] did not include any documented information that Resident #24's RP was notified of COVID-19 testing or positive results for COVID-19. A phone interview was conducted with Resident #24's RP on [DATE] at 12:38 PM. He stated he was contacted by the facility in [DATE], when visitors were no longer allowed but was never informed by the facility that Resident #24 had been tested for COVID-19 or that he had tested positive for COVID-19 until the Nurse Practitioner called him on [DATE] to discuss how symptoms would be handled as they arose. On [DATE] at 10:02 AM, via electronic correspondence with the Administrator, she indicated Resident #24 was tested for COVID-19 on [DATE] with results received on [DATE] revealing he was positive for [MEDICAL CONDITION]. The Administrator further stated Resident #24 was listed on the alert and oriented notification roster which meant the resident was notified of the COVID positive results. In an electronic correspondence with the Administrator on [DATE] at 9:01 AM it read; resident RP's were notified by the corporate nurse if the resident was not capable of making their own decisions. This was done to assist the facility in contacting everyone as fast as possible. The Nurse Practitioner was interviewed via the phone on [DATE] at 10:27 AM and stated when she arrived at the facility on [DATE] she was provided a list of residents who had tested positive for COVID-19. She asked the Administrator if she needed to make any calls and was told no because the corporate office would be notifying all RP's. She added it was her expectation, if the facility said corporate would be contacting RP's, then it should have been done when they were aware the resident had tested positive to COVID-19. In an interview with the Administrator on [DATE] at 11:15 AM, she stated for cognitively intact residents, it was the responsibility of the resident to inform their own RP's of the testing results. She verified Resident #24's RP was not notified he had tested positive for COVID-19 until the Nurse Practitioner called on [DATE] during a routine call. She acknowledged the facility should have followed the regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results. On [DATE] at 11:40 AM, the Medical Director was interviewed via the telephone. He stated he presumed Resident #24's RP knew since he talked frequently on the phone with them. The Medical Director acknowledged the facility should have followed the regulations regarding notification of both the resident and the RP for the significant change of positive COVID-19 results. On [DATE] at 4:30 PM, a phone interview occurred with the Nurse Practitioner, who confirmed when she contacted Resident #24's RP on [DATE] she was informed the facility had not notified him of the COVID results. 4. Resident #18 was admitted on [DATE] with a [DIAGNOSES REDACTED]. The resident's electronic medical record indicated Resident #18 named a family member as his Responsible Party. Resident #18's annual Minimum Data Set ((MDS) dated [DATE] indicated he was cognitively intact. A nursing note dated [DATE] at 6:04 PM read Resident #18's Responsible Party (RP) was informed that a resident at the facility had tested positive for COVID-19. Resident #18's care plan dated [DATE] read he was positive for COVID-19. Interventions included notifying the RP of any changes in Resident #18's condition. In an electronic correspondence with the Administrator on [DATE] at 2:39 PM read Resident #18 was tested for COVID-19 on [DATE] and positive COVID-19 results on [DATE]. The nursing notes from [DATE] to [DATE] do not include any documented information that Resident #18's RP was notified of COVID-19 testing or positive results for COVID-19. Resident #18 expired at the facility on [DATE] at 3:56 PM. A telephone interview was conducted on [DATE] at 1:18 PM with Resident #18's RP. She stated she was contacted on [DATE] and made aware that one resident had tested positive for COVID-19 but that was all she was told. The RP stated she was never notified that Resident #18 was tested for COVID-19 or that he had tested positive for COVID-19 until the Medical Director called her on [DATE]. The RP stated the Medical Director discussed Resident #18's decline and it was decided that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Resident #18 would be on comfort measures only and he expired on [DATE]. In an electronic correspondence with the Administrator on [DATE] at 9:01 AM read resident RP's were notified by the corporate nurse if the resident was not capable of making their own decisions. This was done to assist the facility in contacting everyone as fast as possible. Management was letting the staff know about the COVID-19 outbreak in a meeting with the Resident Council President present. The Administrator indicated at that time, management were helping to provide care for the residents. The Medical Director also spoke with residents and RP's as appropriate regarding their test results. In another email correspondence with the Administrator on [DATE] at 4:46 PM read Resident #18 was on the notification list as alert and oriented and it was an error. The RP was notified on [DATE] of positive COVID-19 results that were received on [DATE]. In an interview on [DATE] at 11:20 AM, the Administrator stated for cognitively intact residents, it was the responsibility of the resident to inform their own RP's of the testing results. She confirmed Resident #18's RP was not notified that he tested positive for COVID-19 until the Medical Director called her on [DATE]. She acknowledged the facility should have followed regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results. In a telephone interview on [DATE] at 11:50 AM, the Medical Director stated he presumed Resident #18's RP knew since they talked frequently on the phone up until he had a significant decline in his condition. He confirmed he contacted Resident #18's RP on [DATE] to discuss comfort measures. The Medical Director acknowledged the facility should have followed regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results. 5. Resident #17 was admitted [DATE] with cumulative [DIAGNOSES REDACTED]. He was diagnosed with [REDACTED]. The resident's electronic medical record indicated Resident #17 named a family member as his Responsible Party. Resident #17's quarterly Minimum Data Set ((MDS) dated [DATE] indicated he was cognitively intact. A nursing note dated [DATE] at 1:16 PM read a message was left for Resident #17's Responsible Party (RP) regarding a facility update. Resident #17's care plan revised on [DATE] read he was positive for COVID-19. Interventions included notifying the RP of any changes in Resident #17's condition. In an electronic correspondence with the Administrator on [DATE] at 2:39 PM read Resident #17 was tested for COVID-19 on [DATE] and positive COVID-19 results were received on [DATE]. There were no nursing notes in Resident #17's medical record from [DATE] to [DATE]. A nursing note dated [DATE] at 1:01 PM read Resident #17 was asymptomatic with COVID-19. A telephone interview was conducted on [DATE] at 1:18 PM with Resident #17's RP. She stated she was contacted on [DATE] and made aware that one resident had tested positive for COVID-19 but that was all she was told. The RP stated she was never notified that Resident #17 was tested for COVID-19 or that he had tested positive for COVID-19. In an electronic correspondence with the Administrator on [DATE] at 9:01 AM she stated resident RP's were notified by the corporate nurse if the resident was not capable of making their own decisions. This was done to assist the facility in contacting everyone as fast as possible. Management was letting the staff know about the COVID-19 outbreak in a meeting with the Resident Council President present. The Administrator indicated at that time, management were helping to provide care for the residents. The Medical Director also spoke with residents and RP's as appropriate regarding their test results In a telephone interview on [DATE] at 1:43 PM, Resident #17 stated he recalled staff putting a swab in his nose but that the staff never informed him of the reason for the testing nor was he informed that he tested COVID-19 positive. In an interview on [DATE] at 11:20 AM, the Administrator stated Resident #17 was cognitively intact and he was informed of the testing results but his RP was not notified. She acknowledged the facility should have followed regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results. In a telephone interview on [DATE] at 11:50 AM, the Medical Director stated he presumed the Resident #17's RP knew since they talked frequently on the phone and Resident #17 was able to tell the RP of the positive results. He acknowledged the facility should have followed regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results. 6. Resident #30 was admitted on [DATE] with cumulative [DIAGNOSES REDACTED]. The resident's electronic medical record indicated that a family member was Resident #30's Responsible Party (RP). Resident #30's most recent quarterly Minimum Data Set ((MDS) dated [DATE] indicated severe cognitive impairment and with no behaviors. He was coded independent with all activities of daily living. Resident #30's nursing note dated [DATE] at 11:42 AM read the nurse spoke with RP letting him know that facility was taking precautions for the COVID 19 virus and asked not to visit at this time. Resident #30's nursing note dated [DATE] at 1:13 PM read the RP was given a facility update. Resident #30's revised care plan dated [DATE] read as suspected [DIAGNOSES REDACTED]. An intervention included notification Resident #30's Responsible Party (RP) of any changes in his condition. Resident #30's nursing note dated [DATE] at 10:30 AM, read Resident #30 was COVID-19 positive. Resident #30's nursing note dated [DATE] at 6:03 PM read Resident #30 continued with COVID-19 and was asymptomatic. A Social Services Progress note dated [DATE] at 1:23 PM read Resident #30 was able to FaceTime video with his RP. Family was informed that they could contact the facility to schedule another video chat. A physician progress notes [REDACTED].#30's RP contacted him to ask about Resident #30's COVID-19 testing. The note specified the Physician informed the RP that Resident #30 refused the COVID-19 testing. In an electronic correspondence with the Administrator [DATE] at 1:41 PM read Resident #30 was not tested on [DATE]. He refused and when attempted again he continued to refuse. The Administrator specified the staff may have got confused and documented that Resident #30 tested positive for COVID-19. She indicated the facility continued to monitor Resident #30 for signs and symptoms of COVID-19 because his roommate had tested COVID-19 positive. In an electronic correspondence with the Administrator on [DATE] at 2:45 PM read she found no evidence of anything documented that Resident #30's RP was made aware of the resident's refusal of COVID-19 testing. A telephone interview was conducted on [DATE] at 1:38 PM with Resident #30's RP. He stated nobody from the facility had contacted him letting him know Resident #30 refused COVID-19 testing on [DATE]. The RP stated it was not until [DATE] when he called the Medical Director to inquire whether Resident #30 was tested for COVID-19 that he was informed that Resident #30 had refused prior testing. The RP stated it was his expectation that the facility would let him know that Resident #30 refused testing earlier in April, so he could have called or video chatted with Resident #30 to convince him to be tested . The RP stated the Medical Director told him that Resident #30 was suspected as having COVID-19 on [DATE] but was asymptomatic. A telephone interview was conducted with Social Worker (SW) #2 on [DATE] at 10:42 AM. She confirmed she was present with Resident #30 during his video chat with RP on [DATE]. She stated at no time during the call did she informed the RP that Resident #30 had refused COVID-19 testing or that he was suspected COVID-19 positive. In an interview on [DATE] at 11:20 AM, the Administrator stated Resident #30's RP should have been notified of his refusal to be tested for COVID-19. She acknowledged the facility should have followed regulations regarding notification of Resident #30's suspected COVID-19 positive [DIAGNOSES REDACTED]. 