STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on February 6-7, 2020 and on February 10, 2020 with an exit conference via telephone on February 11, 2020.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff C, a medication aide's (MA), personnel record revealed: -Staff C was hired on 10/30/19. -There was no documentation of a HCPR check completed for Staff C upon hire in 2019. Attempted interviews with Staff C on 02/10/20 at 9:53 am and 02/11/20 at 8:29 am was unsuccessful. Telephone interview with the Resident Care Director (RCD) on 02/11/20 at 3:55 pm revealed:	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

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D 137	Continued From page 1 -She was responsible for new hire paperwork. -She did not know Staff C did not have a HCPR check. -She recently became employed by the facility on 02/05/20 and she had not reviewed all the personnel records. -She was also assuming the duties of the Business Office Manager (BOM). Telephone interview with the Administrator on 02/11/20 at 4:00 pm revealed: -He did not know Staff C did not have a HCPR check completed. -He had not completed an audit of the personnel records and the RCD was assuming the duties of the BOM at this time. -A HCPR check was completed for Staff C on 02/10/20, and there were no findings. Telephone interview with the former Administrator on 02/11/20 at 5:10 pm revealed: -She was responsible for maintaining personnel records. -A HCPR check was done for Staff C upon hire and there were no findings. -She did not know where the completed HCPR check was located but she placed it in Staff C's personnel record.	D 137		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of	D 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 219	Continued From page 2 this Subchapter. Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator/SIC In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 51-60 Aide 24 24 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 61-70 Aide 28 28 24 Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator On call 71-80 Aide 32 32 24 Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator On call 81-90 Aide 36 36 24 Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.** Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 91-100 Aide 40 40 32 Supervisor 8 8 8**	D 219		

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D 219	Continued From page 3	D 219		

Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
191-200 Aide 80 80 56

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D 219	Continued From page 4	D 219		

Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
221-230 Aide 92 92 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
231-240 Aide 96 96 64
Supervisor 24 24 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, record reviews and interviews, the facility failed to ensure required staffing hours were met on first, second and third shifts based on a census of 61-70 for 12 of 42 shifts sampled from 01/23/20 to 02/05/20.

The findings are:

Review of the facility census record from 01/23/20 to 01/31/20 revealed there was a census of 61 residents.

Review of staff timecards from 01/23/20 to 01/31/20 revealed:
-On 01/24/20, on third shift there was a total of 16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D 219	Continued From page 5	D 219		

hours of aide coverage with a shortage of 8 hours.
-On 01/26/20, on first shift there was a total of 21.25 hours of aide coverage with a shortage of 6.75 hours
-On 01/29/20, on third shift there was a total of 23.50 hours of aide coverage with a shortage of .50 hours.

Review of the facility census record from 02/01/20 to 02/06/20 revealed there was a census of 64 residents.

Review of staff timecards from 02/01/20 to 02/05/20 revealed:
-On 02/01/20, on third shift there was a total of 16.75 hours of aide coverage with a shortage of 7.25 hours.
-On 02/02/20, on first shift there was a total of 19.50 hours of aide coverage with a shortage of 8.5 hours.
-On 02/02/20, on second shift there was a total of 14.50 hours of aide coverage with a shortage of 13.50 hours.
-On 02/03/20, on second shift there was a total of 24.75 hours of aide coverage with a shortage of 3.35 hours.
-On 02/03/20, on third shift there was a total of 17.50 hours of aide coverage with a shortage of 6.50 hours.
-On 02/04/20, on first shift there was a total of 23.50 hours of aide coverage with a shortage of 4.50 hours.
-On 02/04/20, on second shift there was a total of 15.50 hours of aide coverage with a shortage of 12.50 hours.
-On 02/04/20, on third shift there was a total of 15 hours of aide coverage with a shortage of 9 hours.
-On 02/05/20, on third shift there was a total of

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	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

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THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D 219	Continued From page 6 16.50 hours of aide coverage with a shortage of 7.50 hours. Interview with a staff on 02/06/20 revealed: -The facility had been short staffed for a couple of months. -The former Administrator fired several staff; not sure why staff had been fired. -There had been several staff to call out of work and staff would contact the former Administrator to let her know. -The former Administrator would tell staff there was nothing she could do about it. Interview with the Resident Care Coordinator (RCC) on 02/06/20 at 5:05 pm revealed: -She started in the RCC position yesterday (02/05/20). -It was her understanding the former Administrator and Resident Care Director (RCD) were responsible for staffing the facility and scheduling staff. -All the medication aides (MAs) were also trained as personal care aides (PCAs). -The third shift (02/06/20) was scheduled to be staffed with 2 MAs and 2 PCAs. -The facility used a staffing agency to staff the facility as well. Interview with a resident on 02/07/20 at 2:15 pm revealed: -The resident did not get medications on time in the mornings. -The resident was supposed to get medications at 7:30 am and rarely received medications before 10:00 am. -There was not enough staff to give medications on most days. -There had been a couple of nights where the staff could not be found in the facility.	D 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

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D 219	Continued From page 7 -The resident could not sleep and got out of bed to come out into the hall to see what staff was working. -The resident went to the other floors but did not see staff anywhere, so the resident went back to bed. -The resident could not recall the dates. Interview with a MA on 02/07/20 at 2:30 pm revealed: -The MA was usually late passing medications in the mornings because there was not enough staff. -The MA had to pass medications on one floor of the facility, and she shared the medication pass on another floor with a second MA. -The MA would be responsible for passing medications to 30-32 residents between the to 2 floors. -There had been a shortage of staff for a while. Interview with a second MA on 02/10/20 at 9:30 am revealed: -The former Resident Care Director (RCD) was responsible for scheduling staff. -She had been working at the facility for a couple of weeks. -She usually worked third shift and there had been times when staff was short on third shift. -Third shift was supposed to be staffed with 2 MAs and 1 or 2 PCAs. -Lately, there had been 1 MA and 1 PCA on third shift. -She recalled a time when there had been 1 staff scheduled for third shift but did not recall the date. -If there were any issues or concerns with staff or with residents, staff were supposed to call the RCD.	D 219		

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	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

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D 219	Continued From page 8 Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 10:07 am revealed: -The schedule should reflect 3 MAs and 3 PCAs on first shift, 3 MAs and 2 PCAs on second shift and 2 MAs and 2 PCAs on third shift. -The former Administrator would come to work and fire staff. -The former Administrator had fired her and when the RCC became aware the former Administrator had left employment at the facility, she called the current RCD to ask for her job back and was hired back as the RCC. -The former Administrator fired several staff who had worked here for several years. -All the staff remaining at the facility were new and there were no experienced staff to assist them and to train them on the facility processes. Interview with a third MA on 02/10/20 at 11:25 am revealed: -She usually worked first shift. -There had been times when she had left the facility and staff on second shift had not showed up for work. -The former RCD, former Administrator or the facility Nurse would stay until second shift staff arrived. -There always had to be someone to hand off the medication cart keys to. -There was not a time when there was no staff or only 1 staff working on a shift that she knew of. -The facility staff was short at times due to the former Administrator "letting staff go" and staff would call out of work. Interview with a PCA on 02/10/20 at 11:55 am revealed: -She had worked when there was not enough staff or staff called out. -She had never come to work or left work when	D 219		

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THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D 219	Continued From page 9	D 219		

there was no staff or 1 staff in the facility working.

Interview with a fourth MA on 02/10/20 at 4:30 pm revealed:
-She worked second and third shifts.
-There was one time recently (could not recall the date) when she and another staff were the only staff on third shift to cover the facility.
-There was supposed to be 2 MAs and 1 or 2 PCAs working third shift; there had been a few times recently only 1 MA and 1 PCA was scheduled to work on third shift.
-If staff called out, she called the RCC, or RCD.
-There always had to be a MA on duty to give the medication cart keys to.

Interview with the RCD on 02/10/20 at 5:15 pm revealed:
-She was responsible for scheduling staff to work in the facility.
-She started in the position of RCD on 02/06/20.
-She was not aware of any staff shortages at the facility.
-There should be at least 3 MAs and 3 PCAs on first shift, 3 MAs and 2 PCAs on second shift, and 2 MAs and 2 PCAs on third shift.

Interview with the former Administrator on 02/11/20 at 11:50 am revealed:
-Her last day of work at the facility was on 01/31/20.
-She sometimes had to cover staff by providing MA duties due to staff calling out of work.
-She fired a few staff, but most of the experienced staff just quit.
-She wanted to staff with agency staff, but the owner did not want to pay for agency staff to work at the facility so "we had to do the best we could do".
-For the regular staffing pattern, she only needed

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	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

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D 219	Continued From page 10	D 219		

2 staff for each floor, 2 MAs per floor.
-The usual staffing pattern for the facility was supposed to be, on first shift there were 3 MAs and 2 PCAs, on second shift there were 3 MAS and 3 PCAs, and on third shift there were 3 MAs and 2 PCAs.
-Most of the time the facility was staffed with 2 MAs and 3 PCAs on first shift, 2 MAs and 3 PCAs on second shift, and 2 MAs and 2 PCAs on third shift.

Interview with the former RCD on 02/10/20 at 12:20 pm revealed:
-Her last day of work at the facility was on 01/30/20.
-She was responsible for the staff schedule.
-There were a lot of staff who called out of work.
-There was not enough staff working at the facility.
-There were staff shortages.
-Some staff quit, and some staff were fired and there was no staff to take their places.
-The owner did not want to use agency to staff on first shift because there were too many staff working on first shift.
-She would call in agency staff anyway despite what the owner had said.
-The previous Administrator was aware agency staff were being used to staff the facility.
-The usual staffing schedule for the facility was 3 MAs and 2 PCAs and 1 shower staff on first shift, 3 MAs and 2 PCAs on second shift, 2 MAs and 2 PCAs on third shift.
-At times, there would only be 2 MAs and 1 PCA or 3 MAs scheduled for third shift; the owner told the RCD she could use agency staff for staffing second and third shift.
-If she could not get facility staff to work or agency staff to work, she would come back in to work the shift herself.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 219	Continued From page 11 Interview with a fourth-floor resident on 02/06/20 at 12:15 pm revealed: -There were not enough staff in the facility. -She lived on the fourth floor and there were no staff during the night shift on the fourth floor. -There were only two medication aides (MAs) who worked on the night shift for the past 4 or 5 months. -She had not needed anything during the night shift. Interview with another fourth-floor resident on 02/06/20 at 12:30 pm revealed: -There were not enough staff in the facility and the fourth floor needed a PCA because some people on the floor needed assistance some of the time. -There had been times she received her medications late because they did not know who would do the medication pass. -There were only two staff in the building on third shift on 02/05/20. -She did not get her cup filled with ice yesterday, 02/05/20, which was customary on first shift. -She thought they were supposed to have a PCA on each floor of the facility. Interview with a family member on 02/06/20 at 1:00 pm revealed: -His family member had resided at the facility for six years. -When he pushed the call bell for assistance for his family member it took "forever" for staff to respond. -The average time he had waited for staff to respond was 25 minutes. -Often staff who responded found out what he or his family member needed and then left again	D 219		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 219	Continued From page 12	D 219		

because staff stated they needed help with the request.
-When staff left again, it may be another 30 minutes before they returned.
-His family member's baths were delayed due to the lack of staff.
-The baths were supposed to be on Mondays, Wednesdays, and Fridays, but it seemed that her bath was not always done on Mondays.
-His family member was usually changed and dressed for bed at 6:30 pm, but due to low staffing he placed her in the bed at 6:30 pm until staff were able to attend to her later in the shift.

Observation of the fourth floor on 02/10/20 at 8:00 am revealed there were no staff on the floor for 1 1/2 hours.

Interview with another fourth-floor resident on 02/07/20 at 8:58 am revealed:
-She came back to the fourth floor after breakfast and there were no staff on the floor for the past 30 minutes.
-The fourth floor MA was in the dining room helping dietary staff clear the dining room of dishes.
-She wanted some ice and staff had ice in a cooler that they give out to residents.

[Refer to Tag 269 10A NCAC 13 F .0901(a) Personal Care and Supervision (Type B Violation)].

[Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]

[Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

_____
The facility's failure to provide adequate staffing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 219	Continued From page 13 for 61-64 residents for 12 of 42 shifts resulting in delayed medication administration, medications not administered as ordered, no direct staff on the fourth floor for third shift and at other periods throughout the day and evening shifts; delayed response to call bells; a delay in personal care provided related to showers and change of clothing, and a resident who was blind not having clean clothes and linens, not receiving incontinence care, and foot care resulting in long, dirty toenails, dry skin, and foul odors and two PCAs scheduled for 61- 64 residents on second and third shifts; failed to notify the medical equipment company and/or home health agency to obtain colostomy bags for a resident and and failed to contact the Home Health agency to administer medications by injection for 2 residents. This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 02/06/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 26, 2020.	D 219		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 14	D 269		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to assure staff provided personal care assistance for 2 of 6 sampled residents (#2 and #9) regarding a resident not receiving colostomy care (#2), and a resident requiring extensive assistance with personal care (#9).

The findings are:

1. Review of Resident #2's current FL2 dated 02/26/19 revealed:
-Diagnoses included congestive heart failure (CHF), schizophrenia, anxiety, insomnia, psychosis and mood disorder.
-Resident #2 was ambulatory.
-Resident #2 had a colostomy.

Review of Resident #2's hospital discharge summary dated 08/20/19 revealed:
-Resident #2 was admitted for a small bowel obstruction on 08/14/19.
-Resident #2 complained his ostomy had not been working with decreased appetite due to stomach pain.
-Resident #2's small bowel obstruction was resolved with medical management; rest and no surgery was needed.

Review of Resident #5's Colon Rectal Clinic visit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 15	D 269		

dated 09/5/19 revealed:
-Resident #2 had initial colostomy surgery in 2018.
-Resident #2 was recently seen in the hospital for a small bowel obstruction with no surgery required.
-Resident #2 had a bag for his ileostomy taped to his skin but did not have an underlying wafer.
-There was some redundant abrasions around the stoma and would be referred for enterostomal therapy (Home Health) for help with ileostomy care.

Review of Resident #2's record revealed there were no additional hospital discharge summaries available for review.

Review of Resident #2's care plan dated 03/30/19 revealed:
-Resident #2 required extensive assistance with bathing, grooming, dressing and personal hygiene.
-Resident #2 required extensive assistance with mobility, ambulation and transfers.
-Resident #2 required extensive assistance with eating and toileting.

Review of Resident #2's Licensed Health Professional Support (LHPS) dated 01/27/20 revealed:
-Care of a well-established colostomy or ileostomy was documented as a marked task.
-Recommended changes and follow-up recommended to meet the resident's needs was documented as no changes.