7. Resident #20 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #20 had moderate cognitive impairment and had behavior of rejection of care that occurred ,[DATE] days. Resident #20 was discharged to the hospital on [DATE] and did not return. Interview with the Administrator on [DATE] at 1:39 PM revealed that Resident #20 was tested for COVID 19 on [DATE] and the result came back positive on [DATE]. During the interview, the Administrator stated that she didn ' t have documentation that Resident #20 or the resident's family was notified that the resident tested positive for COVID 19. She further reported that the regional office consultant was responsible for notifying the families of residents who were COVID 19 positive. Interview with the regional office consultant on [DATE] at 12:04 PM revealed that she was helping the facility to notify the family members of cognitively impaired residents who tested positive for COVID 19. She indicated that the Nurse Practitioner (NP) and/or the attending Physician were responsible for notifying the alert and oriented residents who tested positive for COVID. The regional office consultant further stated that if the resident was alert and oriented, their family members were not notified unless the resident requested to notify her/his family. She stated that Resident #20 was alert and oriented and was the responsible party (RP) for herself so her family was not notified. A follow up interview with the Administrator was conducted on [DATE] at 2:20 PM regarding notification of residents and family members when a resident was tested positive for COVID 19. She stated the facility ' s system was to notify the alert and oriented residents of the positive result but not the resident's family unless the resident requested to notify them. The Administrator was unable to provide the date or the person who notified Resident #20 of the positive result. The Administrator verified that the family of Resident #20 was not notified since the resident was alert and oriented. Interview with the attending physician of Resident #20 on [DATE] at 1:20 PM revealed that he visited the resident on [DATE] and he didn't remember if he notified the resident of the COVID positive result. He reported that the resident's test result came back on [DATE], so he assumed the resident was already notified by the staff of the COVID positive result before his visit on [DATE]. The Physician stated that on [DATE], he was told that the Corporate Nurse would be calling the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) families of residents who tested positive for COVID 19. On [DATE] at 11:20 AM, the Administrator was interviewed. The administrator stated, that the facility had received over a hundred COVID test results back at the same time and her expectation was for the staff to notify the resident and/or the resident's family within 3 days of the results being received. She further stated that in other circumstances she expected notification within 24 hours. The Administrator acknowledged that there was a lack of documentation for notification of residents and resident family members regarding resident testing positive for COVID. The administrator stated she expected this notification be documented in the resident's medical records. 8. Resident #28 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #28's cognition was intact. A laboratory test collected on [DATE] and reported on [DATE] revealed that Resident #28 tested positive for COVID 19. Interview with the Administrator on [DATE] at 1:39 PM revealed that Resident #28 was tested for COVID 19 on [DATE] and the result came back positive on [DATE]. Interview with the regional office consultant on [DATE] at 12:04 PM revealed that she was helping the facility in notifying the family members of cognitively impaired residents who were tested positive for COVID 19. She indicated that the Nurse Practitioner (NP) and the attending Physician were responsible for notifying the alert and oriented residents that they were positive for COVID. The regional office person further stated that if the resident was alert and oriented, their family members were not notified unless the resident requested to notify her/his family. She stated that Resident #28 was alert and oriented and so his family was not notified of the COVID positive result. An interview with the Nurse Practitioner (NP) was conducted on [DATE] at 1:02 PM. She stated that she visited Resident #28 on [DATE] and she didn ' t think the COVID result was back yet. Resident #28 was tested for COVID 19 on [DATE] and the result came back positive on [DATE]. On [DATE], she was told that the facility had a designated staff member who would notify alert and oriented residents. The NP verified that Resident #28 was alert and oriented and she had not informed the resident nor the family of the COVID 19 positive result. A follow up interview with the Administrator was conducted on [DATE] at 2:20 PM regarding notification of residents and family members when a resident was tested positive for COVID 19. She stated the facility's system was to notify the alert and oriented residents of the positive result, but not the resident's family unless the resident requested to notify them. The Administrator was unable to provide the date or the person who notified Resident #28 of the COVID positive result. The Administrator verified that the family of Resident #28 was not notified since the resident was alert and oriented. On [DATE] at 11:20 AM, the Administrator was interviewed. The administrator stated that the facility had received over a hundred COVID test results back at the same time and her expectation was for the staff to notify the resident and/or the resident's family within 3 days of the results being received. She further stated that in other circumstances she expected notification within 24 hours. The Administrator acknowledged that there was a lack of documentation for notification of residents and resident family members regarding resident testing positive for COVID. The administrator stated she expected this notification be documented in the resident's medical record. 9. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Clinical Resident Profile revealed a family member was listed as emergency contact #1 and Responsible Party (RP). The most recently completed Minimum Data Set (MDS) for Resident #5 was a quarterly assessment dated [DATE]. Resident #5 was assessed as cognitively intact. Resident #5 ' s care plan dated [DATE] read she had a suspected [DIAGNOSES REDACTED].#5 ' s condition. The nursing progress notes dated [DATE] to [DATE] did not include any documented information that Resident #5 ' s RP was notified of COVID-19 testing or COVID-19 results. On [DATE] at 2:45 PM, a phone interview occurred with Resident #5. She confirmed she had been made aware by the facility that she tested positive to COVID-19 but was unable to state the date of notification. A phone interview was conducted with Resident #5 ' s RP on [DATE] at 4:30 PM. The RP reported that the facility normally contacted her for any changes in condition with Resident #5 such as falls or infections. She indicated that on [DATE] she was made aware by local media sources that the facility had a high number of residents who tested positive for COVID-19. She stated that she was alarmed by this information and was concerned as she had not received any information from the facility on whether or not Resident #5 was tested and if so what the results were. The RP reported that she phoned the facility herself twice on [DATE] to find out if Resident #5 was tested for COVID-19. She indicated that on the first phone call she was told by an unknown staff member that someone would call her back later with an update. The RP reported that she waited for several hours and had not received a return phone call, so she phoned the facility again. She stated that on this second phone call on [DATE] she spoke with the Assistant Business Office Manager (ABOM) who informed her that Resident #5 tested positive for COVID-19. On [DATE] at 9:55 AM, via electronic correspondence with the Administrator, she indicated Resident #5 was tested for COVID-19 on [DATE] with results received on [DATE] revealing she was positive for [MEDICAL CONDITION]. The Administrator further stated Resident #5 was listed on the alert and oriented notification roster which meant the resident was notified of the COVID-19 positive results. A phone interview was conducted on [DATE] at 10:35 AM with the ABOM. She stated that on [DATE] the facility started to receive numerous phone calls from family members requesting information on COVID-19 test results. She reported that due to the multitude of phone calls, the Administrator asked her to help field some of the calls that came in. She explained that she was given a list of the residents with the results of their COVID-19 test results and the Administrator asked her to inform the RPs of the test results if they called in. The ABOM indicated that she had not initiated any phone calls herself. She reported that she had a vague recollection of speaking to Resident #5 ' s RP by phone regarding the COVID-19 test results, but she was unsure what date she spoke with her. In an interview with the Administrator on [DATE] at 11:15 AM, she stated for cognitively intact residents, it was the responsibility of the resident to inform their own RP of the testing results. She acknowledged that if Resident #5 ' s RP had not reached out to the facility on [DATE] the facility would not have notified her of the positive COVID-19 test results. The Administrator further acknowledged the facility should have followed the regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results. On [DATE] at 11:40 AM, the Medical Director was interviewed via the phone. He stated he presumed Resident #5 ' s RP knew she had tested positive for COVID-19 as she was capable of talking to them by phone. The Medical Director acknowledged the facility should have followed the regulations regarding notification of both the resident and the RP for the significant change of positive COVID-19 results.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to develop a care plan related to the risk of smoking at the facility for Resident #22. This was for 1 of 3 residents reviewed for accidents. The findings included: Resident #22 was initially admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) completed for Resident #22 was a quarterly assessment dated [DATE]. Her cognition was intact, and she required supervision of 1 for assistance with locomotion on and off unit. She utilized a wheelchair or walker. Resident #22 received oxygen (O2) therapy. A physician's order [REDACTED]. A nursing note dated 3/17/20 completed by the former Director of Nursing (DON) indicated Resident #22 was observed outside in the designated smoking area smoking a cigarette. Resident #22 had a portable O2 tank on the back of her wheelchair. The O2 tank provided continuous O2. The former DON wrote that the O2 was removed and taken inside the facility. The resident stated, I just wanted to smoke and when asked where she got her cigarette and how she lit it she responded, I just got it. Resident #22 was educated that all residents who wished to smoke needed to be assessed for safe smoking and adhere to the facility ' s smoking policy. Resident #22 was informed that due to her use of O2 while smoking and without her being previously assessed for smoking she would not be permitted to smoke at this time at the facility. Resident #22 was noted to nod her head and verbalize understanding. A nursing note dated 3/17/20 completed by former Unit Manager (UM) #1 indicated Resident #22 was found smoking outside with a portable O2 tank attached to her wheelchair. The O2 was running continuously via nasal cannula. Resident #22 was noted to refuse to extinguish her cigarette when staff approached her, so the portable O2 was removed from the wheelchair and taken