Review of Resident #2's progress note dated 11/11/19 revealed there were no colostomy bags, contacted the former Resident Care Director (RCD) and staff was told the former RCD would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 16 get colostomy bags tomorrow (11/12/19). Review of Resident #2's December 2019 progress notes revealed: -On 12/07/19 at 2:47 pm, Resident #2 would not let staff change his colostomy bag. -On 12/08/19 at 12:30 am, Resident #2 was monitored by staff and the colostomy bag was removed. Resident #2 was cleaned up and a new colostomy bag was applied. The resident refused to change his shirt that had bowel movement (BM) on it. -On 12/09/19 (no time documented), Resident #2 refused to let staff change his clothes. -On 12/12/19 (no time documented), Resident #2 refused to let staff change his colostomy bag. -On 12/13/19 at 2: 50 pm and on 12/15/19 (no time documented), resident refused personal care today and refused to let staff check his colostomy bag. -On 12/16/19 at 2:30 pm, Resident #2 refused to let staff change his colostomy bag. -On 12/21/19 at 10:30 pm and on 12/22/19 (no time documented), Resident #2 refused personal care and refused to let staff change his colostomy bag. -On 12/26/19 11:00 pm to 7:00 am, Resident refused personal care and did not sleep all night. -On 12/27/19 at 3:00 pm to 11:00 pm, Resident #2 would not let staff check his colostomy. -On 12/29/19 (no time documented), Resident #2 refused to let staff check his colostomy. -On 12/30/19 at 2:00 pm, resident refused personal care. -On 12/31/19 at 11:00 pm to 7:00 am, resident refused personal care and refused to put on clothes. Review of Resident #2's January 2020 progress notes revealed:	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 17 -On 01/01/20 (no time documented), resident #2 refused personal care and would not let staff provide colostomy care. Resident #2 stated staff would "mess up" his stoma. -On 01/02/20 (no time documented), Resident #2 refused personal care and would not let staff check his colostomy or change his clothes. Resident #2 stated staff were "undercover", and medication was "poison". -On 01/03/20 and 01/04/20 (no times documented), resident refused personal care and would not let staff check his colostomy or change his clothes. -On 01/05/20 at 3:00 pm to 11:00 pm, resident refused colostomy care. -On 01/07/20 at 3:00 pm to 11:00 pm, resident refused colostomy care. -On 01/08/20 (no time documented), resident refused personal care and would not let staff check his colostomy. -On 01/11/20 at 3:00 pm to 11:00 pm, resident refused colostomy care. -On 01/13/20 at 7:00 pm to 7:00 am, resident refused colostomy care and got angry at staff. -On 01/14/20 (no time documented), Resident #2 was yelling and screaming. Staff tried to calm him down and was swinging at staff. Resident was sent to the local hospital by Emergency Medical Services. -On 01/16/20 (no time documented), resident came back from the hospital but was still agitated and having behaviors. -On 01/17/20 at 10:30 pm, resident let staff change his clothes and check his colostomy. Resident #2 refused to change his shirt with BM on it and the resident put a clean shirt over his dirty shirt. -On 01/19/20 at 3:00 pm to 11:00 pm, resident back in the hospital. -On 01/24/20 (no time documented), resident	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 18	D 269		

back from the hospital. Refused to let staff change his colostomy bag.
-On 01/25/20 (no timed documented), Resident #5 still having behaviors and was lying in bed with feces all over him and refused to be cleaned up. The resident had been in the bed all day.
-On 01/27/20 at 7:00 am to 3:00 pm, resident refused to let staff change his clothes but went to his room and changed his clothes by himself.

Review of Resident #2's personal care log for February 2020 revealed on 02/01/20 and 02/02/20 the resident was provided a shower and colostomy care by staff.

Review of Resident #2's personal care logs revealed there were no other personal care logs for review.

Observation of Resident #2's room (205) in the second floor of the facility on 02/07/20 at 11:30 am revealed there were no colostomy bags available.

Interview with Resident #2's primary care provider (PCP) on 02/07/20 at 8:55 am revealed:
-The Home Health Nurse (HAHN) was supposed to take care of the colostomy and to start the order for the colostomy bags in September 2019.
-The PCP was told by staff in December 2019 that Home Health (HH) had "dropped" Resident #2 from HH services.
-That was not like HH to just drop a resident from their services.
-The last time she saw Resident #2 was in January 2020 and she noticed Resident #2 was walking around in the facility with the colostomy bag off and there was bowel movement (BM) all over the front of his shirt.
-She had told the former Resident Care Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 19 (RCD) in January 2020 to make sure to order the colostomy bags for Resident #2. Interview with a medication aide (MA) on 02/07/20 at 10:00 am revealed: -Resident #2 was currently in the hospital. -She did not know when Resident #2 went to the hospital or which hospital Resident #2 was admitted to, but he had to go to the hospital because he had no colostomy bags and he was having behaviors. -One day (did not recall the date), Resident #2 came running down the hall and went into the dining room, took his colostomy bag off and dropped it on the floor in front of other residents during mealtime. -Staff cleaned it up and that was all staff did. -Resident #2 would not let staff assist with his colostomy. -He would run around the hall with no "bag on". -He had run out of colostomy bags a month ago and he would not let staff help him. -Home Health (HH) had been coming out to see Resident #2, but HH just dropped him from their services sometime in December 2019. -She did not know why Resident #2 was discharged, and staff did not know where to order the colostomy bags from. -She thought HH was supposed to supply the colostomy bags, and she was not sure what happened; "the bags just stopped coming". -The MA had not called HH to ask about the colostomy bags because she did not know which HH agency to call. -The colostomy bags were stored in Resident #2's room. -Staff called Resident #2's guardian to see if the guardian could get the colostomy bags, but the guardian had no idea where to get the bags.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 20 Interview with a representative from the HH agency on 02/07/20 at 11:40 am revealed: -The Home Health Nurse (HHN) came out to open services in September 2019 for Resident #2 to provide staff education related to the care of the colostomy, irrigation, bag placement and colostomy bag supplies. -HH initiated the order for the colostomy bags and ordered as many as the agency could and according to the resident's pay source. -HH ordered the colostomy bags for Resident #2 from a medical supply company on 11/15/19. -On 11/18/19, the HHN provided the contact information for the medical supply company to the previous Resident Care Director (RCD) to order the colostomy bags for Resident #2. -The HHN made the former RCD aware that the facility would be responsible for ordering the colostomy bags going forward. -HH services were discontinued on 12/12/19 for Resident #2 because HH only provided start-up and education; then the facility would be responsible for following up and ordering the colostomy bags and that was the extent of HH services. Interview with the RCD on 02/07/20 at 11:45 am revealed: -She did not know what happened to Resident #2's colostomy bags. -She did not know who was responsible for ordering the bags. -"We did not know what to do about the colostomy bags." -She had not called HH about the colostomy bags because she did not know which HH agency to call. -The former RCD did not share the information on where and how staff were to order the colostomy bags.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 21 -Staff were told by the former RCD Resident #2 could not afford to buy the colostomy bags and the resident would not be getting any more colostomy bags. Interview with a representative from the medical supply company on 02/07/20 at 12:00 pm revealed: -The medical supply company was emailing and faxing information to the facility and Resident #2's primary care provider (PCP) for over 2 months. -The medical supply company called and emailed the PCP but never gotten a response from the facility or the PCP. -The PCP had to sign an authorization and complete an assessment form for the supply company to deliver the colostomy bags. -That was why no colostomy bags had been sent. Second interview with the RCD on 02/07/20 at 4:30 pm revealed: -She had located an authorization form on 02/07/20 from the medical supply company in a stack of faxes in the former RCD's office that had never been filed. -She called Resident #2's PCP but the PCP told the RCD she was on vacation. -The authorization form had not been sent to the PCP and had not been signed. Interview with a second MA on 02/10/20 revealed: -She knew Resident #2 was in the hospital but she did not know which hospital Resident #2 was admitted to or when the resident went to the hospital. -Staff had to change Resident #2's colostomy bags. -He could not change the colostomy bags for himself. -Staff was supposed to provide personal and	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 22	D 269		

colostomy care for Resident #2.
-Sometimes Resident #2 would resist personal care and colostomy care, and staff would keep trying to help the resident.

Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 10:07 am revealed:
-The former Administrator told the former RCD not to order the colostomy bags for Resident #2 because the former Administrator was going to order the colostomy bags from another supply company; so the colostomy bags did not get ordered.
-The former Administrator told staff she was not going to order colostomy bags for Resident #2 because he was having behaviors.
-Resident #2 would always take the colostomy bags off and he would not let staff help him.

Interview with a staff on 02/10/20 at 10:20 am revealed:
-Resident #2 did not have any colostomy bags to put on.
-Staff would make colostomy bags out of small white trash bags and tape them on Resident #2.

Interview with a medication aide (MA) on 02/10/20 at 11:25 am revealed:
-Staff would make colostomy bags out of small white trash bags and tape them on Resident #2.
-Resident #2 had been out of colostomy bags "for a while" and staff did not know what to do or where to order the bags from.

Interview with a personal care aide (PCA) on 02/10/20 at 11:55 am revealed:
-She knew Resident #2 was in the hospital and thought the resident was admitted to the hospital sometime in January 2020.
-Resident #2 walked around without a colostomy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 23	D 269		

bag on and the resident always had BM on his shirt.
-The PCA did not know if Resident #2 had any colostomy bags or not.

Interview with a second MA on 02/10/20 at 4:30 pm revealed:
-Resident #2 was able to take his own showers.
-Resident #2's colostomy bags ran out sometime in December 2019.
-Resident #2 would get frustrated and take the colostomy bags off and throw them.
-Staff did whatever they had to do when the colostomy bags ran out; tape small trash bags on Resident #2 or tape a cloth on the stoma to keep Resident #2 from messing up his clothes.
-Sometimes Resident #2 would let staff provide personal care and colostomy care and sometimes he would not.
-The MA was able to provide personal care and colostomy care for Resident #2 by fixing the resident a sandwich or providing him with a snack and then he would let the MA help him.

Interview with the former Administrator on 02/11/20 at 11:50 am revealed:
-Resident #2 had colostomy bags; the supply company did not send enough colostomy bags and the colostomy bags ran out.
-She had ordered the colostomy bags from another (named) medical supply company.
-Home Health had originally sent the colostomy bags to the facility for Resident #2.
-Resident #2 had money to pay for the colostomy bags.
-Resident #2 had colostomy bags, he just would not let staff provide personal care or colostomy care him.
-Resident #2 was independent with personal care and only needed staff assistance with his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 24 colostomy care. -Resident #2 would take the colostomy bags off all the time. Interview with the former RCD on 02/11/20 at 12:30 pm revealed: -Resident #2 was "dropped" for HH services in December 2019. -Forms were sent from another (named) HH agency for the PCP to sign to order the colostomy bags. -The former RCD contacted another (named) medical supply company to order the colostomy bags. -Staff had to go pick the bags up from the medical supply company. -Staff would pay for the colostomy bags. -She had the forms signed by the PCP and sent the forms back to the (named) medical supply company where HH had set up the order for colostomy bags from. -If the colostomy bags ran out, staff was supposed to let the former RCD know and then the former RCD would go pick up the colostomy bags from the medical supply company. -Resident #2 would not let staff provide personal care or colostomy care for him. -Resident #2 would not keep the colostomy bags on; he would walk around with no colostomy bag on and he would have BM all over his clothes. -Resident #2's mental health provider (MHP) and PCP knew the resident resisted personal and colostomy care because the former RCD or staff would call and the MHP and PCP visited the facility every 2 weeks. -Staff were supposed to redirect the resident, clean Resident #2 up, change his clothes, give the resident a shower and provide colostomy care. -Resident #2 would walk around without a	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 25	D 269		

colostomy bag about once a week.
-Resident #2 would be sent to the hospital if he refused colostomy care or if he had behaviors.

Interview on 02/11/20 at 2:00 pm with another (named) HH agency contacted by the former RCD revealed:
-The HH agency had not received any orders for Resident #2.
-This company was a Home Care agency and not a HH agency and did not provide colostomy supplies.

Interview with a representative from another (named) medical supply company on 02/11/20 at 2:30 pm contacted by the former RCD and former Administrator revealed the medical supply company closed in January 2020.

Interview with a representative from a third (named) HH agency on 02/11/20 at 2:05 pm contacted by the former RCD to supply colostomy bags for Resident #2 revealed:
-The HH agency had not received any orders for Resident #2.
-The HH agency did supply colostomy bags.

Attempted telephone interview with Resident #2's physician from the Colon Rectal Clinic on 02/07/20 at 2:55 pm was unsuccessful.

Attempted telephone interviews with Resident #2's Guardian on 02/06/20 at 5:00 pm and on 02/11/20 at 10:00 am was unsuccessful.

2. Review of Resident #9's current FL2 dated 09/07/19 revealed:
-Diagnoses included schizophrenia, and blindness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 26 -Resident #9 was incontinent of bladder. -Resident #9 required assistance with bathing. Review of Resident #9's Care Plan dated 12/31/19 revealed Resident #9 required extensive assistance with bathing, dressing, grooming, eating, ambulation, and transfers. Review of the Personal Care Record for Resident #9 for December 2019 revealed there was no documentation of care provided. Review of the Personal Care Record for Resident #9 for January 2020 revealed: -Resident #9 refused toileting assistance every day during every shift. -Resident #9 was independent of toileting. -Resident #9 was assisted with clothing and dressing daily. -There was no documentation Resident #9 had a shower. Review of the Personal Care Record for Resident #9 for February 2020 revealed there was no documentation of care provided. Observation of Resident #9 on 02/06/20 between 12:30 to 12:45pm revealed: -The resident was in her room sitting on the side of her bed without clothing from the waist down wearing an incontinence brief. -The resident wore yellow socks on both of her feet. -The resident's eyes were closed as she attempted to remove her socks. -When Resident #9 removed her socks a strong odor of urine was present. -After Resident #9 removed her socks she began to attempt to put on a pair trousers. -Resident #9's hair was not groomed and hanging	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 27	D 269		

in her face.
-Resident #9's feet had patches of dry flaky skin.
-All of Resident #9's toe nails on each foot were grown over each toe touching the floor.
-Resident #9's toe nails on 3 of 10 toes had a dark brown appearance.
-Resident #9 pressed her call bell after prompting and waited approximately fifteen minutes until staff came to her room.

Interview with a Resident #9 on 02/06/20 at 12:30pm revealed:
-The previous Administrator told her the facility was very short staffed.
-She needed assistance with getting a bath, clean laundry, bath towels, linens, and assistance to meals.
-She wanted to do as much as possible for herself but, she needed assistance locating her clothes and personal care items.
-She went to the Administrator after speaking to staff when they came into her room day after day requesting them to help her with these tasks.
-Resident #9 was blind and did not know the time of day without asking the staff.
-She was not able to recall the last time she had a shower.
-She would only allow her favorite personal care aide (PCA) to assist her with her shower.
-The PCAs told her they were too busy when she asked them to help her with a shower.
-She was told by the staff and the Administrator she needed to do as much for herself without their help.