inside. Following the incident, the resident refused to state where she obtained her cigarettes and lighter from. Medical record review on 5/8/20 indicated no smoking assessment was completed for Resident #22 prior to or after the 3/17/20 incident of smoking while utilizing continuous O2. The active care plan for Resident #22 was reviewed on 5/8/20 and revealed no care plan was in place to address the risk of Resident #22 smoking. A phone interview was conducted with former UM #1 on 5/8/20 at 9:24 AM. She verified the 3/17/20 note that indicated Resident #22 was found outside in the designated smoking area (an enclosed courtyard) with a lit cigarette and portable O2 tank in place that was providing continuous O2 via nasal cannula. Former UM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) #1 stated that smoking assessments were only completed for residents who wished to smoke at the facility. She explained that Resident #22 had not expressed an interest in smoking at the facility prior to the incident, and she had no previous incidents of smoking at the facility before the 3/17/20 incident. Former UM #1 was asked if Resident #22 ' s care plan incorporated the risk of smoking at the facility and non-compliance with the facility ' s smoking policy and she stated that she was not sure, but that it should have been revised after the incident to address this risk. She stated that care plan revisions were able to be completed by any staff member in addition to MDS Nurse #1 and MDS Nurse #2. Former UM #1 stated that she no longer worked at the facility and that she was unable to recall if she had developed a care plan to address the 3/17/20 smoking incident for Resident #22. On 5/8/20 the following information was provided and received via electronic correspondence: - At 2:15 PM the Administrator was asked if there was any additional information related to the 3/17/20 smoking incident for Resident #22 other than the nursing notes completed by the former DON and former UM #1. - At 2:43 PM the Administrator indicated that there was no additional information. She further confirmed there was no care plan in place to address the incident. A phone interview was conducted on 5/8/20 at 2:43 PM with Nursing Assistant (NA) #13. She stated that she began working at the facility in April 2020 and she worked with Resident #22 frequently. She revealed that she was unaware that Resident #22 was at risk for smoking. She reported that this was important information because Resident #22 utilized continuous O2 which made smoking dangerous if the O2 was running while she was smoking. NA #13 indicated that if she was aware of this risk that she would monitor Resident #22 more closely in an effort to prevent any further incidents. A phone interview was attempted with the former DON on 5/11/20 at 3:27 PM and she was unable to be reached. A phone interview was conducted with MDS Nurse #1 on 5/18/20 at 12:28 PM. The 3/17/20 smoking while utilizing continuous O2 incident for Resident #22 was reviewed with MDS Nurse #1. She stated that she had no recollection of this incident. MDS Nurse #1 reviewed the active care plan and confirmed the care plan made no mention of this incident nor resident ' s risk of smoking and non-adherence to the facility ' s smoking policy. MDS Nurse #1 stated that typically, incidents such as this were reviewed in the morning meetings that occurred Monday through Friday. She revealed that if she had known about the incident she would have developed a care plan for the resident. She explained that Resident #22 was not an identified smoker, she had no smoking assessment, and if she was utilizing O2 while smoking this put her and other residents at risk harm. She further explained that a care plan informed the staff of the risk of smoking for Resident #22 as well as providing them with interventions to implement in order to prevent reoccurrence. A phone interview was conducted with MDS Nurse #2 on 5/18/20 at 12:32 PM. The 3/17/20 smoking while utilizing continuous O2 incident for Resident #22 was reviewed with MDS Nurse #2. She stated that she recalled hearing about this incident during a morning meeting. She reported that normally this type of incident would be addressed in the care plan due to the risk of re-occurrence. MDS Nurse #2 was unable to explain why a care plan was not developed to address Resident #22 ' s risk of smoking at the facility. She stated, I cannot recall what may have happened with that. During an interview with the Administrator on 5/21/20 at 11:20 AM she stated that she expected a care plan to be developed to address Resident #22 ' s risk of smoking at the facility. The Administrator revealed that the facility had multiple new staff, both nurses and NAs, and without a care plan to address the risk for smoking, these staff would have no plan in place with interventions to implement in an effort to prevent further incidents.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and Nurse Practitioner (NP), Physician and staff interviews, the facility failed to transcribe verbal orders for medications and to administer Nurse Practitioner (NP) ordered medications for 1 of 6 sampled residents reviewed for provision of care according to professional standards, care plan and resident ' s choice (Resident #28). Findings included: Resident #28 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #28's cognition was intact. A nurse's note dated 4/10/20 at 4:22 AM (written by Nurse #5) revealed Resident #28's oxygen saturation was in the 80's on room air. Oxygen was started via nasal cannula (the note didn't say how many liters (L) of oxygen). The resident denied pain but was making a whimpering sounds, denied being cold but was holding covers up to his chest. His temperature was 98.2 degrees Fahrenheit (F). He denied cough. Will continue to monitor and to report to doctor in AM. A nurse's note dated 4/10/20 at 7:56 AM (written by Nurse #5) revealed the NP was made aware of the resident's change in condition. New orders for complete blood count (CBC), comprehensive metabolic panel (CMP), erythrocyte sedimentation rate (ESR), chest x-ray and to get COVID 19 test done when available. The NP note dated 4/10/20 revealed Nurse #5 had called the NP. The NP was informed that Resident #28 became hypoxic with oxygen saturation in low 80's and the resident was placed on oxygen at 2 Liters (L) per minute (min). The oxygen saturation went up to 87% and the oxygen was increased to 4 L/min and the oxygen saturation increased to 91%. The note further stated that per Nurse #5, the Nurse Aide (NA) stated that the resident has not been himself for a few days. He had been staying in bed more, was coughing and had increased weakness. The resident stated that he had mild body aches. The assessment/Plan was acute [MEDICAL CONDITION] requiring 4 L/min oxygen. Differential [DIAGNOSES REDACTED]. Orders were given for chest x-ray, complete blood count (CBC) with differential, comprehensive metabolic panel (CMP) and Erythrocyte sedimentation rate (ESR). The note further indicated that after discussing with the attending physician, will start on [MEDICATION NAME] (an antibiotic drug) 500 milligrams (mgs) by mouth daily for 5 days, [MEDICATION NAME] inhaler (used to treat or prevent [MEDICATION NAME]) and [MEDICATION NAME] (a cold and cough medicine). The NP had a long discussion with the resident's family members regarding the plan of care. The family members stated that they were okay with the conservative treatments but if the resident continued to decline, they wanted to transition to comfort measures only. The April 2020 Medication Administration Records (MARs) revealed the NP ordered [MEDICATION NAME] inhaler and [MEDICATION NAME] on 4/10/20 were not transcribed and administered to Resident #20 since 4/10/20. The NP note dated 4/13/20 revealed that Resident #28 continued to have overall functional decline, very poor intake, increased weakness, generalized body aches but remained afebrile. He was seen sitting up in bed, with difficulty keeping his eyes open during the examination. He claimed that he was in pain and was requesting pain medication. He stated that he was short of breath, but his oxygen cannula was lying beside him. He improved after placing him on oxygen at 4 L/min. Due to continued decline in resident's condition, the family stated they wanted to transition to comfort care. The plan of care was communicated with the family. Orders for [MEDICATION NAME] (a narcotic [MEDICATION NAME]) and [MEDICATION NAME] (an antianxiety drug) were written. A nurse's note dated 4/15/20 at 11:45 AM (written by Nurse # 4) revealed that Resident #28 was yelling for pain medication and [MEDICATION NAME] was administered. He was saying that his chest hurt, and he was uncomfortable. His vital signs were 135/70 (blood pressure), 74 (pulse rate), 24 (respiratory rate), 100.6-degree F (temperature) and 91% (oxygen saturation). Interview with the Administrator on 5/11/20 at 1:39 PM revealed Resident #28 was tested for COVID 19 on 4/10/20 and the result came back positive on 4/14/20. On 5/13/20 at 9:38 AM, the NP was interviewed. She reported that Nurse #5 had called on 4/10/20, and she was informed that Resident #28 was hypoxic (inadequate supply of oxygen), and his oxygen saturation was low, he was coughing and with increased weakness. She gave verbal order to the Nurse for chest x-ray, CBC, CMP and ESR. Then after talking to the attending physician, she gave verbal order to start [MEDICATION NAME] inhaler and [MEDICATION NAME]. The NP indicated that she didn't know the name of the nurse she had given verbal order for the medications. The NP reported that she was not aware that the medications she ordered on [DATE] had not been transcribed and administered to the resident. She indicated that she had discussed this plan of care to the family and it was frustrating that the plan of care had not been implemented. The NP stated that she had seen Resident #28 on 4/13/20 and since there was no improvement in his condition, he was made comfort care. The NP also stated that since she had written it on her notes, she was sure that she had called the facility and gave a verbal order to the nurse and the order should have been transcribed and carried out. On 5/13/20 at 3:31 PM, Nurse #5 (3rd shift nurse on 4/9/20) was interviewed. The Nurse stated that she remembered calling the NP on 4/10/20 and notified her of Resident #28 change in condition. The NP gave a verbal order for CBC, CMP, ESR and chest x-ray. She didn't remember receiving orders for [MEDICATION NAME] inhaler and [MEDICATION NAME]. On 5/14/20 at 12:29 PM, a follow up call was conducted with Nurse #5. Nurse #5 reported that she worked 3rd shift on 4/9/20 and she could not remember receiving orders for [MEDICATION NAME] inhaler and [MEDICATION NAME]. She added that the NP might have called back after she left the building and gave the verbal order for the [MEDICATION NAME] and [MEDICATION NAME] to the 1st shift nurse who was an agency nurse (Nurse # 4). On 5/14/20 at 12:29 PM, Nurse #4 was interviewed. She stated that she was an agency nurse and she remembered being assigned to Resident #28 on 4/10/20. She reported that she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	**710 JULIAN ROAD SALISBURY, NC 28147**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) didn't remember receiving a verbal order for [MEDICATION NAME] inhaler and [MEDICATION NAME] from the NP on 4/10/20 but there was a lot going on with Resident #28 that day. On 5/18/20 at 1:04 PM, the current Director of Nursing (DON) was interviewed. She stated that she asked Nurse #5 if she received the orders for the medications from the NP and she denied receiving medication orders. The DON stated the NP indicated that she had called the facility and gave verbal order for the medications. On 5/21/20 at 11:20 AM, interview with the Administrator was conducted. She stated that she expected the plan of care to be implemented for the resident. On 5/21/20 at 11:50 AM, interview with the Physician was conducted. He stated that he expected the facility to implement the plan of care for the resident as recommended by the NP.

F 0698

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Past noncompliance - remedy proposed

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review, staff interviews, and physician interview the facility failed to have a doctor ' s order for residents to receive [MEDICAL TREATMENT] treatments, failed to monitor [MEDICAL TREATMENT] and failed to utilize the communication sheets to exchange information about resident ' s treatments and care with the [MEDICAL TREATMENT] center for 4 of 4 sampled residents reviewed for [MEDICAL TREATMENT] (Residents # 20, #22, #25 & #40). Findings included: 1. Resident #20 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #20 had moderate cognitive impairment and had behavior of rejection of care that occurred ,[DATE] days. The assessment further indicated that the resident was receiving [MEDICAL TREATMENT]. The care plan for Resident #20 dated [DATE] was reviewed. She was care planned for risk of complications related to [MEDICAL TREATMENT]. The goal was for Resident #20 not to experience any complications related to chronic [MEDICAL CONDITION] or receiving [MEDICAL TREATMENT] through next review. The approaches included apply [MEDICATION NAME] cream to fistula on [MEDICAL TREATMENT] days, monitor [MEDICAL TREATMENT] access for bruit and thrill every shift and as needed and monitor for signs/symptoms of fluid overload. Resident #20 ' s February 2020, [DATE], [DATE] and [DATE] Physician ' s orders revealed there was no physician ' s orders for the resident to receive [MEDICAL TREATMENT] treatments. Resident #20 had a doctor ' s order dated [DATE], for [MEDICATION NAME] cream 2.5% (topical local anesthetics) to be applied to [MEDICAL TREATMENT] access area topically on [MEDICAL TREATMENT] days Monday, Wednesday and Friday. On [DATE] at 1:39 PM, the Administrator was interviewed. She reported that Resident #20 was tested for COVID 19 on [DATE] and the result came back positive on [DATE]. On [DATE] at 4:22 PM, the Medical Records/Transportation staff member was interviewed. She reported that before Resident #20 tested positive for COVID 19 on [DATE] she received [MEDICAL TREATMENT] at a center in Salisbury, NC every Monday, Wednesday and Friday at 6:00 AM. After she was tested positive for COVID 19, her [MEDICAL TREATMENT] days were changed to Tuesday, Thursday and Saturday at 1:00 PM and they would be performed at a [MEDICAL TREATMENT] center in Spencer, NC. When asked how the change in the resident ' s [MEDICAL TREATMENT] schedule and location were communicated to the staff, she responded that she posted these changes at the nurse ' s station and in the [MEDICAL TREATMENT] communication book. On [DATE] at 10:15 AM, a follow up interview with the Medical Records/Transportation staff member was conducted. She reported that she was informed by the [MEDICAL TREATMENT] nurse of the change in the [MEDICAL TREATMENT] schedule for Resident #20 on [DATE]. She indicated that she didn ' t know that she had to personally inform the nurse of the [MEDICAL TREATMENT] change in schedule. She indicated that she just posted Resident #20 ' s [MEDICAL TREATMENT] days at the nurse ' s station and in the [MEDICAL TREATMENT] communication book. She reported that she had searched for the [MEDICAL TREATMENT] communication sheets from the thinned records and could not find the resident ' s communication sheets after [DATE]. She indicated that the nurses might have missed to fill out the communication sheet. Resident #20 ' s [DATE] and [DATE] MAR Medication Administration Records (MARs) revealed that staff did not apply the [MEDICATION NAME] cream topically to the resident ' s [MEDICAL TREATMENT] access area on [DATE], [DATE], [DATE], [DATE] and [DATE], when the [MEDICAL TREATMENT] schedule was changed to Tuesday, Thursday and Saturday. On [DATE] at 9:35 AM, interview with the [MEDICAL TREATMENT] Nurse at the Kannapolis, NC location was conducted. She stated that their clinic was for residents who were under observation for COVID. The nurse revealed that Resident #20 had received [MEDICAL TREATMENT] on [DATE] at their clinic. The nurse explained Resident #20 did not have a communication book (with communication sheets) with her during the treatment. On [DATE] at 10:24 AM, Nurse # 1 was interviewed. She remembered being assigned to Resident #20 on [DATE] and stated that she didn ' t know that her [MEDICAL TREATMENT] days were changed to Tuesday, Thursday and Saturday. She indicated that based on the MAR, Resident #20 was to receive [MEDICATION NAME] cream topically on [MEDICAL TREATMENT] days every Monday, Wednesday and Friday. Nurse #1 added that she didn ' t know that Resident #20 did not have a doctor ' s order for [MEDICAL TREATMENT]. Nurse #1 stated she that she didn ' t know where the [MEDICAL TREATMENT] communication book was kept for the resident. On [DATE] at 12:50 PM, Nurse #4 was interviewed. She was assigned to Resident #20 on [DATE] and [DATE]. The nurse revealed that she had sent Resident #20 to [MEDICAL TREATMENT] on [DATE] but she didn ' t remember filling out the [MEDICAL TREATMENT] communication sheet. She stated that she just heard it from somebody that Resident #20 ' s [MEDICAL TREATMENT] days were changed from Monday, Wednesday and Friday to Tuesday, Thursday and Saturday. Nurse #4 reported that she didn ' t remember the exact date and the person who told her about the change. She also stated that she didn ' t know who was supposed to change the order for the [MEDICATION NAME] cream to be applied to the resident ' s [MEDICAL TREATMENT] access area on Tuesdays, Thursdays and Saturdays when the resident ' s [MEDICAL TREATMENT] days were changed. She also reported that she didn ' t know that the resident did not have an order for [REDACTED].#20 had received [MEDICAL TREATMENT] on [DATE], [DATE], [DATE], [DATE] and [DATE]. She indicated that she was informed by the facility that Resident #20 had refused [MEDICAL TREATMENT] on [DATE] and [DATE]. The [MEDICAL TREATMENT] nurse reported that the facility did not send the communication book with the resident during the treatments. Attempts to contact Nurse #2, who was assigned to Resident #20 on [DATE], and Nurse #3, who was assigned to the resident on [DATE], were unsuccessful. On [DATE] at 2:07 PM, the current Director of Nursing (DON) was interviewed. She stated that resident on [MEDICAL TREATMENT] should have a doctor ' s order to receive [MEDICAL TREATMENT] treatment and the order should include the number of [MEDICAL TREATMENT] treatments per week. She didn ' t realize that the orders had dropped off during the transition to a new company and new computer system for electronic records in February 2020. She added that after it was brought to her attention during the survey, the facility reinstated the order to all current residents receiving [MEDICAL TREATMENT]. On [DATE] at 10:06 AM, a follow up interview was conducted with the current DON. She stated that the [MEDICAL TREATMENT] clinic did not inform her of the change in the [MEDICAL TREATMENT] schedule/location for Resident #20. They might have informed the transportation person of the change. She expected the transportation person to notify the nurse of the change in the [MEDICAL TREATMENT] schedule and expected the nurse to change the order for the application of the [MEDICATION NAME] cream. The current DON stated that she didn ' t know why the order for the [MEDICATION NAME] cream was not changed. The current DON stated the facility was using the communication sheet to communicate with the [MEDICAL TREATMENT] clinic. The nurse was supposed to fill out the sheet in the [MEDICAL TREATMENT] binder and sent the binder with the resident during the [MEDICAL TREATMENT] treatment. The current DON stated that she didn ' t know why the [MEDICAL TREATMENT] binder was not sent with the resident to [MEDICAL TREATMENT] after [DATE]. On [DATE] at 11:20 AM, interview with the Administrator was conducted. She stated that the facility ' s protocol was for [MEDICAL TREATMENT] orders to be in place. She reported that she thought the orders for [MEDICAL TREATMENT] were dropped off when the facility changed ownership and the electronic records were switched. She added that the orders were not entered into the electronic records and she had no record of orders that may have been in place previously. She stated that she expected the facility to have a consistent communication with the [MEDICAL TREATMENT] clinic. The system was for the facility nurse to complete the communication sheet and the [MEDICAL TREATMENT] binder was sent with the resident each time they went to [MEDICAL TREATMENT]. Then the [MEDICAL TREATMENT] clinic would complete the form and the binder was returned to the facility with the resident. The Administrator added that when COVID 19 happened and [MEDICAL TREATMENT] schedule had changed, the staff were not used to prepping the residents for [MEDICAL TREATMENT] and education was not provided to send the binder with the resident. She reported that since the issue was brought to her attention during the survey, the staff had been provided with education. On [DATE] at 11:50 AM, the Physician was interviewed. He stated that he doesn ' t always write orders for [MEDICAL TREATMENT] however he would expect the facility ' s normal protocol regarding [MEDICAL TREATMENT] orders to be followed and if the facility ' s protocol was to have orders then he would write the order. 2. Resident #22 was initially admitted to the facility on [DATE] and most recently readmitted on [DATE]. Her [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) completed for Resident #22 was a quarterly assessment dated [DATE]. Her cognition was intact, and she was on [MEDICAL TREATMENT]. A Risk Meeting nursing note dated [DATE] completed by former Unit Manager (UM) #1 indicated Resident #22 was continued on [MEDICAL TREATMENT] 4 times a week. Resident #22's active care plan included the focus area of the risk for impaired renal function and complications related to [MEDICAL TREATMENT]. The interventions included, in part, transferring resident to [MEDICAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	**710 JULIAN ROAD SALISBURY, NC 28147**

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 0698

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 6)
TREATMENT] unit for treatments, sending communication book to [MEDICAL TREATMENT] and reviewing book upon return, and
monitoring her [MEDICAL TREATMENT] every shift and as needed. 2a. The physician's order summary from [DATE] through [DATE]
revealed no physician's orders for Resident #22 to have [MEDICAL TREATMENT] treatment or for staff to monitor her [MEDICAL TREATMENT]. A phone interview was conducted on [DATE] at 9:24 AM with former UM #1. She stated that it was the facility's normal protocol to have physician's orders for [MEDICAL TREATMENT] treatment as well as physician's orders to monitor and assess the resident's access site at least once per shift. A phone interview with the Director of Nursing (DON) was conducted on [DATE] at 11:26 AM. She stated that the facility's normal protocol was to have physician's orders for [MEDICAL TREATMENT] treatment that included the days the resident was to attend [MEDICAL TREATMENT] as well as orders for assessing the resident's access site. Resident #22's physician's order summary from [DATE] through [DATE] that included no physician's orders for [MEDICAL TREATMENT] treatment and no orders for assessing the resident's access site were reviewed with the DON. She was unable to explain why there were no physician's orders for [MEDICAL TREATMENT] treatment or assessing the access site. On [DATE] physician's orders for Resident #22's [MEDICAL TREATMENT] treatment and assessing of her access