Interview with the medication aide (MA) on 02/06/20 at 12:47pm revealed:
-She was delayed getting to Resident #9 on 02/06/20 because she was answering all the call bells and passing medications while the PCAs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 28 were in the dining room assisting residents with their meals. -She needed to find Resident #9's clean clothes and socks. -Resident #9 did not have any clean trousers and socks to change into in her room. Interview with the personal care aide (PCA) on 02/06/20 at 3:10pm revealed: -Resident #9 did not want anyone to help with personal care. -She never showered Resident #9. -Resident #9 become very upset when anyone attempted to help with personal care. -She did not like to go into Resident #9's room because Resident #9 accused staff of stealing things from her room. -She told the former RCD and former Administrator about Resident #9's refusal to allow staff to help with bathing and grooming. -Resident #9 changed her own brief when it was soiled. -Resident #9 dressed herself. Observation of Resident #9 on 02/07/20 at 8:00am revealed: -Resident #9 was asleep on her bed without linens. -Resident #9 was wearing the same yellow socks and trousers as yesterday (02/06/20). Observation of Resident #9 on 02/07/20 at 12:00pm revealed: -Resident #9 was sitting on her bed without linens. -Resident #9 was wearing the same yellow socks and trousers as yesterday (02/06/20). -Resident #9 walked with a PCA to the dining room.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 29 Observation of Resident #9 on 02/07/20 from 1:15pm to 2:00pm revealed: -Resident #9 was sitting at dining room table with a tray food alone. -Resident #9 had spilled food onto her lap. -Resident #9 asked for someone to get her some sweetener for her tea. -Resident #9 did not get sweetener for her tea. Observation of Resident #9 on 02/07/20 at 4:00pm revealed: -Resident #9 was in her room sitting on her bed. -The MA came into the room looking for clothes and socks for Resident #9. -The MA did not find clean clothes and socks in Resident #9's room. -The MA went to the laundry room and did not find clean clothes and socks for Resident #9. Interview with the MA on 02/07/20 at 4:00pm revealed: -She did help Resident #9 because the previous Resident Care Director (RCD) told her Resident #9 would not allow anyone to help her when she needed help. -Resident #9 allowed one PCA help her when she needed help, but the PCA left to go home today (02/07/20) because of a family emergency. Telephone interview with the former RCD on 02/11/20 at 11:00am revealed: -Resident #9 needed more help than what she would allow the staff provide. -Resident #9 refused everything even her medications. -She did not have a care plan meeting with Resident #9's Mental Health Provider (MHP). -She did not get a chance to discuss Resident #9's care plan with the MHP because she was always on the medication cart passing	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 30 medications. Telephone interview with Resident #9's Mental Health Provider on 02/11/20 revealed: -Resident #9 refused a lot of help from the staff but she required assistance with hands off tasks like providing her with clean clothes and linens, reminders of the time of day, and assistance with her meals. -Resident #9 required a gentle and patient approach to get her to allow anyone to help when she needed help. -She did not know Resident #9's toe nails were overgrown and dirty. -The staff was expected to report Resident #9's overgrown toe nails to her because there was a risk Resident #9 could acquire an infection or injury her toes. Telephone interview with the former Administrator on 02/11/20 at 9:50am revealed: -Resident #9 was able "to do for herself". -Resident #9 had "no problem counting her money and swinging her cane when she wanted something". -Resident #9 allowed only one PCA to help her when she needed help. -Resident #9 refused care and swung her cane attempting to hit her when she offered to do something for Resident #9. _____ The facility failed to provide personal care assistance for 2 of 5 sampled residents which resulted in a resident not having colostomy supplies and staff having to resort to taping trash bags or wash clothes to his skin or nothing while the resident's intestinal contents leaked out onto his skin and clothing (Resident #2), and a resident who was blind not having clean clothes and linens, not receiving incontinence care, and	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 31 foot care resulting in long, dirty toenails, dry skin, and foul odors (Resident #9). This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/10/20 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 27, 2020.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews, observations and interviews the facility failed to ensure referral and follow-up with health care providers, a medical equipment company and Home Health agency for 3 of 6 sampled residents (Residents #1, #2, and #13) regarding colostomy bags not obtained and an order for an antipsychotic medication injection to be administered by a Home Health Nurse	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 32	D 273		

(HHN) (#2), a resident ordered clozapine with missed doses of medication due to weekly labs not obtained (#1), and a resident with an order for an immunosuppressive injection to be administered by a HHN (#13).

The findings are:

1. Review of Resident #2's current FL2 dated 02/26/2019 revealed diagnoses included congestive heart failure (CHF), schizophrenia, anxiety, insomnia, psychosis and mood disorder.

a. Review of Resident #2's physician's orders dated 01/24/20 revealed paliperidone injection (Invega) 156 mg/ml 1 dose per month (a long-acting anti-psychotic injection used to treat acute and maintenance therapy for schizophrenia).

Review of Resident #2's progress notes for January 2020 revealed on 01/25/20 (no timed documented), Resident #5 still having behaviors and was lying in bed with feces all over him and refused to be cleaned up. The resident had been in the bed all day.

Review of Resident #2's progress notes for January 2020 revealed no documentation related to new medication orders, contacting Home Health to administer the paliperidone injection and no mention of Resident #2 having been sent to the hospital.

Review of Resident #2's January 2020 Medication Administration Record (MAR) revealed:
-There was a handwritten entry for paliperidone 156 mg/ml inject once for 1 dose (Home Health Nurse).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 33 -There was no documentation paliperidone injection was administered in January 2020. Review of Resident #2's February 2020 MAR revealed: -There was a handwritten entry for paliperidone 156 mg/ml inject once for 1 dose by Home Health Nurse (HHN). -There was no documentation paliperidone injection was administered in February 2020. Interview with a medication aide (MA) on 02/06/20 at 10:20 am revealed: -She did not know what paliperidone was or how it was to be administered. -She knew she was not supposed to administer paliperidone injections. -She did not know it was supposed to be administered by the HHN. -The HHN had not come out to administer the paliperidone to Resident #2. -She had not asked or told another MA or staff about the paliperidone, but knew it was available in the medication cart. Interview with a HHN on 02/06/20 at 10:30 am revealed she did not know anything about paliperidone injections to be administered for any resident. Interview with a representative from the Home Health agency on 02/06/20 at 11:40 am revealed the Home Health agency never received an order for paliperidone injections to be administered by the HHN for Resident #2. Interview with Resident #2's primary care provider (PCP) on 02/07/20 at 8:55 am revealed: -She had written the order for paliperidone injections on 01/24/20 for 1 injection each month	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 34	D 273		

by the HHN.
-She worked closely with Resident #2's mental health provider (MHP) and the MHP told her Resident #2 had not received paliperidone injections.
-Resident #2 was admitted to the hospital on 02/05/20 to an acute psychiatric unit.
-Resident #2 not receiving his paliperidone injections, among other antipsychotic medications contributed to his hospitalization.

Interview with Resident #2's mental health provider (MHP) on 02/07/20 at 11:10 am revealed:
-She had visited the Resident at the facility on 01/24/20 and had reviewed the MARs and medications on hand.
-There was no paliperidone injection at the facility on 01/24/20.
-She was so concerned about Resident #2 not getting the paliperidone injection because Resident #2 was compliant, stable, had decreased behaviors and less resistant to care if he did received his antipsychotic medications including the paliperidone injection.
-Resident #2 was admitted to the hospital on 02/05/20 to an acute psychiatric unit.
-The reason Resident #2 had to be sent to the hospital was likely because he did not receive this anti-psychotic medications including the paliperidone injection.

Interview with a representative from the contracted pharmacy on 02/10/20 at 10:50 am revealed:
-Paliperidone (Invega) 156 mg/mi injection 1 dose each month was a current order.
-One injection syringe was dispensed on 01/28/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 35 Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 10:07 am revealed: -Residents' medications were delivered to the facility twice each day. -She thought the HHN was supposed to be coming to administer paliperidone injections to Resident #2. -If the MAs had not noticed the medication had not been administered, then MAs should have followed-up with HH and the PCP. Interview with the former RCD on 02/11/20 at 12:30 pm revealed: -The former RCD's last day of employment at the facility was on 01/30/20. -If HH was supposed to administer a resident's injection but was not administering the injection, the MAs were to let the former RCD know and would follow-up with HH. -She had sent the order to another (named) HH agency to give the paliperidone injection to Resident #2. -If HH was not coming to the facility to give Resident #2 his injections, the former RCD did not know anything about it; MAs did not let her know. Interview with a representative from another (named) HH agency on 02/11/20 at 2:05 pm contacted by the former RCD revealed: -The HH agency had not received any orders for Resident #2. -This company was a Home Care agency that provided in-home personal services for the elderly. -This company was not a HH agency and did not provide Registered Nurse services for medication by injection. b. Review of Resident #2's Colon Rectal Clinic	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 36	D 273		

visit dated 09/5/19 revealed:
-Resident #2 had initial colostomy surgery in 2018.
-Resident #2 was recently seen in the hospital for a small bowel obstruction with no surgery required.
-Resident #2 had a bag for his ileostomy taped to his skin but did not have an underlying wafer.
-There was some redundant abrasions around the stoma and would be referred for enterostomal therapy (Home Health) for help with ileostomy care and education.

Observation of Resident #2's room on the second floor of the facility on 02/07/20 at 11:30 am revealed there were no colostomy bags available.

Interview with Resident #2's primary care provider (PCP) on 02/07/20 at 8:55 am revealed:
-The Home Health Nurse (HHN) was supposed to take care of the colostomy and to start the order for the colostomy bags in September 2019.
-The PCP was told by staff in December 2019 that Home Health (HH) had "dropped" Resident #2 from HH services.
-It was not like HH to just drop a resident from their services.
-The last time she saw Resident #2 was in January 2020 and she noticed Resident #2 was walking around in the facility with the colostomy bag off and there was bowel movement (BM) all over the front of his shirt.
-She had told the former Resident Care Director (RCD) in January 2020 to make sure to order the colostomy bags for Resident #2.

Interview with a medication aide (MA) on 02/07/20 at 10:00 am revealed:
-Resident #2 went to the hospital a couple of days ago because he had no colostomy bags and he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 37	D 273		

was having behaviors.
-Home Health (HH) had been coming out to see Resident #2, but HH discharged him from their services sometime in December 2019.
-She did not know why Resident #2 was discharged, and staff did not know where to order the colostomy bags from.
-She thought HH was supposed to supply the colostomy bags, and she was not sure what happened; "the bags just stopped coming".
-The colostomy bags were stored in Resident #2's room.
-Staff called the guardian to see if the guardian could get the colostomy bags, but the guardian had no idea where to get the bags.

Interview with a representative from the HH agency on 02/07/20 at 11:40 am revealed:
-The Home Health Nurse (HHN) came out to open services in September 2019 for Resident #2 to provide staff education related to the care of the colostomy, irrigation, bag placement and colostomy bag supplies.
-HH initiated the order for the colostomy bags in September 2019 and ordered as many as the agency could and according to the resident's pay source.
-HH ordered the colostomy bags for Resident #2 from a medical supply company on 11/15/19.
-On 11/18/19, the HHN provided the contact information for the medical supply company to the former Resident Care Director (RCD) to order the colostomy bags for Resident #2.
-The HHN made the former RCD aware that the facility would be responsible for ordering the colostomy bags going forward.
-HH services were discontinued on 12/12/19 for Resident #2 because HH only provided start-up and education; then the facility would be responsible for following up and ordering the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 38	D 273		

colostomy bags and that was the extent of HH services for Resident #2.

Interview with the RCD on 02/07/20 at 11:45 am revealed:
-She did not know what happened to Resident #2's colostomy bags.
-She did not know who was responsible for ordering the bags.
-"We did not know what to do about the colostomy bags."
-She had not contacted HH because she did not know what HH agency to contact about the order for the colostomy bags for Resident #2
-The former RCD had not shared the information on where and how staff were to order the colostomy bags.
-Staff were told by the former RCD Resident #2 could not afford to buy the colostomy bags and the resident would not be getting any more colostomy bags.

Interview with a representative from the medical supply company on 02/07/20 at 12:00 pm revealed:
-The medical supply company was emailing and faxing information to the facility and Resident #2's primary care provider (PCP) for over 2 months.
-The medical supply company called and emailed the PCP but never got a response from the facility or the PCP.
-The PCP had to sign an authorization and complete an assessment form for the supply company to deliver the colostomy bags.
-The PCP did not sign the assessment and that was the reason colostomy bags were not sent.

Second interview with the RCD on 02/07/20 at 4:30 pm revealed:
-She located an authorization form on 02/07/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 39	D 273		

from the medical supply company in a stack of faxes in the previous RCD's office that had never been filed.
-She called Resident #2's PCP but the PCP told the RCD she was on vacation.
-The authorization form had not been sent to the PCP and had not been signed.

Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 10:07 am revealed:
-Resident #2 ran out of colostomy bags about a month ago.
-She did not know where to order the colostomy bags from.
-She had not contacted HH about the colostomy bags being ordered, because she did not know which agency or medical supply company the colostomy had been ordered from.
-The former Administrator told the former RCD not to order the colostomy bags for Resident #2 because the former Administrator was going to order the colostomy bags from another supply company, so the colostomy bags did not get ordered.
-The former Administrator told staff she was not going to order colostomy bags for Resident #2 because he was having behaviors.

Interview with a staff on 02/10/20 at 10:20 am revealed:
-Resident #2 did not have any colostomy bags.
-Staff would make colostomy bags out of small white trash bags or gloves and tape them on Resident #2.

Interview with a medication aide (MA) on 02/10/20 at 11:25 am revealed:
-Staff would make colostomy bags out of small white trash bags and tape them on Resident #2.
-Resident #2 had been out of colostomy bags "for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 40	D 273		

a while" and staff did not know what to do or where to order the bags from.

Interview with a personal care aide (PCA) on 02/10/20 at 11:55 am revealed:
-Resident #2 walked around all the time without a colostomy bag on.
-The PCA did not know if Resident #2 had any colostomy bags or not.

Interview with a second MA on 02/10/20 at 4:30 pm revealed:
-Resident #2's colostomy bags ran out sometime in December 2019.
-Resident #2 would get frustrated and take the colostomy bags off and throw them.
-Staff did whatever they had to do when the colostomy bags ran out; tape small trash bags on Resident #2 or tape a cloth on the stoma to keep Resident #2 from messing up his clothes.
-Resident #2 was currently in the hospital.

Interview with the former Administrator on 02/11/20 at 11:50 am revealed:
-Resident #2 had colostomy bags and ran out because the supply company did not send enough colostomy bags and the colostomy bags ran out.
-The former Administrator had ordered the colostomy bags from another medical supply company different from the supply company set up by HH.
-She contacted another supply company she had conducted business with in the past.
-Home Health originally sent the colostomy bags.
-When Resident #2 had colostomy bags, he would not keep the colostomy bag on.

Interview with the former RCD on 02/11/20 at 12:30 pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 41 -Resident #2 was discharged from HH services in December 2019. -Forms were sent from another (named) HH agency for the PCP to sign to order the colostomy bags form. -The former RCD contacted another (named) medical supply company to order the colostomy bags sometime in December 2019. -Staff had to go pick the bags up from the medical supply company. -She had the forms signed by the PCP (date unknown) and sent the forms back to the (named) medical supply company where (named) HH had set up the order for colostomy bags from. -If the colostomy bags ran out, staff were supposed to let her know and then she would go pick up the colostomy bags from the medical supply company. -Resident #2 would not keep the colostomy bags on. Interview with a representative from another (named) HH agency on 02/11/20 at 2:00 pm contacted by the former RCD revealed: -The HH agency had no orders for Resident #2 and had not received any orders for Resident #2. -This company was a Home Care agency and not a HH agency and did not provide colostomy supplies. Interview with a representative from another (named) medical supply company on 02/11/20 at 2:30 pm contacted by the former RCD and former Administrator revealed the medical supply company closed in January 2020. Interview with a representative from a third (named) HH agency on 02/11/20 at 2:05 pm contacted by the former RCD to supply colostomy bags revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 42 -They had not received any orders for colostomy bags for Resident #2. -The agency did not supply colostomy bags. Attempted telephone interviews with Resident #2's Guardian on 02/06/20 at 5:00 pm and on 02/11/20 at 10:00 am was unsuccessful. 2. Review of Resident #1's current FL-2 dated 01/03/20 revealed diagnoses included schizoaffective disorder, hypertension, major depressive disorder, anxiety disorder, an unspecific lesion of mucosa. Interview with Resident #1 on 02/06/20 at 1:00pm revealed: -She had not received clozapine twice daily since 02/03/20. -She was beginning to feel very anxious. -She was staying in her room to feel better. -She was supposed to have labs drawn weekly before her prescription could be refilled. -Resident #1's labs were not drawn weekly. -She had labs drawn on 02/04/20 but she had not been given her clozapine. -She asked the MAs on every shift since 02/04/20 for her medications. -Since December 2019 she was not administered her clozapine every day. -She did not take her clozapine for more than one or two days in a row, but she could not remember specific dates. Telephone interview with Resident #1's Mental Health Practitioner (MHP) on 02/06/20 at 5:03pm revealed: -Resident #1 was required to have a Complete Blood Count (CBC) drawn monthly to be submitted to registry so clozapine was dispensed	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 43	D 273		

by the pharmacy.
-When Resident #1 missed a monthly CBC draw that was not submitted in December 2019 the registry began requiring a CBC blood draw to be done weekly.