site were entered into the electronic medical record and were signed by the Medical Director on [DATE]. A follow up interview was conducted with the DON by phone on [DATE] at 1:46 PM. She revealed that after her previous interview on [DATE] at 11:26 AM she realized there were no physician's orders for [MEDICAL TREATMENT] treatment or assessment of the access site for any of the current [MEDICAL TREATMENT] residents (Residents #22 and #40) at the facility. She stated she spoke with the Medical Director that afternoon and received physician ' s orders that were entered into the electronic record on [DATE] and signed by the Medical Director on [DATE] for Resident #22. The DON explained that the facility ' s corporate ownership changed in February 2020 and she believed that the [MEDICAL TREATMENT] orders were missed when the electronic medical records system was transferred to the current system. During an interview with the Administrator on [DATE] at 11:20 AM she verified former UM #1's interview and the DON's interview that the facility's normal protocol was to have physician's orders for [MEDICAL TREATMENT] treatment that included the days the resident was to attend [MEDICAL TREATMENT] as well as orders for assessing the resident's access site. She explained that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them. A phone interview was conducted with the Medical Director on [DATE] at 12:58 PM. He stated that every facility he provided services for had different protocols related to physician's orders for [MEDICAL TREATMENT] treatment and assessing of the access sites. He reported that his normal procedure was to follow the facility's protocol. 2b. Resident #22 was discharged to the hospital on [DATE] and was readmitted to the facility on [DATE]. The [MEDICAL TREATMENT] communication documentation for Resident #22 from [DATE] through [DATE] revealed no evidence of routine communication with the [MEDICAL TREATMENT] center. On [DATE] at 8:09 AM via electronic correspondence the Administrator
indicated that the facility's protocol for routine communication with the [MEDICAL TREATMENT] center was maintained in a binder. She wrote that each [MEDICAL TREATMENT] resident had their own binder which was sent back and forth with the resident to the [MEDICAL TREATMENT] center on each visit. A phone interview was conducted on [DATE] at 9:24 AM with former
Unit Manager (UM) #1. She stated that the facility's normal protocol for routine communication with the [MEDICAL TREATMENT] center was for a binder to be sent back and forth with the resident to the [MEDICAL TREATMENT] center on each visit. She
reported that each resident at the facility who was on [MEDICAL TREATMENT] had their own binder. She explained that each binder was kept at the nurse's station. She further explained that this binder contained communication forms that were completed by a facility nurse prior to the resident leaving for [MEDICAL TREATMENT], a portion was completed by the [MEDICAL TREATMENT] center staff post-[MEDICAL TREATMENT] treatment, and then the final portion was completed by the facility nurse upon return to the facility. Former UM #1 reported that the form contained pertinent information such as an assessment of the resident's access site, the resident's weight, and vital signs. A phone interview with the Director of Nursing (DON) was conducted on [DATE] at 11:26 AM. She verified the Administrator and former UM #1's reports that the facility's normal protocol for routine communication with the [MEDICAL TREATMENT] center was for a binder to be sent back and forth with the resident to the [MEDICAL TREATMENT] center on each visit. She revealed that on [DATE] when evidence of routine communication with the [MEDICAL TREATMENT] center was requested for review she realized there were no communication forms for Resident #22 since her readmission on [DATE]. She further revealed that staff had not been sending the communication binder with Resident #22 to the [MEDICAL TREATMENT] center from [DATE] through [DATE]. The DON stated that
there were multiple new staff at the facility as well as changes that occurred with the times Resident #22 attended [MEDICAL TREATMENT]. She explained that due to these changes, different staff were preparing Resident #22 for [MEDICAL TREATMENT] transport and they were not familiar with the facility's protocol to complete the communication form prior to [MEDICAL TREATMENT], send the binder with the resident for the [MEDICAL TREATMENT] staff to complete post [MEDICAL
TREATMENT], and then to review the information from the [MEDICAL TREATMENT] center and complete the remainder of the form
when the resident returned from [MEDICAL TREATMENT]. During an interview with the Administrator on [DATE] at 11:20 AM she
stated that she expected all staff to follow the facility's protocol for ongoing routine communication with the [MEDICAL TREATMENT] center. She reiterated the DON's report that the facility had multiple new staff at the facility and they had not been educated on the facility's protocol for maintaining routine communication with the [MEDICAL TREATMENT] center. The Administrator added that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them. 3. Resident #40 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #40's cognition was intact, and he was on [MEDICAL TREATMENT]. Resident #40's active care plan included the focus area of the risk for complications related to [MEDICAL TREATMENT] 3 days per week. The interventions included, in part, monitor vital signs pre and post [MEDICAL TREATMENT] treatment and monitor access site. 3a. The physician's order summary from [DATE] through [DATE] revealed no physician's orders for Resident #40 to have [MEDICAL TREATMENT] treatment or for staff to monitor his [MEDICAL TREATMENT]. A phone interview was conducted on [DATE] at 9:24 AM with former Unit Manager
(UM) #1. She stated that it was the facility's normal protocol to have physician's orders for [MEDICAL TREATMENT] treatment as well as physician's orders to monitor and assess the resident's access site at least once per shift. A phone interview with the Director of Nursing (DON) was conducted on [DATE] at 11:26 AM. She stated that the facility's normal protocol was to have physician's orders for [MEDICAL TREATMENT] treatment that included the days the resident was to attend [MEDICAL TREATMENT] as well as orders for assessing the resident's access site. On [DATE] physician's orders for Resident #40's [MEDICAL TREATMENT] treatment and assessing of his access site were entered into the electronic medical record and were signed by the Medical Director on [DATE]. A follow up interview was conducted with the DON by phone on [DATE] at 1:46 PM. She revealed that after her previous interview on [DATE] at 11:26 AM related to the facility ' s normal protocol for physician's orders for [MEDICAL TREATMENT] residents she realized there were no physician sorders for [MEDICAL TREATMENT]
treatment or assessment of the access site for any of the current [MEDICAL TREATMENT] residents (Residents #40 and #22) at the facility. She stated she spoke with the Medical Director that afternoon and received physician's orders that were entered into the electronic record on [DATE] and signed by the Medical Director on [DATE] for Resident #40. The DON explained that the facility's corporate ownership changed in February 2020 and she believed that the [MEDICAL TREATMENT] orders were missed when the electronic medical records system was transferred to the current system. During an interview with the Administrator on [DATE] at 11:20 AM she verified former UM #1's interview and the DON's interview that the facility's normal protocol was to have physician's orders for [MEDICAL TREATMENT] treatment that included the days the resident was to attend [MEDICAL TREATMENT] as well as orders for assessing the resident's access site. She explained that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them. A phone interview was conducted with the Medical Director on [DATE] at 12:58 PM. He stated that every facility he provided services for had different protocols related to physician's orders for [MEDICAL TREATMENT] treatment and assessing of the access sites. He reported that his normal procedure was to follow the facility's protocol. 3b. The [MEDICAL TREATMENT] communication documentation for Resident #40 from [DATE] through [DATE] revealed the last communication form completed by facility staff was dated [DATE]. Communication forms dated [DATE] and [DATE] were completed by the [MEDICAL TREATMENT] center's staff, but not completed by the facility's staff. On [DATE] at 8:09 AM via electronic correspondence the Administrator indicated that the facility's protocol for routine communication with the [MEDICAL TREATMENT] center was maintained in a binder. She wrote that each [MEDICAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) TREATMENT] resident had their own binder which was sent back and forth with the resident to the [MEDICAL TREATMENT] center on each visit. A phone interview was conducted on [DATE] at 9:24 AM with former Unit Manager (UM) #1. She stated that the facility's normal protocol for routine communication with the [MEDICAL TREATMENT] center was for a binder to be sent back and forth with the resident to the [MEDICAL TREATMENT] center on each visit. She reported that each resident at the facility who was on [MEDICAL TREATMENT] had their own binder. She explained that each binder was kept at the nurse's station. She further explained that this binder contained communication forms that were completed by a facility nurse prior to the resident leaving for [MEDICAL TREATMENT], a portion was completed by the [MEDICAL TREATMENT] center staff post-[MEDICAL TREATMENT] treatment, and then the final portion was completed by the facility nurse upon return to the facility. Former UM #1 reported that the form contained pertinent information such as an assessment of the resident's access site, the resident's weight, and vital signs. A phone interview with the Director of Nursing (DON) was conducted on [DATE] at 11:26 AM. She verified the Administrator and former UM #1 ' s reports that the facility's normal protocol for routine communication with the [MEDICAL TREATMENT] center was for a binder to be sent back and forth with the resident to the [MEDICAL TREATMENT] center on each visit. She revealed that on [DATE] when evidence of routine communication with the [MEDICAL TREATMENT] center was requested for review she realized there were no completed communication forms for Resident #40 from [DATE] through present. The DON stated that there were multiple new staff at the facility as well as changes that occurred with the times Resident #40 attended [MEDICAL TREATMENT]. She explained that due to these changes, different staff were preparing Resident #40 for [MEDICAL TREATMENT] transport and they were not familiar with the facility's protocol to complete the communication form prior to [MEDICAL TREATMENT], send the binder with the resident for the [MEDICAL TREATMENT] staff to complete post [MEDICAL TREATMENT], and then to review the information from the [MEDICAL TREATMENT] center and complete the remainder of the form when the resident returned from [MEDICAL TREATMENT]. During an interview with the Administrator on [DATE] at 11:20 AM she stated that she expected all staff to follow the facility's protocol for ongoing routine communication with the [MEDICAL TREATMENT] center. She reiterated the DON's report that the facility had multiple new staff at the facility and they had not been educated on the facility's protocol for maintaining routine communication with the [MEDICAL TREATMENT] center. The Administrator added that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them. 4. Resident #25 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #25's cognition was intact, and he was on [MEDICAL TREATMENT]. Resident #25's care plan included the focus area of the risk for complications related to [MEDICAL TREATMENT] initiated on [DATE]. The interventions included, in part, encourage resident to go to scheduled [MEDICAL TREATMENT] appointments on Monday, Wednesdays, and Fridays, check and change dressing daily at access site and document, and monitor vital signs as indicated. Resident #25 expired at the facility on [DATE]. 4a. The physician's order summary from [DATE] through [DATE] revealed no physician's orders for Resident #25 to have [MEDICAL TREATMENT] treatment or for staff to monitor his [MEDICAL TREATMENT]. A phone interview was conducted on [DATE] at 9:24 AM with former Unit Manager (UM) #1. She stated that it was the facility's normal protocol to have physician's orders for [MEDICAL TREATMENT] treatment as well as physician's orders to monitor and assess the resident's access site at least once per shift. A phone interview with the Director of Nursing (DON) was conducted on [DATE] at 11:26 AM. She stated that the facility's normal protocol was to have physician's orders for [MEDICAL TREATMENT] treatment that included the days the resident was to attend [MEDICAL TREATMENT] as well as orders for assessing the resident's access site. A follow up interview was conducted with the DON by phone on [DATE] at 1:46 PM. She revealed that after her previous interview on [DATE] at 11:26 AM related to the facility's normal protocol for physician's orders for [MEDICAL TREATMENT] residents she realized there had been no physician's orders for [MEDICAL TREATMENT] treatment or assessment of the access site for Resident #25 during his stay at the facility ([DATE] through [DATE]) or for any of the current [MEDICAL TREATMENT] residents at the facility. She stated she spoke with the Medical Director that afternoon and received physician's orders for the current [MEDICAL TREATMENT] residents (Residents #22 and #40) that were entered into the electronic record on [DATE] and signed by the Medical Director on [DATE] for Resident #25. The DON explained that the facility's corporate ownership changed in February 2020 and she believed that the [MEDICAL TREATMENT] orders were missed when the electronic medical records system was transferred to the current system. During an interview with the Administrator on [DATE] at 11:20 AM she verified former UM #1's interview and the DON's interview that the facility's normal protocol was to have physician's orders for [MEDICAL TREATMENT] treatment that included the days the resident was to attend [MEDICAL TREATMENT] as well as orders for assessing the resident's access site. She explained that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them. A phone interview was conducted with the Medical Director on [DATE] at 12:58 PM. He stated that every facility he provided services for had different protocols related to physician's orders for [MEDICAL TREATMENT] treatment and assessing of the access sites. He reported that his normal procedure was to follow the 's protocol. 4b. The [MEDICAL TREATMENT] communication documentation for Resident #25 from [DATE] through [DATE] revealed 1 communication form dated [DATE] for Resident #25. Documentation from the [MEDICAL TREATMENT] center indicated Resident #25 attended [MEDICAL TREATMENT] on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 8:09 AM via electronic correspondence the Administrator indicated that the facility's protocol for routine communication with the [MEDICAL TREATMENT] center was maintained in a binder. She wrote that each [MEDICAL TREATMENT] resident had their own binder which was sent back and forth with the resident to the [MEDICAL TREATMENT] center on each visit. A phone interview was conducted on [DATE] at 9:24 AM with former Unit Manager (UM) #1. She stated that the facility's normal protocol for routine communication with the [MEDICAL TREATMENT] center was for a binder to be sent back and forth with the resident to the [MEDICAL TREATMENT] center on each visit. She reported that each resident at the facility who was on [MEDICAL TREATMENT] had their own binder. She explained that each binder was kept at the nurse's station. She further explained that this binder contained communication forms that were completed by a facility nurse prior to the resident leaving for [MEDICAL TREATMENT], a portion was completed by the [MEDICAL TREATMENT] center staff post-[MEDICAL TREATMENT] treatment, and then the final portion was completed by the facility nurse upon return to the facility. Former UM #1 reported that the form contained pertinent information such as an assessment of the resident's access site, the resident's weight, and vital signs. A phone interview with the Director of Nursing (DON) was conducted on [DATE] at 11:26 AM. She verified the Administrator and former UM #1's reports that the facility ' s normal protocol for routine communication with the [MEDICAL TREATMENT] center was for a binder to be sent back and forth with the resident to the [MEDICAL TREATMENT] center on each visit. She revealed that on [DATE] when evidence of routine communication with the [MEDICAL TREATMENT] center was requested for review she realized there was only one communication form completed for Resident #25 during his stay at the facility ([DATE] through [DATE]). The DON stated that there were multiple new staff at the facility and they were not familiar with the facility ' s protocol to complete the communication form prior to [MEDICAL TREATMENT], send the binder with the resident for the [MEDICAL TREATMENT] staff to complete post [MEDICAL TREATMENT], and then to review the information from the [MEDICAL TREATMENT] center and complete the remainder of the form when the resident returned from [MEDICAL TREATMENT]. During an interview with the Administrator on [DATE] at 11:20 AM she stated that she expected all staff to follow the facility's protocol for ongoing routine communication with the [MEDICAL TREATMENT] center. She reiterated the DON ' s report that the facility had multiple new staff at the facility and they had not been educated on the facility's protocol for maintaining routine communication with the [MEDICAL TREATMENT] center. The Administrator added that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them.

F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility ' s COVID-19 Policy/Plan for Facilities, and interviews with resident, family, staff, Medical Director, and Nurse Practitioner, the facility failed to update, have and to follow current Infection Control guidance provided by the CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare and Medicaid Services) by failing to have new admissions and readmissions separated from current residents for 12 of 12 residents (Residents #2, #11, #19, #22, #25, #27, #32, #33, #34, #35, #36, and #39) who were admitted and/or readmitted to the facility from [DATE] through [DATE]. In addition, the facility also failed to fully implement CDC and CMS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 8) guidance for the use of facemasks for staff and residents until 5 days after the guidance was released ([DATE]). This system failure occurred during the COVID-19 pandemic and had a high likelihood of affecting all residents by placing them at an increased risk of developing and transmitting COVID-19. The facility ' s first COVID-19 positive resident was identified on [DATE] (Resident #19). On [DATE] mass COVID-19 testing of facility residents was completed which showed a total of 100 out of 124 residents were COVID-19 positive. As of [DATE] a total of 105 residents had tested positive for COVID 19. The findings included: CMS (Centers for Medicare and Medicaid Services) guidance from QSO-,[DATE]-NH dated [DATE], in accordance with CDC (Centers for Disease Control and Prevention) guidance, indicated the following: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room). 1. The following facility corporate policy titled, COVID-19 Policy/Plan for Facilities dated [DATE], indicated the following information related to new admissions: Each facility will attempt to locate new admissions to a common part of the facility for a waiting period of 5 days prior to being placed in a room within the general resident community. This [DATE] facility corporate policy did not incorporate the CDC and CMS guidance (effective [DATE]) of placing residents who entered the facility in quarantine for 14 days. A review of the admissions/readmissions list from [DATE] through [DATE] revealed 3 residents (Residents #27, #32, and #33) were admitted and/or readmitted to the facility on general population halls that were not designated for quarantine purposes. 1a. Resident #27 was admitted to the facility from the hospital on [DATE]. Her admission [DIAGNOSES REDACTED]. Review of Resident #27 ' s electronic medical record indicated she was admitted to a semi-private room with a roommate (Resident #37) within the general population on 300 hall indicating that Resident #27 was not quarantined. Review of a nursing note dated [DATE] at 7:10 PM read Resident #27 complained about wanting to move into another room. The note read her requested would be communicated to management. Review of Resident #27 ' s electronic medical record indicated she was moved from the 300 hall to the 200 hall into another semi-private room with a roommate (Resident #22) on [DATE]. The 200 hall was a general population hall indicating that Resident #27 was not quarantined. Resident #27 ' s admission Minimum Data Set ((MDS) dated [DATE] indicated her cognition was intact. Review of a nursing note dated [DATE] at 2:46 PM read Resident #27 was encouraged to wear a mask when she was out of her room since she was susceptible to infection. Resident #27 was care planned for suspected COVID-19 on [DATE]. The goal was for Resident #27 ' s care and symptoms be managed per CDC guidance and the facility protocol. Interventions included placing Resident #27 in a private room with a dedicated bathroom as available or cohort with other residents in separate wing/hall who were confirmed COVID-19 positive. Resident #27 was swabbed for COVID-19 on [DATE] and with positive results received on [DATE]. In a telephone interview on [DATE] at 10:26 AM, former UM #1 confirmed Resident #27 was admitted on [DATE] into room within the general population with a roommate (Resident #37). On [DATE] Resident #27 moved into a different semi-private room with a new roommate (Resident #22) on a general population hall. In a telephone interview on [DATE] at 1:38 PM, Nursing Assistant (NA) #3 stated she had not recalled Resident #27 being on any form of quarantine after admission ([DATE]) and she had not worn anything but gloves when caring for Resident #27 while working with her on the 300 and 200 hall during the 14-day timeframe after her admission. In a telephone interview on [DATE] at 2:16 PM, Occupational Therapy (OT) stated that she had no recollection of Resident #27 being quarantined on admission but rather she was admitted into a semi-private room with a roommate within the general population of the facility on [DATE]. She stated it was her understanding that the Administrator and DON made decisions regarding placement of new admissions and readmissions. In a video phone call with Resident #27 on [DATE] at 3:32 PM, she stated that she was not on any type of quarantine during the 14-day timeframe after her admission ([DATE]). In a telephone interview on [DATE] at 3:50 PM, Resident #27 ' s emergency contact stated she was under the impression that Resident #27 was going to be placed in a private room on admission for a quarantine purposes, but that had not occurred. During a phone interview with the Medical Director on [DATE] at 12:58 PM he reported that his expectation was for Resident #27 to have been placed on a 14-day quarantine on admission to facility ([DATE]) in accordance with CDC and CMS guidelines. 