Review of physician orders for Resident #1 dated 01/03/20 revealed an order for CBC weekly.

Telephone interview with a representative from the facility's contracted lab phlebotomy department on 02/06/20 at 4:25pm revealed:
-They visited the facility every Tuesday to collect all labs ordered for the residents.
-The lab received orders for CBCs drawn on 11/12/19, 11/26/19, 01/07/20, and 02/04/20.
-The results were faxed to the facility when Resident #1's CBC was drawn on 11/12/19, 11/26/19, 01/07/20, and 02/04/20.
-They did not obtain a CBC for Resident #1 in December 2019.
-They did not receive the order dated 01/03/20 for weekly CBC draws and therefore they did not obtain a CBC for Resident #1 on 01/14/02, 01/21/20, and 01/28/20.
-Resident #1's CBC lab results on 11/12/19, 11/26/19, 01/07/20, and 02/04/20 indicated Resident #1's white cell count were within normal limits.

Telephone interview with a representative from the facility's contracted pharmacy on 02/06/20 at 3:15pm revealed:
-Resident #1's clozapine required submission of a CBC to the FDA (Food and Drug Administration) registry prior to being dispensed.
-Prior to dispensing Resident #1's clozapine the registry was checked to verify a CBC was completed.
-He was not capable of reviewing when a CBC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 44	D 273		

was submitted to the registry.
-He was able to provide Resident #1's clozapine dispensing history.
-A seven-day supply was delivered to the facility on 12/12/19, 12/17/19, 01/03/20, 01/11/20, 01/26/20.
-Resident #1's clozapine was not dispensed to the facility since 01/26/20.

Interview with a second shift medication aide (MA) on 02/06/20 at 3:55pm revealed:
-Resident #1 required labs drawn prior to getting clozapine.
-She did not contact the lab to see if Resident #1 had labs drawn or pending results.
-She did not tell the Resident Care Director (RCD) on 02/04/20 because the RCD did not come to work that day.

Interview with a third shift medication aide (MA) on 02/06/20 at 11:42am revealed:
-She called the lab on 02/04/20 to request the lab results for Resident #1 and her labs had not been processed.
-She put the request for refill in the communication box that hung on the wall beside the RCD's office.
-The RCD was supposed to follow-up on Resident #1's labs so she could get her clozapine.

Interview with the RCD on 02/07/20 at 12:00pm revealed:
-She was hired 02/06/20.
-She did not know Resident #1 had an order for a CBC to be drawn weekly.
-She did not know Resident #1 did not have any clozapine.
-The MAs were expected to notify her of all issues with following up on lab draws.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 45 -The MAs failed to tell her about Resident #1's missing clozapine and labs. Telephone interview with Resident #1's Mental Health Practitioner (MHP) on 02/06/20 at 5:03pm revealed: -Last week when she saw Resident #1 she was told the CBC had not been drawn since 01/07/20. -Resident #1 did not have a CBC drawn on 01/14/20, 01/21/20, and 01/28/20. -Resident #1 was hospitalized within the last year related to uncontrolled hallucinations and anxiety. -The risks of Resident #1 not continuously having her labs drawn weekly to get her clozapine could lead to hallucinations and increased anxiety that could cause her to hurt herself and other people. -Weekly CBCs were to monitor Resident #1 for neutropenia (a low white cell count) which puts Resident #1 at risk for serious and fatal infections. -Weekly CBCs were required because Resident #1's clozapine was managed by the REMS (Risk Evaluation and Mitigation Strategy) program. -The REMS program was a FDA mandated program implemented by the manufacturers of Clozapine. -The REMS program was intended to help Healthcare Providers ensure the safety of patients on Clozapine. Interview with the Administrator 02/07/20 at 12:30pm revealed: -He was hired yesterday (02/06/20). -He expected the MAs to ensure all the residents' health care needs were completed. -The MAs should report any issues to the RCD. -The RCD was hired yesterday (02/06/20), and she did not have an opportunity to audit the resident's records for orders pertaining to all referrals and follow ups.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 46 Telephone interview with the former RCD on 02/11/20 at 10:44am revealed: -Her last day of work was 01/30/20. -Resident #1 knew she required a CBC drawn prior to clozapine being dispensed by the pharmacy. -Resident #1's MHP ordered monthly CBCs to be drawn. -The MHP was responsible for ensuring Resident #1's labs were submitted to the registry. -She had encountered a lot of errors the facility's pharmacy caused with Resident #1's clozapine. -When Resident #1 missed having her labs drawn monthly, she requested a weekly CBC order from the MHP. -Resident #1 was able to continuously remind the MAs to have her labs drawn weekly. -Because Resident #1 was able to remind the MAs she did not follow up with the lab since the weekly lab order was sent to the laboratory service. -She did not audit the medication carts, physician orders, and MARs because the facility was understaffed, and she was required to pass medications. 3. Review of Resident #13's current FL2 dated 02/26/19 revealed diagnoses included bipolar depression, anxiety, hypertension, chronic obstructive pulmonary disease, gastro esophageal reflux disease, pain and kidney failure. Review of Resident #13's physician's order dated 12/19/19 revealed an order for Humira 40mg injection every 14 days (used to treat autoimmune disorders). Review of Resident #13's December 2019 Medication Administration Record (MAR)	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 47	D 273		

revealed there was no entry for Humira 40mg every 14 days.

Review of Resident #13's January 2020 MAR revealed:
-An entry for Humira Pen injection 40mg/.4 ml inject 1 pen under the skin every 14 days.
-The dates of 01/14/19 and 01/28/19 were circled with no initials documented.
-There was no documentation of administration of Humira 40mg or explanation for not administering for the month of January 2020.

Review of Resident #13's February MAR revealed:
-An entry for Humira Pen injection 40mg/.4 ml inject 1 pen under the skin every 14 days.
-The dates of 02/01/20, 02/02/20, and 02/03/20 were initialed and circled indicating the medication was not administered with no explanation for not administering the Humira.
-The dates of 02/04/20, 02/05/20 and 02/06/20 were initialed and documented as administered.

Interview with Resident #13 on 02/07/20 at 9:55am revealed:
-A doctor had ordered the Humira injection for Resident #13's arthritis about a month ago.
-Resident #13 had not received any doses of the Humira injection.

Interview on 02/07/20 at 10:20am with the Medication Aide (MA) revealed:
-She usually administered medications on another floor.
-She was unable to locate the Humira injection for Resident #13.
-She did not know why the Humira injection had not been administered to Resident #13.
-The Humira injection would have to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 48 administered to Resident #13 by a nurse with home health. Interview on 02/07/20 at 12:10pm with the Resident Care Coordinator (RCC) revealed: -She had only been the RCC for 2 days and was new to the facility. -She did not know Resident #13 had a Humira injection ordered. -She had not had the opportunity to review all the resident records, and had not reviewed the record for Resident #13. Interview on 02/07/20 at 12:30pm with the Resident Care Director (RCD) revealed: -She had been the RCD for 2 days. -She did not know Resident #13 had a Humira injection ordered. -She did not know the Humira injection had not been administered to Resident #13. Interview with a contracted pharmacy representative on 02/10/20 at 10:25am revealed: -One pen of the Humira was dispensed on 12/20/19. -The Humira Pen injection 40mg/.4 ml pen had not been refilled for Resident #13. -The facility would have to request any refills for the Humira Pen injection 40mg/.4 ml. Interview with a representative for the prescribing provider on 02/10/20 at 10:25am revealed; -The physician order Resident #13 to start the Humira Pen injection 40mg/.4 ml inject 1 pen under the skin every 14 days on 12/19/19. -The physician did not know the Humira had not been administered to Resident #13. The facility failed to ensure referral and follow-up with the health care providers concerning missed	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 49 doses of medications including clozapine for Resident #1 resulting in an increased in his anxiety, missed doses of paliperidone injections for Resident #2 resulting in increased behaviors leading to a hospitalization to an acute psychiatric unit, and Humira injections not administered for Resident #13 resulting in a delay of treatment for a progressive autoimmune disorder. The facility also failed to notify the medical equipment company and/or home health agency to obtain colostomy bags for Resident #2 which resulted in intestinal contents leaking out onto his skin and clothing for over a month. This failure resulted in serious neglect to the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 02/07/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 12, 2020.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews the facility failed to ensure 3 of 8 sampled residents (Resident #11, #9, #2) were free of abuse and neglect resulting in a resident being physically and verbally assaulted by a personal care aide	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 50	D 338		

(Staff D) (#11), a resident required extensive assistance with activities of daily living (#9), and a resident not provided adequate colostomy care or colostomy supplies (#2).

The findings are:

1. Review of Resident #11's current FL2 dated 01/06/20 revealed:
-Diagnoses included schizoaffective disorder, morbid obesity, muscle weakness, and unsteadiness of feet.
-Resident #11 was intermittently disoriented.

Review of Resident #11's Care Plan dated 01/06/20 revealed Resident #11 required supervision with eating, toileting, ambulation, bathing, dressing, grooming and transferring.

Review of a police report dated 01/20/20 revealed:
-There was a simple assault at the facility between Staff D and Resident #11.
-The report noted the suspect (Staff D) assaulted victim (Resident #11) by punching.

Review of a second police report dated 01/20/20 revealed:
-There was a simple assault at the facility between Resident #11 and Staff D.
-The report noted the suspect (Resident #11) assaulted victim (Staff D) by punching.

Observation on 02/06/20 at 12:45 pm revealed Staff D was in the second floor common room serving plates to eight residents for the lunch meal service.

Observation on 02/06/20 at 12:50 pm revealed Staff D provided prompting for a resident to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 51	D 338		

complete her lunch meal.

Observation on 02/06/20 at 1:55 pm revealed Staff D was working on the second floor and exiting a resident's room after providing personal care assistance to the resident and speaking very loudly to the resident.

Interview with Staff D on 02/06/20 at 12:05 pm revealed:
-She was the Personal Care Aide (PCA) supervisor.
-She was primarily assigned to the second floor as the PCA.

Interview with Resident #11 on 02/07/20 at 12:54pm revealed:
-A couple of weeks after she moved into the facility there was an incident that took place between Resident #1 and Staff D.
-She was physically attacked by Staff D on 01/20/20.
-She did not why Staff D and the previous Administrator had come at her yelling and telling her to go into her room.
-She went into her room and closed her door.
-Staff D came into Resident #11's room and closed the door after Resident #11 was inside.
-Staff D and Resident #11 began arguing and Staff D physically attacked her.
-The police came, and she was taken to the hospital.
-She did not have any injuries as a result of the attack.
-She did not remember hitting Staff D.

Interview with a housekeeper on 02/07/20 at 10:00am revealed:
-She witnessed the incident on 01/20/20 between Resident #11 and Staff D.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 52	D 338		

-Staff D and Resident #11 was yelling at each other when Resident #11 hit Staff D.
-Resident #11 went into her room and the previous Administrator came up to Resident #11's room.
-Staff D and the Administrator went into Resident #11's room.
-Staff D and the Administrator began yelling at Resident #11 calling her names.
-Resident #11 said "I didn't do anything".
-Staff D told Resident #11 "you don't know who you're dealing with".
-The Administrator left Staff D in Resident #11's room alone and closed the door telling Staff D to deal with Resident #11.
-She heard more yelling and cussing between Resident #11 and Staff D.
-She heard a loud crack and items in the room being thrown.
-The police came and Resident #11 left in an ambulance.
-When she went into Resident #11's room to clean it Resident #11's clothes and personal items were scattered all around the room.
-Resident #11's room was a mess.

Interview with another personal care aide (PCA) on 02/07/20 at 10:29am revealed:
-She witnessed the incident on 01/20/20 between Resident #11 and Staff D.
-Resident #11 hit Staff D when they were having an argument.
-She heard the argument from the other end of the hallway.
-Staff D was very bossy and loud with the residents and coworkers.
-She saw Staff D and the Administrator go into Resident #11's room and close the door.
-The Administrator came out of Resident #11's room leaving Staff D in the room with the door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 53	D 338		

closed.
-Resident #11 and Staff D continued to yell at each other with the door closed.
-The police and ambulance came to take Resident #11 to the hospital.

Interview with a resident on 02/07/20 at 10:40am revealed:
-She witnessed the incident between Resident #11 and Staff D on 01/20/20.
-Staff D was yelling at Resident #11 on 01/20/20 when Resident #11 hit Staff D.

Interview with the Administrator on 02/07/20 at 12:00pm revealed:
-Staff D was a current employee and worked at the facility for approximately eight years.
-He spoke to the former Administrator on the telephone about the incident that took place on 01/20/20 between Resident #11 and Staff D today (02/07/20).
-The former Administrator told him Staff D was loud and bossy with the residents and coworkers.
-Staff D was a hard worker so she was able to accept Staff D's behavior.
-The previous Administrator did not suspend Staff D from work and perform an investigation into the incident that took place on 01/20/20.

2. Review of Resident #9's FL2 dated 09/07/19 revealed:
-Diagnoses included schizophrenia, and blindness.
-Resident #9 was semi-ambulatory.
-Resident #9 was incontinent of bladder.

Review of Resident #9's care plan dated 12/31/19 revealed Resident #9 required extensive assistance with eating, toileting, ambulation, bathing, grooming, dressing, and transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 54 Interview with Resident #9 on 02/06/20 at 12:30pm revealed: -Resident #9 was blind. -She needed assistance finding her clothes and belongings because she was blind. -She needed staff to come and remind her of meal times. -She had missed meals and wore the same clothes because she couldn't find clean ones in her room. -Staff D told her to do things for herself. -She was not allowing Staff D to help her do anything because she was very loud and mean. -There was only one PCA she would allow to help her when she needed help. Telephone interview with the previous Administrator on 02/11/20 at 9:50am revealed: -Resident #9 was able to do for herself. -Resident #9 had no problem counting her money and swinging her cane when she wanted something. -Resident #9 allowed only one PCA to help her when she needed help. -Resident #9 refused and swung her cane attempting to hit her when she offered to do something for Resident #9. 3. Review of Resident #2's current FL2 dated 02/26/19 revealed: -Diagnoses included congestive heart failure (CHF), schizophrenia, anxiety, insomnia, psychosis and mood disorder. -Resident #2 was ambulatory. -Resident #2 had a colostomy. Review of Resident #2's December 2019 progress notes revealed: -On 12/08/19 at 12:30 am, Resident #2 was	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 55	D 338		

cleaned up and a new colostomy bag was applied. The resident would not let staff change his shirt that had bowel movement (BM) on it.
-On 12/09/19 (no time documented), Resident #2 would not let staff change his clothes.
-On 12/31/19 at 11:00 pm to 7:00 am, Resident #2 would not let staff change his clothes.