1b. Resident #32 was originally admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Review of Resident #32 ' s electronic medical record indicated he was hospitalized from [DATE] through [DATE]. The resident ' s record also specified he was readmitted to the facility to his private room on the 300 hall in the general population indicating Resident #32 was not quarantined. Resident #32 expired in the facility on [DATE]. A Significant Change in Status Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #32 was cognitively intact and required total assistance with mobility and transfers. He had 2 venous/arterial ulcers as well as surgical wounds and received intravenous antibiotics. A phone interview was conducted with Nurse #5 on [DATE] at 5:10pm, who recalled Resident #32 was readmitted to the same private room on the 300 hall in the general population. She could not recall any special precautions taken by the staff when providing his care. On [DATE] a phone interview occurred with Nurse Aide (NA) #1 at 9:35am. She was familiar with Resident #32 and stated when he was readmitted from the hospital ([DATE]), he returned to the same private room, within the general population of the facility. NA #1 could not recall any special precautions taken when rendering personal care. She added he was bedbound on readmission from the hospital. A phone interview was held with NA #2 on [DATE] at 9:42am, who was familiar with Resident #32. She confirmed he was readmitted from the hospital on [DATE] to the same private room within the general population of the facility and was bedbound. NA #2 added that no special precautions were taken when providing his care. 1c. Resident #33 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission list for [DATE] indicated Resident #33 was admitted ([DATE]) from the hospital. Review of Resident #33 ' s electronic medical record indicated he was admitted to a private room within the general population on the 500 hall indicating that he was not quarantined. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #33 ' s cognition was intact, and he was independent with Activities of Daily Living (ADLs). Resident #33 was care planned for suspected COVID-19 on [DATE]. The goal was for Resident #33 ' s care and symptoms be managed per CDC guidelines and facility protocol. Interventions included initiating droplet and contact precautions and to restrict resident to his room to the extent possible. Record review indicated Resident #33 had a planned discharge to the community on [DATE]. A phone interview was conducted with Nurse #7 on [DATE] at 3:40 PM. She stated that she was familiar with Resident #33 and recalled that he was admitted ([DATE]) to a private room within the general population of the facility. She indicated that Resident #33 was not quarantined on admission. She reported that Resident #33 left his room for rehabilitation via a self-propelled wheelchair. Nurse #7 was unable to explain why Resident #33 was not quarantined for 14 days after his admission ([DATE]). A review of the facility ' s census for [DATE] through [DATE] revealed the 100-hall had a total of 26 beds (12 double occupancy rooms and 2 single occupancy rooms) and all beds were open and available during this timeframe. Record review revealed the first COVID-19 positive facility resident was identified on [DATE] (Resident #19). On [DATE] mass COVID-19 testing of facility residents was completed with results returning on [DATE] and [DATE]. A facility listing of residents with COVID-19 test results as of [DATE] included a total of 124 residents. This list revealed 100 of 124 residents were COVID-19 positive. During an interview with the Administrator on [DATE] at 1:35 PM she stated that the 100-hall was a closed hall prior to the pandemic and that the facility ' s plan was to utilize this hall for quarantine purposes related to COVID-19. A phone interview was conducted on [DATE] at 3:21 PM with the Administrator. She was asked to confirm the facility ' s corporate policy for COVID-19 related to new admissions/readmissions. She stated that from [DATE] to [DATE] the facility ' s corporate policy was for new admissions to be placed in a section of the facility that was separate from the general population for a waiting period of 5 days prior to being placed in a room within the general population. She stated that during this 5-day timeframe, these residents were to be placed in a private room with a private bathroom and quarantined to their room. The Administrator indicated that the purpose of this 5-day quarantine and separation from the general population within the facility was to protect current residents from new admissions as these residents were coming in from environments that increased their possibility of being exposed to [MEDICAL CONDITION] (COVID-19). When asked if this facility policy applied to readmissions she stated that readmissions were to be placed on the 100-hall if they were symptomatic for COVID-19. She was unable to explain why the facility ' s corporate policy had not applied to readmissions as these residents were also coming from environments that increased their possibility of being exposed to [MEDICAL CONDITION] (COVID-19). The Administrator was also unable to explain why the [DATE] facility corporate policy was for a 5-day quarantine rather than a 14-day quarantine as indicated in the CDC and CMS guidance dated [DATE]. She was additionally unable to explain why the 100-hall, which was empty, was not utilized for quarantine placement of new admissions and/or readmissions in order to separate these residents from the general population of the facility. On [DATE] at 3:57 PM via electronic correspondence the Administrator indicated that the former DON and the former Unit Managers (UMs)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 9) were responsible for room placement decisions for admissions/readmissions in [DATE]. Phone interviews were attempted with the former Director of Nursing (DON) on [DATE] at 5:07 PM and [DATE] at 3:27 PM. She was unable to be reached. A phone interview was conducted with former UM #2 (primarily assigned to the 500 and 600 halls) on [DATE] at 4:30 PM. She stated that she made recommendations to the former DON and Administrator for room placement of new admissions/readmissions in [DATE] through the beginning of [DATE], but the management had not heeded her clinical recommendations. She stated that she believed new admissions/readmissions should have been quarantined to a private room away from the general population. UM #2 explained that these new admissions/readmissions were at high risk for coming into contact with [MEDICAL CONDITION] (COVID-19) while at the hospital and/or in the community. A phone interview was conducted with former UM #1 (primarily assigned to the 100, 200, and 300 halls) on [DATE] at 10:26 AM. She stated that room placement decisions throughout the COVID-19 pandemic were made by management and she had not agreed with their decisions. She explained that she believed new admissions and/or readmissions should have been placed in quarantine as they were at high risk for coming into contact with [MEDICAL CONDITION] (COVID-19) while at the hospital and/or in the community. A phone interview was conducted with the Infection Control Preventionist/Staff Development Coordinator (ICP/SDC) on [DATE] at 12:10 PM. She stated that in [DATE] the facility was not quarantining any new admissions and/or readmissions related to COVID-19. She reported that she had no input in room placement decisions. She stated that the former DON, Medical Director, and Administrator were making room placement decisions. The ICP/SDC revealed that throughout [DATE] the facility was not following the guidance from the CDC and/or CMS. A phone interview was conducted with the Medical Director on [DATE] at 12:58 PM. He stated that he was not involved in any decision-making regarding room placement of new admissions and/or readmissions during the COVID-19 pandemic. He reported the facility had their own COVID-19 corporate plan that they were following. The Medical Director indicated his expectation was for the facility to follow CDC and CMS guidance regarding placement of new admissions and readmissions. On [DATE] the following information was provided and received via electronic correspondence with the Administrator: - At 2:20 PM the Administrator was asked if she was aware the facility was not following CDC and CMS guidance that was effective on [DATE] which indicated that if possible, the facility was to dedicate a unit/wing exclusively for any residents coming or returning from the hospital where they were to remain for 14 days with no symptoms prior to being integrated into the general population. - At 3:27 PM the Administrator responded, I do believe that was a recommendation and not a requirement on ,[DATE]. She revealed that she was not aware the facility was not in compliance with guidance from the CDC and CMS. On [DATE] at 10:48 AM via electronic correspondence the Administrator revealed that as of [DATE] a total of 105 facility residents had tested positive for COVID-19 out of a census high of 127. In a follow up interview on [DATE] at 11:20 AM, the Administrator confirmed that from [DATE] through [DATE] the facility ' s corporate policy for COVID-19 related to admissions and readmissions was not in accordance with the CDC and CMS guidelines. She additionally confirmed that the CDC and CMS guidelines for admissions/readmissions were not followed from [DATE] through [DATE]. The Administrator indicated that new admissions/readmissions should have been placed in a designated section of the facility and quarantined for 14 days. She confirmed the 100-hall was open and available as a quarantine section of the facility from [DATE] through [DATE]. 2. The facility corporate policy titled, COVID-19 Policy/Plan for Facilities was revised on [DATE]. The section of the policy related to new admissions that stated, Each facility will attempt to locate new admissions to a common part of the facility for a waiting period of 5 days prior to being placed in a room within the general resident community was struck through indicating that it was no longer part of the facility corporate policy. There was no mention in this revised policy (dated [DATE]) of the separation of new admissions/readmissions from the general population for quarantine purposes. This revised facility corporate policy included the addition of the following related to new admissions: The Infection Preventionist and/or the Director of Nursing will assist in placing the newly admitted resident in a location within the facility that considers the reasons for admission, any associated risks for infection and the protection of the new resident as well as other residents and staff. This [DATE] facility corporate policy did not incorporate the CDC and CMS guidance (effective [DATE]) of placing residents who entered the facility in quarantine for 14 days. The facility corporate policy titled, COVID-19 Policy/Plan for Facilities was revised again on [DATE] with the addition of the following related to referrals for admissions: As of ,[DATE], the facility is not admitting residents with known positive tests or who have been tested by the hospital until they are symptom free and have a negative test. This includes residents who are sent to the emergency room due to symptoms of COVID 19 such as fever, new onset shortness of breath. Staff is encouraged to complete a careful assessment to rule out other causes of symptoms and to prevent any unnecessary emergency visits or hospital stays. While we are focused on not contributing to overwhelming the hospitals, we are also committed to keeping the facilities free of infection. This [DATE] facility corporate policy continued to not incorporate the CDC and CMS guidance (effective [DATE]) of placing residents who entered the facility in quarantine for 14 days. CMS guidance, dated [DATE], titled COVID-19 Long-Term Care Facility Guidance indicated CMS and CDC recommended immediate actions to keep patients and residents safe. These actions included, in part, the following: Long-term care facilities should ensure all staff are using appropriate (Personal Protective Equipment (PPE)) when they are interacting with patients and residents, to the extent PPE is available and per CDC guidance on conservation of PPE. For the duration of the state of emergency in their State, all long-term care facility personnel should wear a facemask while they are in the facility. Full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE. If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 [DIAGNOSES REDACTED].g., [MEDICAL TREATMENT] patients) should wear facemasks when outside of their rooms. The facility corporate policy for COVID-19 regarding PPE use that was in place at the time of the above [DATE] CMS guidance indicated: The (Infection Preventionist) will assist in determining the correct use of PPE by staff, determine the need for and the type of isolation required and assure staff has received appropriate training and guidance in caring for any resident who has the potential to infect others. The (Infection Preventionist) will establish and monitor any isolation required including proper PPE and required posting of the type of isolation to serve as notice to others. A review of the admissions/readmissions list from [DATE] through [DATE] revealed 8 of 8 residents (Residents #2, #11, #19, #25, #34, #35, #36, and #39) who were admitted and/or readmitted to the facility were placed on general population halls that were not designated for quarantine purposes. 