Review of Resident #2's January 2020 progress notes revealed:
-On 01/01/20 (no time documented), Resident #2 would not let staff change his colostomy bag. Resident #2 stated staff would "mess up" his stoma.
-On 01/02/20 (no time documented), Resident #2 would not let staff check his stoma or change his clothes.
-On 01/03/20 and 01/04/20 (no times documented), Resident #2 would not let staff check his stoma or change his clothes.
-On 01/17/20 at 10:30 pm, Resident #2 would not let staff change his shirt with BM on it and put a clean shirt over his dirty shirt.
-On 01/25/20 (no time documented), Resident #2 had BM all over him and would not let staff change his clothes.
-On 01/27/20 at 7:00 am to 3:00 pm, Resident #2 would not let staff change his clothes.

Interview with a medication aide (MA) on 02/07/20 at 10:00 am revealed:
-Resident #2 went to the hospital a couple of days ago (dated unknown) because he had no colostomy bags and he was having behaviors.
-One day (did not recall the date), Resident #2 came running down the hall and went into the dining room, took his colostomy bag off and dropped it on the floor in front of other residents during mealtime.
-Staff cleaned it up and that was all staff did.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 56	D 338		

-He would not let staff do anything for him; check his colostomy.
-He would run around the hall with no "bag on".
-He had run out of colostomy bags a month ago and he would not let staff help him.
-He was able to care for his own colostomy; staff would check the bag and help to apply the bags and check the stoma.

Interview with Resident #2's primary care provider (PCP) on 02/07/20 at 8:55 am revealed:
-The last time she saw Resident #2 was in January 2020 and she noticed Resident #2 was walking around in the facility with the colostomy bag off and there was bowel movement (BM) all over the front of his shirt.
-She had told the former Resident Care Director (RCD) in January 2020 to make sure to order the colostomy bags for Resident #2.

Interview with the Resident Care Coordinator on 02/10/20 at 10:07 am revealed:
-The previous Administrator had told staff she was not going to order any colostomy bags for Resident #2 because he was having behaviors.
-Resident #2 kept taking the colostomy bags off or he would not leave the colostomy bags on.
-The colostomy bags ran out and no one knew where to order the bags from.
-The former RCD would tell staff when Resident #2 would have BM on his clothes to just leave Resident #2 alone.

Interview with a housekeeping staff on 02/10/20 at 10:20 am revealed:
-She noticed Resident #2 walking around with bowel movement (BM) all over his shirt at least once a week for about a month.
-The former Resident Care Director would tell staff to leave Resident #2 alone and not clean

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 57	D 338		

him up.
-She remembered when Resident #2 went into the main dining room on the first floor and took his colostomy off and threw it in the floor where the other residents were eating.
-Housekeeping had to come and clean it up.

Interview with a resident on 02/10/20 at 4:45 pm revealed:
-The resident remembered Resident #2 came into the dining room on the first floor and threw his colostomy bag on the dining room floor.
-The resident was not sure when this happened.
-Residents were eating in the dining room and the resident did not like that at all.
-Resident #2 walked back out of the dining room and staff went after Resident #2.
-Another staff came in and cleaned up the mess on the floor.
-The resident saw Resident #2 walking around the facility with BM on his clothes and "it did not smell so good either".

Interview with a second resident on 02/10/20 at 4:53 pm revealed:
-The resident remembered Resident #2 came running into the first floor dining room, took his colostomy bag off and dropped it on the dining room floor while residents were eating.
-Staff went out after Resident #2 and another staff came in to clean the colostomy bag off the floor.
-The resident was not able to finish the meal and "that was not right".

Interview with a third resident on 02/10/20 at 5:00 pm revealed:
-Resident #2 came running into the first floor dining room and dropped a colostomy bag on the dining room floor while the resident was eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 58 -Staff ran after Resident #2 down the hall and another staff came in to clean it up. -This was very disturbing. -The resident had seen Resident #2 in the facility with his clothes messed up with BM on his clothes. Interview with a personal care aide (PCA) on 02/10/20 at 11:55 am revealed: -Resident #2 walked around all the time without a bag over his colostomy. -He always had BM on his shirt when the PCA saw the resident walking in the hall. -Staff would clean Resident #2 up when staff saw the resident walking around with BM on his shirt. Interview with a medication aide (MA) on 02/10/20 at 4:30 pm revealed: -Resident #2 walked around all the time with BM on his shirt. -When Resident #2 resisted staff assistance to get cleaned up, the former Administrator would tell staff to just walk away. Interview with the former Administrator on 02/11/20 at 11:50 am revealed: -Resident #2 would not let staff provide personal care and colostomy care to him. -Resident #2 was independent with his care and only needed assistance with colostomy care. Interview with the former RCD on 02/11/20 at 12:30 pm revealed: -Resident #2 would not let staff take care of him or help him. -Resident #2 walked around all the time with no colostomy bag and would have BM all over himself. -Resident #2 had colostomy bags, he just took the colostomy bag off.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D 338	Continued From page 59 -Staff would have to clean Resident #2 up and give him a shower. -About once a week Resident #2 would run around the facility with no colostomy bag on. -Staff would try to redirect Resident #2, do personal care, clean him up, change his clothes and clean the stoma. -Resident #2 only needed assistance with colostomy care. -Staff would offer food to Resident #2 so staff could clean the resident up and change his clothes. _____ The facility failed to protect one resident from abuse which resulted in the resident being sent to emergency room after being physically and verbally assaulted by Staff D (Resident #11) and Staff D continued to work at the facility; a resident not being protected from neglect which resulted in the resident walking about the facility with intestinal contents on his skin and clothes because he was not provided adequate colostomy care and supplies (Resident #2) and the odor was offensive to other residents at the facility. This failure resulted in substantial risk of serious abuse, serious injury, serious neglect to residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 02/07/20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 12, 2020.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

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D 358	Continued From page 60 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 4 residents (Residents #1, #10, #13 and #14) observed during the morning medication pass related to a medication for schizophrenia (#1), 2 bronchodilators (#10) an asthma medication, and a medication for dry eyes (#13) and a blood thinner (#14); and for 5 of 5 sampled residents (Residents #1, #2, #3, #4, and #5) for record review related to a medication for schizophrenia (#1) antipsychotic medications (#2), an anti-psychotic, a blood thinner, and two anti-hypertension medications (#3), 2 anti-psychotic medications (#4), a diuretic medication (#5). . The findings are: 1. The medication error rate was 19% as evidenced by the observation of 7 errors out of 36 opportunities during the morning medication pass on 02/07/20. a. Review of Resident #13's current FL2 dated 02/26/19 revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 61	D 358		

-Diagnoses included bipolar depression, anxiety, hypertension, chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease (GERD), pain and kidney failure.
-There were physician's orders for:
-Clonazepam 1mg three times daily (used to treat panic attacks).
-Advair 1 puff twice daily (used to treat asthma).
-Artificial Tears 2 drops twice daily to both eyes (used to treat dry eyes).

Observation of a medication aide during the morning medication pass on 02/07/20 at 9:55am revealed:
-The MA prepared and administered 10 oral medications to Resident #13, but the total medications scheduled to be given on 02/07/20 at the morning medication pass was 13.
-The MA did not administer clonazepam 1mg, Advair 1 puff and artificial tears 2 drops to Resident #13.

Review of Resident #13's February 2020 Medication Administration Record (MAR) revealed:
-There was an entry for clonazepam 1mg three times daily at 8:00am, 2:00pm and 8:00pm.
-Clonazepam 1mg was initialed and circled as not administered on 02/07/20 at 8:00am.
-There was an entry for Advair 250/50 mg inhale 1 puff twice daily at 7:00am and 5:00pm.
-Advair 250/50mg was initialed and circled as not administered on 02/07/20 at 7:00am.
-There was an entry for artificial tears instill 2 drops twice daily at 7:00am and 5:00pm.
-Artificial tears was initialed and circled as not administered on 02/07/20 at 7:00am.

Observation of medications on hand for Resident #13 on 02/07/20 at 9:55 am revealed clonazepam

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

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THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 62 1mg, Advair 20/50mg and artificial tears were not available for administration. Interview on 02/27/20 at 9:55 am with the Medication Aide (MA) revealed: -There was no clonazepam 1 mg available for administration for Resident #13. -The last dose documented as administered was on 02/04/20, three days ago. -There was no Advair 250/50 available for administration for Resident #13. -The last last dose of Advair 250/50 documented as administered to Resident #13 was on 02/06/20. -There was no artificial tears available for administration to Resident #13. -The last dose of artificial tears documented as administered to Resident #13 was on 02/06/20. -She knew it was the MA's responsibility to order medications from the pharmacy, but she was not usually working on this medication cart. Interview on 02/10/20 at 11:30am with the contracted pharmacy representative revealed: -The facility had to request refills as needed for the clonazepam 1mg, Advair 250/50 and the artificial tears for Resident #13. -The clonazepam 1mg was dispensed on 02/08/20 with 60 tablets. -The clonezepam 1mg was dispensed on 01/04/20 with 45 tablets. -The Advair 250/50 was dispensed on 10/06/19, with a 30 day supply. -No refills had been requested from the facility for the Advair 250/50 for Resident #13. -The artificial tears was dispensed on 10/02/20, with a 30 day supply. -No refills had been requested from the facility for the artificial tears for Resident #13.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 63 Interview on 02/10/20 at 10:15 am with Resident #13's primary care provider (PCP) revealed: -She expected the facility to keep prescribed medications on hand for administration and to administer medications as ordered. -The clonazepam 1mg was prescribed because Resident #13 was very anxious. -The Advair 250/50 was prescribed because Resident #13 had COPD. -The artificial tears was prescribed to Resident #13 for dry eyes. -She was not aware the clonazepam 1mg, Advair 250/50 or the artificial tears were not available for administration to Resident #13. -Resident #13 could experience a greater risk of a panic attacks, breathing difficulty or dry eyes by not receiving the clonazepam 1mg, Advair 250/50 or artificial tears as ordered. Interview with Resident #13 on 02/07/20 at 2:20pm revealed; -Her medications were frequently out of stock and the MAs were unable to administer medications as ordered. -She depended on the facility staff to provide medications as ordered by her physician. Refer to telephone interview with the previous Administrator on 02/11/20 at 9:30am. b. Review of Resident #10's current FL2 dated 08/22/19 revealed: -Diagnoses included encephalopathy, chronic pain syndrome, anxiety disorder, chronic obstructive pulmonary disease (COPD), muscle weakness and major depressive disorder. -There was a physician's order for Spiriva Handihaler 18mcg inhale 1 capsule once daily (used to treat COPD). -There was a physician's order for Ventolin HFA	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D 358	Continued From page 64 inhale 2 puffs into lungs every 6 hours as needed for wheezing (used to treat COPD). Observation of a medication aide (MA) during the morning medication pass on 02/07/20 at 9:15am at revealed: -During the medication pass, Resident #10 requested the scheduled spiriva handihaler and the as needed ventolin. -The spiriva handihaler 18mcg and ventolin HFA were not administered to Resident #10. -The MA was observed to tell Resident #10 the medications were not available and she would order the medications as soon as possible. Review of Resident #10's February 2020 medication administration record (MAR) revealed: -There was an entry for spiriva handihaler 18mcg inhale 1 capsule once daily at 7:00 am. -Spiriva handihaler was left blank and not documented as administered on 02/07/20 at 7:00 am. -There was an entry for ventolin HFA inhale 2 puffs into lungs every 6 hours as needed for wheezing. -There was no documentation of administration for ventolin on 02/07/20. Observation of medications on hand for Resident #10 on 02/07/20 at 9:15 am revealed neither the spiriva handihaler 18mcg nor the ventolin HFA were available for administration. Interview on 02/27/20 at 9:55 am with the Medication Aide (MA) revealed: -Neither the spiriva handihaler 18mcg nor the ventolin HFA were not available for administration for Resident #10. -She usually worked on a different medication cart, but knew it was the MA's responsibility to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 65	D 358		

order medications.
-She did not know how long the spiriva handihaler 18mcg and the ventolin HFA had been unavailable for administration to Resident #10.

Interview on 02/10/20 at 11:30am with the contracted pharmacy representative revealed:
-The spiriva handihaler 18mcg for Resident #10 was dispensed on 09/25/19 with a 30 day supply.
-The facility had not requested any additional refills for the spiriva handihaler 18mcg for Resident #10.
-The ventolin HFA for Resident #10 was dispensed on 01/06/20 with a 60 dose supply, on 12/16/19 with a 60 dose supply and on 09/25/19 with a 60 dose supply.

Interview on 02/10/20 at 10:15 am with Resident #10's primary care provider (PCP) revealed:
-She had the expectation the facility staff would keep prescribed medications on hand for administration and to administer medications as ordered.
-The spiriva handihaler and the ventolin HFA were prescribed to Resident #10 because of the diagnosis of COPD.
-She did not know the spiriva handihaler 18mcg nor the ventolin HFA were not available for administration for Resident #10.
-Resident #10 could experience a greater risk of difficulty breathing by not receiving the spiriva handihaler 18mcg or the ventolin HFA as ordered.

Interview with Resident #10 on 02/10/20 at 1:50 pm revealed:
-The facilty often ran out of her medications.
-She depended on the facility to provide her medications as ordered by her physician.

Refer to telephone interview with the previous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 66 Administrator on 02/11/20 at 9:30am. c. Review of Resident #14's current FL2 dated 12/15/19 revealed: -Diagnoses included history of cerebral vascular accident (CVA), rhabdomyolysis, diabetes, leukocytosis and facial weakness. -There was a physician's orders for aspirin 325mg daily (used to prevent blood clots). Observation of a medication aide (MA) during the morning medication pass on 02/07/20 at 9:35am revealed: -The MA prepared 4 oral medications and administered the medications to Resident #14. -Aspirin 325mg was not included with the 4 oral medications. -Aspirin 325mg was not administered to Resident #14 on 02/07/20 during the morning medication pass. Review of Resident #14's February MAR revealed: -There was an entry for aspirin 325mg daily at 8:00am. -Aspirin 325mg daily was initialed and circled as not administered on 02/07/20 at 8:00am. Observation of medications on hand for Resident #14 on 02/07/20 at 9:35am revealed aspirin 325mg was not available for administration. Interview with the MA on 02/07/20 at 9:35am revealed: -There was no aspirin 325mg available for administration for Resident #14. -She usually worked a different medication cart, but knew MAs were responsible for ordering medications for the pharmacy.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 67 Interview on 02/10/20 at 11:30am with the contracted pharmacy representative revealed the aspirin 325mg for Resident #14 was dispensed on 02/08/20 with a 30 day supply and on 01/08/20 with a 30 day supply. Interview on 02/10/20 at 10:15 am with Resident #10's primary care provider (PCP) revealed: -She expected the facility to keep prescribed medications on hand for administration and to administer medications as ordered. -The aspirin 325mg was prescribed to Resident #14 because of the history of a CVA. -Resident #14 could experience a greater risk of blood clots by not receiving the aspirin 325 as ordered. Interview with Resident #14 on 02/07/20 at 9:45 am revealed: -The facility sometimes ran out of her medication, but not often. -She depended on the the facility to administer medications as ordered by her physician. Refer to telephone interview with the previous Administrator on 02/11/20 at 9:30am. 2. Review of Resident #1's current FL-2 dated 01/03/20 revealed diagnoses included schizoaffective disorder, hypertension, major depressive disorder, anxiety disorder, an unspecific lesion of mucosa. Interview with Resident #1 on 02/06/20 at 1:00pm revealed: -She did not receive clozapine twice daily since 02/03/20 for her clozapine. -She was beginning to feel very anxious. -She was staying in her room to feel better. -She was supposed to have labs drawn weekly	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 68	D 358		

before her prescription could be refilled.
-She had labs drawn on 02/04/20 but she had not been given her clozapine.
-She asked the MAs on every shift since 02/04/20.
-Since December 2019 she was not administered her clozapine every day.
-She did not take her clozapine for more than one or two days in a row, but she could not remember specific dates.

a. Review of physician orders for Resident #1 dated 01/03/20 revealed a medication order for clozapine (to treat schizophrenia) 100mg tablet every morning.