2a. Resident #35 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission list for [DATE] indicated Resident #35 was admitted ([DATE]) from home. Review of Resident #35 ' s electronic medical record indicated she was admitted to a private room within the general population on the 600 hall indicating that he was not quarantined. Nursing notes dated [DATE], [DATE] and [DATE] indicated Resident #35 wandered in the common area of the 600 hall. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated her cognition was moderately impaired and she was independent with Activities of Daily Living (ADLs). She was receiving Speech Therapy (ST), Physical Therapy (PT), and Occupational Therapy (OT). A nursing note dated [DATE] completed by MDS Nurse #2 indicated Resident #35 was ambulatory with rolling walker and was out of her room daily. Resident #35 was care planned for suspected COVID-19 on [DATE]. The goal was for Resident #35 ' s care and symptoms be managed per CDC guidance and the facility protocol. Interventions included initiating droplet and contact precautions, supply resident with face mask and encourage resident to wear if she must leave the room, and to restrict resident to her room to the extent possible. These interventions were initiated on [DATE]. A phone interview with MDS Nurse #2 was conducted on [DATE] at 12:10 PM. She stated she was familiar with Resident #35 and stated that she was admitted to a private room on a general population hall (600 hall) for rehabilitation. She stated there was no quarantine in place for the resident at the time of admission ([DATE]). A phone interview was conducted with OT on [DATE] at 12:20 PM. She recalled working with Resident #35 and stated that she was not quarantined on admission ([DATE]). 2b. Resident #19 was admitted from the hospital on [DATE]. Review of the electronic medical record indicated he was admitted on to the 300 hall into a semi-private room with no roommate but within the general population. Her admission [DIAGNOSES REDACTED]. Resident #19 ' s admission Minimum Data Set ((MDS) dated [DATE] indicated she was cognitively intact. She required limited assistance with transfer, ambulation and locomotion on and off the unit. Review of a nursing note dated [DATE] at 10:12 AM read, Resident #19 complained of shortness of breath, a dry cough and generalized weakness. The Physician was notified, and she was sent to the hospital for an evaluation. Review of a nursing note dated [DATE] at 11:30 PM read Resident #19 returned from the emergency roiagnom on [DATE] at 6:15 PM. Review of the emergency room discharge note dated [DATE] indicated Resident #19 was seen for shortness of breath, cough and minimal yellow sputum. She was negative for a fever, chills of chest tightness. Resident #19 exhibited no evidence of respiratory distress, but she was tested for COVID-19. The note continued Resident #19 was living in a facility that could quarantine. There was no need for admission at this time. Review of the electronic medical record revealed Resident #19 was readmitted from the emergency roiagnom on [DATE] into the same semi-private

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 10) room without a roommate into the general population on 300 hall. Review of a nursing note dated [DATE] at 9:19 PM read the hospital notified the facility that Resident #19 had tested positive for COVID-19 in the emergency roiagnom on [DATE]. The Physician was notified and Resident #19 remained on droplet precautions. Resident #19 requested to go to the hospital at 8:45 PM. The Physician was notified of Resident #19 ' s request to go to the hospital and she was transported to the hospital at 9:00 PM. In a telephone interview on [DATE] at 4:30 PM, the former Unit Manager (UM) #2 stated Resident #19 tested positive for COVID-19 at the emergency roiagnom on [DATE] and returned to the facility the same day back into the same room. An interview occurred with the Administrator on [DATE] at 11:15 AM regarding Resident #19 ' s emergency room visit on [DATE] where she was tested for COVID-19 and returned to the facility with symptoms present. The Administrator was unable to explain why the [DATE] facility corporate policy related to COVID-19 that indicated residents tested in the emergency room due to symptoms of COVID-19 would not be readmitted until they are symptom free and have a negative test result. 2c. Resident #34 was admitted from the hospital on [DATE]. Review of the electronic medical record indicated he was admitted into a semi-private room with Resident #16 on the 300 hall in the general population. Resident #34 ' s [DIAGNOSES REDACTED]. Resident #34 ' s admission Minimum (MDS) data set [DATE] indicated he was cognitively intact. He was coded as requiring extensive staff assistance with his activities of daily living and non-ambulatory. Resident #34 was care planned for suspected COVID-19 on [DATE]. The goal was for Resident #34 ' s care and symptoms be managed per CDC guidance and the facility protocol. Interventions included placing Resident #34 in a private room with a dedicated bathroom as available or cohort with other residents in separate wing/hall who were confirmed COVID-19 positive. In a telephone interview on [DATE] at 10:26 AM, former Unit Manager (UM) #1 confirmed Resident #34 was admitted on [DATE] into room within the general population with a roommate (Resident #16). In a telephone interview on [DATE] at 11:29 AM, Social Worker (SW) #1 stated Resident #34 was admitted from the hospital on [DATE] into a semi-private room with Resident #16. SW #1 stated at one point, the facility was placing new admissions into private rooms for 3 days then moving them into semi-private rooms. She stated this practice stopped and she was unable to recall why or exactly when it stopped. SW #1 stated she thought at the time of Resident #34 ' s admission, she was waiting on a private room to open up but the other resident did not end up going home. In another telephone interview on [DATE] at 1:56 PM. SW #1 indicated when Resident #34 was admitted , there were no open private rooms or semi-private rooms other than the rooms on the 100-hall. She stated 100 hall was designated for quarantine purposes, so he was placed in the room with a roommate (Resident #16). She was unable to explain why Resident #34 was placed in a room within the general population rather than on the designated quarantine hall. In a telephone interview on [DATE] at 12:58 PM with the Medical Director he reported that his expectation was for Resident #34 to have been placed on a 14-day quarantine on admission to facility ([DATE]) in accordance with CDC and CMS guidelines. 2d. Resident #25 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission list for [DATE] indicated Resident #25 was admitted ([DATE]) from the hospital. Review of Resident #25 ' s electronic medical record indicated he was admitted to a semi-private room with a roommate (Resident #38) within the general population on the 500 hall indicating that Resident #25 was not quarantined. Review of the electronic record indicated that on the same the day as Resident #25 ' s admission ([DATE]), he moved to a different semi-private room on the 500 hall with a new roommate (Resident #21). A nursing note dated [DATE] indicated Resident #25 attended [MEDICAL TREATMENT] on Monday, Wednesdays, and Fridays. On [DATE] Resident #25 was moved from the 500 hall to the 600 hall in a private room. The 600 hall was a general population hall and was not being utilized for quarantine purposes. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #25 ' s cognition was intact, and he was independent for Activities of Daily Living (ADLs). Resident #25 was care planned for suspected COVID-19 on [DATE]. The goal was for Resident #25 ' s care and symptoms be managed per CDC guidance and the facility protocol. Interventions included initiating droplet and contact precautions, supply resident with face mask and encourage resident to wear if she must leave the room or be transported from the facility, and to restrict resident to his room to the extent possible. These interventions were initiated on [DATE]. Record review indicated Resident #25 expired at the facility on [DATE]. A phone interview was conducted with Nursing Assistant (NA) #10 on [DATE] at 9:40 AM. She stated that upon admission ([DATE]) Resident #25 self-propelled his wheelchair throughout the facility, was not on quarantine, attended [MEDICAL TREATMENT] three times a week, and the resident wore no mask when in or out of his room. She stated she also wore no mask when providing care to the resident upon admission through [DATE]. She was unable to recall the date that residents began wearing masks at the facility, but she knew it was sometime after the staff began wearing masks on [DATE]. A phone interview was conducted with former Unit Manager (UM) #1 on [DATE] at 10:26 AM. She confirmed that Resident #25 was admitted to a semi-private room with a roommate. She stated that she thought this was an inappropriate placement for Resident #25 as he was coming from the hospital and should have been quarantined for a period 14 days. She indicated that Resident #25 self-propelled his wheelchair throughout the facility and attended [MEDICAL TREATMENT] outside of the facility three times a week. Former UM #2 recalled Resident #25 moving about the facility with no mask on. She was unable to recall the date that residents began wearing masks, but she was able to state that it was sometime after [DATE] when staff began wearing masks. A phone interview with Social Worker (SW) #1 was conducted on [DATE] at 2:00 PM. She was asked to explain Resident #25 ' s room assignments. She stated that there were roommate differences with his first placement on admission ([DATE]) so his room was moved to another semi-private room on the same hall (500 hall) on the same day as admission. She reported that on [DATE] she realized there was an open private room on the 600 hall so Resident #25 was moved to that room. SW #1 revealed that there were multiple open rooms on the 100-hall at the time of Resident #25 ' s admission. She was unable to explain why Resident #25 was placed in 3 different rooms (2 on the 500 hall and 1 on the 600 hall) within the general population rather than on the designated quarantine hall when he was admitted . 2e. Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission list for [DATE] indicated Resident #11 was admitted ([DATE]) from home. Review of Resident #11 ' s electronic medical record indicated he was admitted to a semi-private room with a roommate (Resident #26) within the general population on the 300 hall indicating that Resident #25 was not quarantined. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #11 had moderately impaired cognition and required supervision only for locomotion on the unit and was independent for locomotion off the unit. He utilized either a walker or wheelchair for locomotion. Resident #11 was care planned for suspected COVID-19 on [DATE]. The goal was for Resident #11 ' s care and symptoms be managed per CDC guidance and the facility protocol. Interventions included initiating droplet and contact precautions, supply resident with face mask and encourage resident to wear if she must leave the room or be transported from the facility, and to restrict resident to his room to the extent possible. These interventions were initiated on [DATE]. Record review indicated Resident #11 expired at the facility on [DATE]. A phone interview was conducted with Resident #11 ' s Responsible Party (RP) on [DATE] at 8:15 AM. She reported