Review of Resident #1's December 2019 medication administration record (MAR) on 02/07/20 revealed:
-There was an entry for clozapine 100mg tablet take one tablet every morning scheduled at 7:00am.
-Clozapine 100mg was documented as not administered for 19 out of 31 opportunities from 12/01/19 to 12/31/19.
-There were circles around the staff initials for documenting administration for the clozapine from 12/08/19 to 12/19/19, 12/22/19 and 12/25/19 to 12/31/19.
-The were no reason/comments for these dates to indicate the reason the medication was not administered.

Review of Resident #1's January 2020 medication administration record (MAR) on 02/07/20 revealed:
-There was an entry for clozapine 100mg tablet take one tablet every morning scheduled at 7:00am.
-Clozapine 100mg was documented as not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 69	D 358		

administered for 10 out of 31 opportunities from 01/01/20 to 01/31/20.
-There were circles around the staff initials for documenting administration for the clozapine from 01/01/20 to 01/03/20, 01/07/20 to 01/11/20, 02/18/20, and 01/27/20.
-The were no reason/comments for these dates to indicate the reason the medication was not administered.

Observation of a medication aide (MA) during the morning medication pass on 02/07/20 at 8:00am revealed:
-The MA prepared 13 oral medications and administered the medications to Resident #1.
-Clozapine 100mg was not included in the 13 oral medications administered to Resident #1.
-Clozapine 100mg was not administered to Resident #2 during the morning medication pass on 02/07/20.

Review of Resident #1's February 2020 medication administration record (MAR) on 02/07/20 revealed:
-There was an entry for clozapine 100mg tablet take one tablet every morning scheduled at 7:00am.
-Clozapine 100mg was documented as not administered for 5 out of 7 opportunities from 02/03/20 to 02/07/20.
-There were circles around the staff initials for documenting administration for the clozapine from 02/03/20 to 02/07/20.
-The were no reason/comments for these dates to indicate the reason the medication was not administered.

Observation of Resident #1's available medications on hand on 02/07/20 at 3:00pm revealed there was no clozapine 100mg tablets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 70 available for administration. Review of Resident #1's pharmacy requests for refills of medications on 02/07/20 revealed the clozapine 100mg tablets had not been requested for refill. Telephone interview with a representative from the facility's contracted pharmacy on 02/06/20 at 3:15pm revealed: -Resident #1 had a current physician order for clozapine 100mg tablet take one tablet every morning with instructions to be refilled for twelve months beginning 01/03/20. -Resident #1's for clozapine 100mg tablet take one tablet every morning was not dispensed to the facility since 01/26/20. -A seven-day supply was delivered to the facility on 01/03/20, 01/11/20, 01/26/20. -The pharmacy had not received additional request for refills. -Resident #1's clozapine required submission of a CBC (complete blood count) to the FDA (federal drug association) registry prior to being dispensed. -From 01/03/20 to 02/06/20 the pharmacy dispensed 21 doses of clozapine 100mg but the facility would have needed 34 tablets during this time. Telephone interview with a representative from the facility's contracted lab phlebotomy department on 02/06/20 at 4:25pm revealed: -The lab received an order for CBC on 11/12/19, 11/26/19, 01/07/20, and 02/04/20. -There was not a standing order for the CBC to drawn weekly. -The results were faxed to the facility not the pharmacy.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 71 Interview with a second shift medication aide (MA) on 02/06/20 at 3:55pm revealed: -Resident #1 was out of clozapine 100mg since 02/03/20 when she came into work. -She did not send a request for a refill for clozapine 100mg because she was told Resident #1 required labs drawn prior to getting anymore of the medication. -She had told the third shift MA on 02/04/20 that Resident #1 was out of clozapine. -She did not contact the lab to see if Resident #1 had labs drawn or pending results. -She did not tell the Resident Care Director (RCD) on 02/04/20 because the RCD did not come to work that day. Interview with a first shift medication aide (MA) on 02/07/20 at 10:55am revealed: -She knew Resident #1 was out of her clozapine 100mg tablets. -She worked yesterday and the day before. -She did not request a refill for Resident #1's clozapine 100mg because she was told the third shift MA had requested the refill. -The MAs did not use a communication book to communicate medication changes, lab request or refill requests. Interview with a third shift medication aide (MA) on 02/06/20 at 11:42am revealed: -Resident #1 had been without clozapine 100mg tablets since 02/02/20. -She called the pharmacy to request a refill and found out Resident #1 required her labs to before the pharmacy could dispense it. -She called the lab on 02/04/20 to request the lab results and her labs had not been processed. -She put the request for refill in the hot box on the wall beside the RCD's office. -The RCD was supposed to follow-up on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 72 Resident #1's labs so she could get her clozapine. Interview with the RCD on 02/07/20 at 12:00pm revealed: -She was hired 02/06/20 after the previous RCD quit. -The MAs were supposed to contact the pharmacy when a resident ran out of their medications. -She did not know Resident #1 was out of clozapine. -The previous RCD did not use a shift communication book for the MAs to communicate resident's orders and refills between shifts. -There was not an effective hot box system in place to put medication orders in a central location to verify them and restock the medication carts. -She did not audit the medications carts to assess for missing medications. Telephone interview with Resident #1's Mental Health Practitioner (MHP) on 02/06/20 at 5:03pm revealed: -She did not know Resident #1's last dose of clozapine was 02/02/20. -Resident #1 was not supposed to miss any doses of clozapine. -Resident #1 had been taking clozapine for many years. -It was crucial Resident #1 take clozapine as ordered. -Resident #1 required assistance with management of her clozapine, she expected the MAs and RCD to ensure she got clozapine. -Resident #1 was hospitalized within the last year related to uncontrolled hallucinations and anxiety. -The risks of Resident #1 not continuously taking the clozapine could lead to hallucinations and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 73 increased anxiety that could cause her to hurt herself and other people. -Improper management and missed does of clozapine were associated with neutropenia (a low neutrophil count) which puts Resident #1 at risk for serious and fatal infections. -Clozapine was a medication managed by the REMS (Risk Evaluation and Mitigation Strategy) program. -The REMS program was an FDA-mandated program implemented by the manufacturers of Clozapine. -The REMS program was intended to help Healthcare Providers ensure the safety of patients on Clozapine. -Resident #1 was required to have a CBC blood drawn monthly to be submitted to registry so clozapine was dispensed by the pharmacy. -When Resident missed labs that was not submitted in December 2019 the registry began requiring a CBC blood draw to be done weekly. Interview with the Administrator 02/07/20 at 12:30pm revealed: -He was hired yesterday (02/06/20). -He did not know Resident #1 was out of clozapine. -The MAs had informed him there was a problem with the current pharmacy the facility used causing residents to go without medications. -He did not research what was causing residents to go without medications. -He expected the MAs to ensure all the resident's medications were always available. -The MAs should report any issues they had getting the resident's medications to the RCD. -The present RCD was hired yesterday, and she did not have an opportunity to audit resident's medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 74 Telephone interview with the previous Resident Care Director (RCD) on 02/11/20 at 10:44am revealed: -Her last day of work was 01/30/20. -Resident #1 knew she required a CBC drawn prior to clozapine being dispensed by the pharmacy. -Resident #1's MHP did order monthly CBC's to be drawn. -The MHP was responsible for ensuring Resident #1's labs were submitted to the registry. -She had encountered a lot of errors the facility's pharmacy caused with Resident #1's clozapine. -When Resident #1 missed having her labs drawn monthly, she requested a weekly CBC order from the MHP. -Resident #1 was able to continuously remind the MAs to have her labs drawn weekly. -Because Resident #1 was able to remind the MAs she did not follow up the pharmacy when Resident #1 missed her clozapine. -She did not audit the medication carts, physician orders, and MARs because the facility was understaffed, and she was required to pass medications. Refer to telephone interview with the previous Administrator on 02/11/20 at 9:50am. b. Review of physician orders for Resident #1 dated 01/01/20 revealed a medication order for clozapine 150mg 1-1/2 tablets at bedtime. Review of Resident #1's January 2020 medication administration record (MAR) on 02/07/20 revealed: -There was an entry for clozapine 100mg tablet take 1-1/2 tablets at bedtime scheduled at 8:00pm. -Clozapine 150mg was documented as not administered for 10 out of 31 opportunities from	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 75 01/01/20 to 01/31/20. -There were circles around the staff initials for documenting administration for the clozapine from 01/01/20 to 01/03/20, 01/07/20 to 01/11/20, 01/18/20, and 01/27/20. -The were no reason/comments for these dates to indicate the reason the medication was not administered. Review of the February 2020 medication administration record (MAR) for Resident #1 on 02/07/20 revealed: -There was an entry for clozapine 150mg tablet take 1-1/2 tablets at bedtime scheduled at 8:00pm. -Clozapine 150mg was documented as not administered for 5 out of 7 opportunities from 02/02/20 to 02/06/20. -There were circles around the staff initials for documenting administration for the clozapine from 02/03/20 to 02/06/20. -The were no reason/comments for these dates to indicate the reason the medication was not administered. Observation of Resident #1's available medications on hand on 02/07/20 at 3:00pm revealed there was no clozapine 150mg 1-1/2 tablets available for administration. Review of Resident #1's pharmacy requests for refills of medications on 02/07/20 revealed the clozapine 150mg 1-1/2 tablets had not been requested for refill. Telephone interview with a representative from the contracted pharmacy on 02/06/20 at 3:15pm revealed: -Resident #1 had a current physician order f for clozapine 150mg tablet take 1-1/2 tablets at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 76	D 358		

bedtime with instructions to be refilled for twelve months beginning 01/03/20.
-Resident #1's clozapine 150mg tablet take 1-1/2 tablets at bedtime was not dispensed to the facility since 01/26/20.
-A seven-day supply was delivered to the facility on 01/10/20, 01/20/20, and 01/26/20.
-From 01/03/20 to 02/06/20 the pharmacy dispensed 21 doses but the facility would have required 34 doses during that time.

Interview with a second shift medication aide (MA) on 02/06/20 at 3:55pm revealed:
-Resident #1 was out of clozapine 150mg since 02/03/20 when she came into work.
-She did not send a request for a refill for clozapine 150mg because she was told Resident #1 required labs drawn prior to getting anymore of the medication.
-She had told the third shift MA on 02/04/20 that Resident #1 was out of clozapine.
-She did not contact the lab to see if Resident #1 had labs drawn or pending results.
-She did not tell the Resident Care Director (RCD) on 02/04/20 because the RCD did not come to work that day.

Interview with a first shift medication aide (MA) on 02/07/20 at 10:55am revealed:
-She knew Resident #1 was out of her clozapine 150mg tablets.
-She worked yesterday and the day before.
-She did not request a refill for Resident #1's clozapine 150mg because she was told the third shift MA had requested the refill.
-The MAs did not use a communication book to communicate medication changes, lab request or refill requests.
-When she faxed physician's order to the pharmacy, she placed the order in a hot box on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 77	D 358		

the wall beside the RCD's office.
-The RCD or MA who received the order wrote it on the MAR.
-The RCD was supposed to verify the medication when it was delivered by the pharmacy with the order and place it on the medication cart.

Interview with a third shift medication aide (MA) on 02/06/20 at 11:42am revealed:
-Resident #1 had been without clozapine 150mg tablets since Monday.
-She called the pharmacy to request a refill and found out Resident #1 required her labs to before the pharmacy could dispense it.
-She called the lab on 02/04/20 to request the lab results and her labs had not been processed.
-She put the request for refill in the hot box on the wall beside the RCD's office.
-RCD was supposed to follow-up on Resident #1's labs so she could get her clozapine.

Interview with the RCD on 02/07/20 at 12:00pm revealed:
-She was hired 02/06/20.
-The MAs were supposed to contact the pharmacy when a resident ran out of their medications.
-She did not know Resident #1 was out of clozapine.
-The previous RCD did not use a shift communication book for the MAs to communicate resident's orders and refills between shifts.
-There was not an effective hot box system in place to put medication orders in a central location to verify them and restock the medication carts.
-She did not audit the medications carts to assess for missing medications.

Telephone interview with Resident #1's Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 78 Health Practitioner (MHP) on 02/06/20 at 5:03pm revealed: -She did not know Resident #1's last dose of clozapine was 02/02/20. -Resident #1 was not supposed to miss any doses of clozapine. -Resident #1 had been taking clozapine for many years. -It was crucial Resident #1 take clozapine twice daily. -Resident #1 required assistance with management of her clozapine, she expected the MAs and RCD to ensure she got clozapine twice daily. -Resident #1 was hospitalized within the last year related to uncontrolled hallucinations and anxiety. -The risks of Resident #1 not continuously taking the clozapine could lead to hallucinations and increased anxiety that could cause her to hurt herself and other people. -Improper management and missed does of clozapine were associated with neutropenia (a low white count) which puts Resident #1 at risk for serious and fatal infections. -Clozapine was a medication managed by the REMS (Risk Evaluation and Mitigation Strategy) program. -The REMS program was an FDA-mandated program implemented by the manufacturers of Clozapine. -The REMS program was intended to help Healthcare Providers ensure the safety of patients on Clozapine. -Resident #1 was required to have a CBC blood drawn monthly to be submitted to registry so clozapine was dispensed by the pharmacy. -When Resident missed labs that was not submitted in December 2019 the registry began requiring a CBC blood draw to be done weekly.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 79 Interview with the Administrator 02/07/20 at 12:30pm revealed: -He was hired yesterday (02/06/20). -He did not know Resident #1 was out of clozapine. -The MAs had informed him there was a problem with the current pharmacy the facility used causing residents to go without medications. -He did not research what was causing residents to go without medications. -He expected the MAs to ensure all the resident's medications were always available. -The MAs should report any issues they had getting the resident's medications to the RCD. -The present RCD was hired yesterday, and she did not have an opportunity to audit resident's medications. Telephone interview with the previous Resident Care Director (RCD) on 02/11/20 at 10:44am revealed: -Her last day of work was 01/30/20. -Resident #1 knew she required a CBC drawn prior to clozapine being dispensed by the pharmacy. -Resident #1's MHP ordered monthly CBC's to be drawn. -The MHP was responsible for ensuring Resident #1's labs were submitted to the registry. -She had encountered a lot of errors the facility's pharmacy caused with Resident #1's clozapine. -When Resident #1 missed having her labs drawn monthly, she requested a weekly CBC order from the MHP. -Resident #1 was able to continuously remind the MAs to have her labs drawn weekly. -Because Resident #1 was able to remind the MAs she did not follow up the pharmacy when Resident #1 missed her clozapine. -She did not audit the medication carts, physician	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 80	D 358		

orders, and MARs because the facility was understaffed, and she was required to pass medications.

Refer to telephone interview with the previous Administrator on 02/11/20 at 9:50am.

3. Review of Resident #5's current FL-2 dated 01/03/20 revealed diagnoses included history of deep vein thrombosis, osteoarthritis, hypertension, congestive heart failure, peripheral vascular disease, and chronic kidney disease.

Interview with Resident #5 on 02/06/20 at 12:45pm revealed:
-She went to the emergency room last night and returned to the facility after she was treated for fluid overload.
-She was supposed to be taking furosemide beginning today.
-The furosemide was supposed to continue to remove fluid from her heart so she can breathe better.

Review of physician orders for Resident #5 dated 02/05/20 revealed a medication order for furosemide 20mg daily for 14 days.

Review of the February 2020 medication administration record (MAR) for Resident #5 on 02/07/20 revealed:
-There was a hand-written entry for furosemide 20mg take one tablet twice daily for 14 days to begin on 02/09/20 at 7:00am and stop on 02/22/20 at 2:00pm.
-Furosemide was not documented as administered.

Observation of Resident #5's available medications on hand on 02/07/20 at 3:00pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 81	D 358		

revealed there was no furosemide 20mg tablets available for administration on the medication cart.

Telephone interview with a representative from the facility's contracted pharmacy on 02/07/20 at 1:31pm revealed:
-The pharmacy had received a faxed physician order for furosemide 20mg one tablet for fourteen days.
-The furosemide was dispensed on 02/06/20 to the facility.
-The furosemide was delivered to the facility on 02/06/20.

Interview with a second shift medication aide (MA) on 02/06/20 at 3:55pm revealed:
-Resident #5 did not have furosemide 20mg available on the medication cart because the start date of the order was 02/09/20.
-Resident #5 asked her about getting her furosemide this morning.
-She did not review the furosemide order to verify the start date.
-The third shift MA told her the furosemide was not going to be available from the pharmacy for a few days.
-The third shift MA wrote the start date of 02/09/20 on the MAR.
-She did not tell the Resident Care Director (RCD) the medication delivery from the pharmacy was delayed because she was told medications took a few days to be delivered.
-She did not have access to the totes the pharmacy delivered with medications in them.
-The RCD opened all pharmacy totes and reviewed the medications before putting them on the medication cart.

Interview with the RCD on 02/07/20 at 12:00pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 82	D 358		

revealed:
-She was hired 02/06/20 after the former RCD quit.
-She did not know Resident #5 went to the emergency room for congestive heart failure.
-She did not know Resident #5 had a physician order for furosemide.
-The MAs were responsible for signing for all pharmacy deliveries.
-The MAs were expected to open the pharmacy totes and make the available on the medication cart.
-There was a lot of pharmacy delivery totes in the stock room that she did not have time to open.

Interview with the Administrator 02/07/20 at 12:30pm revealed:
-He was hired yesterday (02/06/20).
-He expected the MAs to ensure all the resident's medications were always available.
-The MAs should report any issues they had getting the resident's medications to the RCD.
-The RCD was hired yesterday, and she did not have an opportunity to audit resident's medications.

Refer to telephone interview with the former Administrator on 02/11/20 at 9:50am.

4. Review of Resident # 2's current FL2 dated 02/26/19 revealed diagnoses included congestive heart failure (CHF), schizophrenia, anxiety, insomnia, psychosis and mood disorder.

a. Review of Resident #2's physician's orders dated 01/24/20 revealed paliperidone injection (Invega) 156 mg/ml 1 dose per month (a long-acting anti-psychotic injection used to treat acute and maintenance therapy for schizophrenia).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 83 Review of Resident #2's record revealed no hospital records for review for December 2019, January 2020 or February 2020. Review of Resident #2's Licensed Health Professional Support (LHPS) dated 01/27/20 revealed medication administration through injections was documented as understood by medication aide (MA) staff an injection was to be administered by Home Health (HH) agency. Review of Resident #2's January 2020 Medication Administration Record (MAR) revealed: -There was an entry for paliperidone 156 mg/ml inject once for 1 dose (Home Health Nurse). -There was no documentation paliperidone was administered in January 2020. Review of Resident #2's February 202 MAR revealed: -There was an entry for paliperidone 156 mg/ml inject once for 1 dose by Home Health Nurse (HHN). -There was no documentation paliperidone was administered in February 2020. Observation of Resident #2's medications on hand on 02/06/20 at 10:10 am revealed: -There was 1 unopened box of paliperidone 156 mg/ml with instructions to inject 1 dose. -Paliperidone was dispensed on 01/28/20 for 1 dose. Interview with a medication aide (MA) on 02/06/20 at 10:20 am revealed: -She did not know what paliperidone was or how it was to be administered. -She did not know it was supposed to be	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 84 administered by the HHN. -As far as she knew, the HHN had not come out to administer the paliperidone to Resident #2. -She had not asked another MA or staff about the paliperidone, but just knew it was available in the medication cart. Interview with a representative from the Home Health agency on 02/06/20 at 11:40 am revealed the Home Health agency never received an order for paliperidone injections to be administered by the HHN. Interview with Resident #2's primary care provider (PCP) on 02/07/20 at 8:55 am revealed: -She had written the order for paliperidone injections for 1 injection each month by the HHN. -She worked closely with Resident #2's mental health provider (MHP) and the MHP told her Resident #2 had not received paliperidone injections. -She was aware Resident #2 had been noncompliant with taking his medications. -Resident #2 was currently in the hospital in an acute psychiatric unit. -She was very concerned because Resident #2 did not receive the paliperidone injection and felt this was the reason Resident #2 was sent to the hospital on 02/05/20. Interview with Resident #2's mental health provider (MHP) on 02/07/20 at 11:10 am revealed: -Resident #2 had been admitted to the hospital about 2 weeks ago and again recently. -Resident #2 was sent to the hospital both times because he would not eat, and he was not taking his medications. -Resident #2 became unstable when he did not take his medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 85 -She had visited the Resident at the facility on 01/24/20 and had reviewed the MARs and medications on hand and she could tell Resident #2 was not getting his medications. -There was no paliperidone injection at the facility on 01/24/20. -The MHP was so concerned about Resident #2 not getting the correct medications, correct doses and missed medications because Resident #2 was compliant, stable, had decreased behaviors and less resistance to care if he received his anti-psychotic medications including the paliperidone injection. -The MHP felt the reason Resident #2 was sent to the hospital was because he had not received his 4 anti-psychotic medications including the paliperidone injections as ordered. Interview with a representative from the contracted pharmacy on 02/10/20 at 10:50 am revealed: -Paliperidone (Invega) 156 mg/mi injection 1 dose each month was a current order. -One injection syringe was dispensed on 01/28/20. -Medication orders were called in to the pharmacy by the PCP and MHP and some orders medication orders were written orders sent to the pharmacy by the facility staff. -The pharmacy staff had difficulty getting in touch with the facility. Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 10:07 am revealed: -Residents' medications were delivered to the facility twice each day. -She thought the HHN was supposed to be coming to administer paliperidone injections to Resident #2. -All the staff working were new and there was no	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 86 experienced staff left to train the new staff what to do. Interview with a second MA on 02/10/20 at 11:15 am revealed: -All orders were sent to the pharmacy. -The MAs and the RCD were responsible to send orders to the pharmacy. -Any hospital discharge summaries were to be reviewed for any orders and those were sent to the pharmacy as well. -She knew Resident #2 was sent to the hospital, but did not know when he went to the hospital or which hospital Resident #2 was admitted to. Interview with the former RCD on 02/11/20 at 12:30 pm revealed: -If there was an order for a medication that HH was to give, the former RCD would send the order to HH. -If HH was supposed to administer a resident's injection but was not administering the injection, the MAs were to let the former RCD know and the former RCD would follow-up with HH. -The order for paliperidone injections was sent to another HH agency to give the paliperidone injection to Resident #2. -Resident #2 was "dropped" from the HH agency, so the former RCD contacted another HH agency. -Resident #2 was not discharged from HH services, he was "dropped " from HH because he could not pay for HH services. -If HH was not coming to the facility to give Resident #2 his injections, the former RCD did not know anything about it; MAs did not let her know. Interview on 02/11/20 at 2:05 pm with another HH agency contacted by the former RCD revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 87 -The HH agency had not received any orders for Resident #2. -This company was a Home Care agency and not a HH agency. Attempted telephone interviews with Resident #2's Guardian on 02/06/20 at 5:00 pm and on 02/11/20 at 10:00 am was unsuccessful. Attempted telephone interview with the mental health provider for Resident #2 at the local hospital on 02/10/20 at 3:30 pm was unsuccessful. Refer to interview with the former Administrator on 02/11/20 at 9:30 am. b. Review of Resident #2's physician's order dated 12/20/19 revealed paliperidone ER 6 mg 1 tablet at bedtime (used to treat dementia related psychosis). Review of Resident #2's subsequent physician's order dated 01/24/20 revealed paliperidone 6 mg 24-hour tablet 1 tablet every morning for 30 days. Review of Resident #2's physician's orders revealed no discontinue order for paliperidone 6 mg tablets. Review of Resident #2's December 2019 Medication Administration Record (MAR) revealed: -There was an entry for paliperidone 6 mg ER 1 tablet at bedtime schedule for administration at 8:00 pm. -Paliperidone was not documented as administered from 12/20/19 to 12/31/19. -Discontinued (D/C) was handwritten on the MAR.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 88 Review of Resident #2's January 2020 MAR revealed: -There was an entry for paliperidone 6 mg take 1 tablet every morning scheduled for administration at 8:00 am. -There was a second entry for paliperidone 6 mg every morning times 30 days scheduled for administration at 8:00 am. -Paliperidone was not documented as administered from 01/01/20 to 01/31/20. Review of Resident #2's February 2020 MAR revealed: -There was an entry for paliperidone 6 mg take 1 tablet every morning schedule for administration at 8:00 am. -There was documentation paliperidone 6 mg tablets was administered on 02/01/20, 02/02/20 and on 02/03/20. Observation of Resident #2's medications on hand on 02/06/20 revealed there was no paliperidone 6 mg tablets available for administration. Interview with Resident #2's primary care provider (PCP) on 02/07/20 at 8:55 am revealed: -She knew Resident #2 was noncompliant with his medications and he had a lot of mental health issues. -She was at the facility on 01/08/20 and noticed Resident #2 was not being administered his medications. -She thought Resident #2 not getting his anti-psychotic medications including paliperidone tablets contributed to his recent hospitalization to an acute psychiatric unit at a local hospital. Interview with Resident #2's mental health	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 89	D 358		

provider (MPH) on 02/07/20 at 11:10 am revealed:
-Resident #2 had been admitted to the hospital about 2 weeks ago and again recently.
-Resident #2 was sent to the hospital because he would not eat, and he was not taking his medications.
-Resident #2 became unstable when he did not take his medications.
-The MHP visited the facility last week (01/23/20) and there was no paliperidone tablets available in the facility.
-The MHP was so concerned about Resident #2 not getting the correct medications, correct doses and missed medications because Resident #2 was compliant, stable, had decreased behaviors and less resistance to care if he received his antipsychotic medications.
-The MHP felt the reason Resident #2 was sent to the hospital was because he had not received his 4 anti-psychotic medications including paliperidone tablets as ordered.

Interview with a medication aide (MA) on 02/06/20 at 10:20 am revealed she thought paliperidone tablets had been discontinued because "discontinued" was written on the MARs.

Interview with a representative from the contracted pharmacy on 02/07/20 at 4:05 pm revealed:
-Paliperidone 6 mg tablets 6 mg 1 tablet at bedtime was an expensive medication.
-The pharmacy had not contacted Resident #2's PCP about needing a prior authorization form for paliperidone tablets, but a prior authorization form was sent to the facility for Resident #2's primary care provider (PCP) to sign in order to dispense the paliperidone tablets.
-The pharmacy never received the signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 90	D 358		

authorization from Resident #2's PCP and the paliperidone tablets were never dispensed to the facility.
-The pharmacy staff had difficulty getting in touch with the facility and there was a lack of cooperation dealing with the previous Administrator.
-The PCP changed the paliperidone order to a different medication (Risperidone 3 mg at bedtime -used to treat mood disorders) on 12/12/19.

Interview with the Resident Care Director (RCD) on 02/07/20 at 4:30 pm revealed:
-The Resident Care Coordinator (RCC) had called the contracted pharmacy about the paliperidone tablets.
-Paliperidone tablets were never sent because the pharmacy did not have a prescription on profile for paliperidone tablets for Resident #2.
-She found the unsigned prior authorization form for paliperidone tablets on 02/07/20 in a stack of faxes in the previous RCD's office and the prior authorization was never sent to Resident #2's PCP or the MHP to complete and sign.

Interview with the former Administrator on 02/11/20 at 11:50 am revealed she did not know anything about medication orders or any authorization for the PCP to sign.

Interview with the former RCD on 02/11/20 at 12:30 pm revealed:
-The MAs were responsible to ensure medications were in the facility.
-The MAs were responsible for processing orders and sending orders to the pharmacy.
-She thought the paliperidone tablets had been sent to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 91	D 358		

Attempted telephone interviews with Resident #2's Guardian on 02/06/20 at 5:00 pm and on 02/11/20 at 10:00 am was unsuccessful.

Attempted telephone interview with the mental health provider for Resident #2 at the local hospital on 02/10/20 at 3:30 pm was unsuccessful.

Refer to interview with the previous Administrator on 02/11/20 at 9:30 am.

c. Review of Resident #2's physician's orders revealed physician's orders dated 12/12/19 and 01/02/20 for Risperdal 1 mg every morning and 3 mg at bedtime (used to treat mood disorders).

Review of Resident #2's December 2020 medication administration record (MAR) revealed:
-There was an entry for Risperdal 3 mg 1 tablet every night at bedtime scheduled for administration at 8:00 pm.
-Risperdal 3 mg was not documented as administered at 8:00 pm from 12/12/19 to 12/17/19, and on 12/20/19.
-There was documentation Risperdal was refused on 12/16/19.
-There was no entry for Risperdal 1 mg every morning on the MAR.

Review of Resident #2's progress notes for December 2019 revealed Resident #2 refused medications on 12/21/19 and 12/30/19.

Review of Resident #2's physician's order dated 01/07/20 revealed an order to discontinue Risperdal 1 mg every morning and to start Risperdal 2 mg every morning.

Review of Resident #2's physician's order dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 92 01/09/20 revealed an order for Risperdal 1 mg 2 tablets every morning, discontinue previous Risperdal orders and continue Risperdal 3 mg at bedtime. Review of Resident #2's January 2020 MAR revealed: -There was an entry for Risperdal 1 mg 1 tablet every morning scheduled for administration at 8:00 am. -Risperdal 1 mg was documented as not administered at 8:00 am from 01/07/20 to 01/14/20 and from 01/17/20 to 01/19/20 and from 01/21/20 to 01/25/20 with the initials circled and marked through on the MAR and "D/C" handwritten on the MAR. -There was a second entry for Risperdal 2 mg 1 tablet once daily and scheduled for administration at 7:00 am. -Risperdal 2 mg was not documented as administered on 01/01/20 and 01/28/20. -Discontinued was handwritten on the MAR. -There was a third entry for Risperdal 3 mg 1 tablet every night at bedtime schedule for administration at 8:00 pm. -Risperdal 3 mg was documented as not administered at 8:00 pm by circled initials from 01/02/20 to 01/04/20, and from 01/06/20 to 01/14/20 and on 01/25/20. -Risperdal 3 mg documentation of administration was left blank on 01/17/20, from 02/20/20 to 01/23/20 and from 01/27/20 to 01/31/20. -"Hospital" was handwritten for the dates of 01/15/20, 01/16/20, 01/18/20 and 01/19/20. -There was no documentation for the reason Risperdal was not administered as ordered. -Discontinued was handwritten on the MAR. Review of Resident #2's progress notes for January 2020 revealed Resident #2 refused	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 93	D 358		

medications on 01/02/20, 01/04/20, 01/07/20, 01/08/20, and on 01/11/20.

Review of Resident #2's physician's orders revealed there was no order dated 01/30/20 to discontinue all Risperdal orders.

Review of Resident #2's February 2020 medication administration record (MAR) revealed:
-There was an entry for Risperdal 3mg 1 tablet at bedtime scheduled for administration at 8:00 pm.
-"Discontinued " was handwritten over the entry for Risperdal 3mg.
-There were no other entries on the February MAR for Risperdal.

Observation of Resident #2's medications on hand on 02/06/20 at 5:10 pm revealed there was no Risperdal available for administration.

Interview with Resident #2's primary care provider (PCP) on 02/07/20 at 8:55 am revealed:
-She knew Resident #2 was noncompliant with his medications and he had a lot of mental health issues.
-She was at the facility on 01/08/20 and noticed Resident #2 was not being administered his medications.
-She thought Resident #2 not getting his anti-psychotic medications including the Risperdal contributed to his recent hospitalization to an acute psychiatric unit at a local hospital.

Interview with Resident #2's mental health provider (MHP) on 02/07/20 at 11:10 am revealed:
-She visited Resident #2 every two weeks.
-When she visited on 01/23/20, the resident was still getting Risperdal 1 mg and she thought she had written an order to discontinue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 94 -Resident #2 was sent back to the hospital because he was not eating and he would not take his medications. -The MHP was so concerned about Resident #2 not getting the correct antipsychotic medications, correct doses and missed antipsychotic medications because Resident #2 was compliant, stable, had decreased behaviors and less resistance to care if he received his medications. -Resident #2 was currently in the hospital in an acute psychiatric unit and she felt his admission to the hospital was caused by not receiving his anti-psychotic medications including Risperdal as ordered. Interview with a medication aide (MA) on 02/10/20 at 9:30 am revealed: -She knew Resident #2 was in the hospital but she did not know when the resident went to he hospital or which hospital Resident #2 was admitted to. -Resident #2's primary care provider would sometimes send orders to the pharmacy. -Sometimes the medication orders would not be in the residents' records. -The MAs were to fax physician orders to the pharmacy. -Residents' medications were on a cycle-filled system except for controlled medications. -The pharmacy delivered medications to the facility daily. Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 10:07 am revealed: -Some medications were just discontinued on the MARs because the MAs did not have the medications on the medication carts, or the MAs thought the residents needed a new prescription. -The MAs did not know what to do. -The MAs were responsible for placing the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 95	D 358		

medications received in the medication carts but thought that was not being done because the MAs did not know to do that.
-She did not think medication orders were being sent to the pharmacy, so medications were not being sent to the facility.
-All the staff working was new and there was no experienced staff left to show the new staff what to do.

Interview with a second MA on 02/10/20 at 11:15 am revealed:
-She knew Resident #2 was admitted to the hospital but she did not know when the resident went to the hospital.
-She thought Risperdal may have been discontinued, but she was not sure; discontinued was written on the MAR.
-Staff initials circled on the MARs meant the medications were not administered, or could not be given for some reason such as, resident refused the medication or medication was not available in the medication cart.
-The MAs were responsible for contacting the PCP.

Interview with the former RCD on 02/11/20 at 12:30 pm revealed:
-The MAs were responsible to ensure medications were in the facility.
-The MAs were responsible for processing orders and sending orders to the pharmacy.
-The MAs and former RCD were responsible for creating the MARs; the pharmacy did not provide pre-printed MARs.
-The MAs were supposed to go back to Resident #2 and try to administer his medications when he refused.

Review of Resident #2's current orders and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 96	D 358		

dispensing records provided by the contracted pharmacy revealed:
-There was an order on file for Risperdal 3 mg at bedtime dated 12/12/19 to replace Paliperidone 6 mg tablets.
-There was no order on file dated 01/07/20 for Risperdal 1 mg every morning and to start Risperdal 2 mg every morning.
-On 01/09/20, an order was received to increase Risperdal 1mg to 2 mg every morning and continue Risperdal 3 mg at bedtime.
-Risperdal 3 mg 1 tablet at bedtime was dispensed on 12/17/19 for 5 tablets.
-Risperdal 1 mg 2 tablets each morning was dispensed on 01/10/20 for 60 tablets.
-Risperdal 1 mg 1 tablet each morning was dispensed on 01/25/20 for 30 tablets.
-All Risperdal orders were discontinued on 01/30/20.

Attempted telephone interviews with Resident #2's Guardian on 02/06/20 at 5:00 pm and on 02/11/20 at 10:00 am was unsuccessful.

Attempted telephone interview with the mental health provider for Resident #2 at the local hospital on 02/10/20 at 3:30 pm was unsuccessful.

Refer to interview with the previous Administrator on 02/11/20 at 9:30 am.

d. Review of Resident #2's physician's order dated 12/05/19 revealed Depakote 250 mg 1 tablet twice daily (used to treat psychosis).

Review of Resident #2's physician's orders revealed no order to discontinue Depakote 250 mg twice daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 97 Review of Resident #2's December 2019 medication administration record (MAR) revealed: -There was an entry for Depakote 250 mg 1 tablet twice daily scheduled for administration at 7:00 am and 5:00 pm. -Depakote was not documented as administered at 7:00 am from 12/05/10 to 12/31/19. -Depakote was not documented as administered at 5:00 pm on 12/02/19 and from 12/05/19 to 12/31/19. -There was documentation for the reason Depakote was not administered as refused on 12/05/19, 12/08/19 and on 12/27/19. -Discontinued was handwritten on the MAR and "VOID" was handwritten over the entry for Depakote on the MAR. Review of Resident #2's subsequent physician's order dated 01/07/20 revealed Depakote 250 mg twice daily. Review of Resident #2's January 2020 MAR revealed: -There was an entry for Depakote 250 mg 1 tablet twice daily scheduled for administration at 7:00 am and 5:00 pm. -Depakote was not documented as administered at 7:00 am or 7:00 pm from 01/01/20 to 01/31/20. -Discontinued was handwritten on the MAR. -There was a second entry for Depakote 250 mg 1 tablet twice daily scheduled for administration at 7:00 am and 7:00 pm. -Depakote was not documented as administered at 7:00 am from 01/01/20 to 01/31/20. -Depakote 250 mg was not documented as administered at 7:00 pm from 01/01/20 to 01/26/20. -There was no documentation for the reason Depakote was not administered as ordered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 98 Review of Resident #2's February 2020 MAR revealed: -There was an entry for Depakote 250 mg 1 tablet twice daily scheduled for administration at 7:00 am and 7:00 pm. -Depakote was documented as not administered by circled initials at 7:00 am on 02/02/20, 02/03/20 and at 7:00 pm on 02/02/20. -Depakote was not documented as administered on 02/04/20 and "hospital" was written on the MAR on 02/05/20 and 02/06/20. -There was no documentation for the reason Depakote was not administered as ordered. Observation of Resident #2's medications on hand on 02/06/20 at 5:10 pm revealed: -Depakote 250 mg was available for administration. -There were 2 unopened bubble packs with 30 tablets each dispensed on 01/30/20 with instructions to administer 1 tablet twice daily. Review of Resident #2's current orders and dispensing records provided by the contracted pharmacy revealed: -There was an order for Depakote 250 mg twice daily dated 01/07/20. -There was no discontinue order on file for Depakote. -The order for Depakote 250 mg twice daily was received by the pharmacy on 01/09/20. -Depakote was dispensed on 01/30/20 for 60 tablets. Interview with Resident #2's primary care provider (PCP) on 02/07/20 at 8:55 am revealed: -She knew Resident #2 was noncompliant with his medications and he had a lot of mental health issues. -She was at the facility on 01/08/20 and noticed	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 99	D 358		

Resident #2 was not being administered his antipsychotic medications.
-She thought Resident #2 not getting his anti-psychotic medications including Depakote contributed to his recent hospitalization to an acute psychiatric unit at a local hospital.

Interview with Resident #2's mental health provider (MHP) on 02/07/20 at 11:10 am revealed:
-She visited Resident #2 every two weeks.
-She had ordered Depakote for Resident #2 and he was supposed to be taking Depakote.
-The facility did not make her aware Resident #2 was not taking Depakote; she had discovered this by reviewing the MARs on 01/23/20 and there was no Depakote in the facility.
-She knew Resident #2 would refuse medications, but staff should try to administer his medications.
-The MHP was so concerned about Resident #2 not getting the correct antipsychotic medications, correct doses and missed antipsychotic medications because Resident #2 was compliant, stable, had decreased behaviors and less resistance to care if he received his medications.
-Resident #2 was currently in the hospital in an acute psychiatric unit and she felt his admission to the hospital was caused by not receiving his anti-psychotic medications including Depakote as ordered.

Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 10:07 am revealed:
-Some medications were just discontinued on the MARs because the MAs did not have the medications on the medication carts, or the MAs thought the residents needed a new prescription.
-The MAs did not know what to do.
-The MAs were responsible for placing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 100	D 358		

medications received in the medication carts but thought that was not being done because the MAs did not know to do that.
-She did not think medication orders were being sent to the pharmacy, so medications were not being sent to the facility.
-All the staff working was new and there was no experienced staff left to show the new staff what to do.

Interview with a medication aide (MA) on 02/10/20 at 11:15 am revealed:
-She knew Resident #2 was sent out to the hospital but she did not know when Resident #2 went to the hospital.
-She administered medications to Resident #2.
-She thought Depakote may have been discontinued, but she was not sure; discontinued was written on the MAR.
-Staff would sometimes write discontinued on the MARs because medications would not available in the medication cart.

Interview with the former Administrator on 02/11/20 at 11:50 am revealed she would take order entries off the MARs because she could not find the orders.

Interview with the former Resident Care Director on 02/11/20 at 12:30 pm revealed:
-The MAs and the former RCD would call the MHP and the primary care provider if Resident #2 went without his medications for 2 days.
-The MHP was aware when Resident #2 went without his medications.
-MAs were responsible for reviewing the MARs, checking the medication cart and if medication was not on the cart, the MAs were supposed to call the pharmacy.
-Medications were delivered to the facility each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 101	D 358		

day at 5:00 am and at 5:00 pm.
-Third shift MAs were responsible for placing medications on the medication carts.

Attempted telephone interviews with Resident #2's Guardian on 02/06/20 at 5:00 pm and on 02/11/20 at 10:00 am was unsuccessful.

Attempted telephone interview with the mental health provider for Resident #2 at the local hospital on 02/10/20 at 3:30 pm was unsuccessful.

Refer to interview with the previous Administrator on 02/11/20 at 9:30 am.

e. Review of Resident #2's current FL2 dated 02/26/19 revealed a physician's order for Cogentin 1 tablet every 8 hours (used to treat movement disorders secondary to anti-psychotic medications).

Review of Resident #2's subsequent physician's order dated 12/05/19 and 12/12/19 revealed benztropine 1 mg at lunch combined with 2 mg twice daily.

Review of Resident #2's physician's orders revealed no order to discontinue Cogentin 1 mg at lunch.

Review of Resident #2's December 2019 medication administration record (MAR) revealed:
-There was an entry for Cogentin 2 mg twice daily scheduled for administration at 7:00 am and 5:00 pm .
-Cogentin 2 mg was not documented as administered at 5:00 pm from 12/05/19, 12/08/19, 12/011/19, 12/015/19, 12/28/19, 12/29/19, and on 12/31/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 102 -There was an entry for Cogentin 1 mg at lunch time scheduled for administration at 11:30 am. -Cogentin 1 mg 1 tablet at lunch was not documented as administered at 11: 30 am from 12/05/19 to 12/19/19, 12/21, 12/23/19, 12/28/19, 12/29/19 and on 12/31/19. -There was no documentation for the reason Cogentin was not administered as ordered. Review of Resident #2's progress notes for December 2019 revealed Resident #2 refused medications on 12/21/19 and 12/30/19. Review of Resident #2's January 202 MAR revealed: -There was an entry for Cogentin 1 mg 1 tablet daily at lunch scheduled for administration at 11:30 am. -Cogentin 1 mg was not documented as administered at 11:30 am from 01/01/20 to 01/16/20, from 01/19/20 to 01/23/20, from 01/25/20 to 01/27/20 on 01/29/20 and on 01/30/20. -Discontinued was handwritten on the MAR. -There was an entry for Cogentin 2 mg twice daily scheduled for administration at 7:00 am and 5:00 pm. -Cogentin 2 mg was not documented as administered at 7:00 am from 01/02/20 to 01/06/20, from 01/08/20 to 01/20/20, from 01/22/20 to 01/26/20, and on 01/27/20. -"Hospital" was written on the MAR for 01/15/20, 01/16/20, 01/19/20 and 01/20/20. -Cogentin 2 mg was documented as not administered at 5:00 pm by circled initials on the MAR from 01/08/20 to 01/14/20, on 01/17/20, and from 01/21/20 to 01/25/20. -There was no documentation for the reason Cogentin was not administered as ordered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 103	D 358		

Review of Resident #2's progress notes for January 2020 revealed Resident #2 refused medications on 01/02/20, 01/04/20, 01/07/20, 01/08/20, and on 01/11/20.

Review of Resident #2's February 2020 MAR revealed:
-There was an entry for Cogentin 2 mg twice daily scheduled for administration at 7:00 am and 5:00 pm.
-Cogentin 2 mg was documented as not administered at 7:00 am and 5:00 pm on 02/02/20 by circled initials on the MAR and 02/03/20 was blank.
-There was no documentation for the reason Cogentin was not administered as ordered.
-"Hospital" was written on the MAR for 02/04/20 to 02/06/20.
-There was no entry for Cogentin 1 mg 1 tablet daily at lunch scheduled for administration at 11:30 am on the MAR.

Review of Resident #2's progress notes for February 2020 revealed there were no progress notes documented for February 2020.

Observations of Resident #2's medications on hand 02/07/20 at 10:10 am revealed:
-Cogentin 2 mg tablets and Cogentin 1mg tablets were available for administration.
-There were 2 unopened bubble packs of Cogentin 2 mg tablets with 30 tablets in each bubble pack and dispensed on 02/01/20 and instructions to administer twice daily.
-There was 1 unopened bubble pack of Cogentin 1 mg tablets with 30 tablets in the bubble pack and dispensed on 01/30/20 and instructions to administer at lunch time daily.

Review of Resident #2's current orders and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 104 dispensing records provided by the contracted pharmacy revealed: -There was an order dated 12/12/19 for Cogentin 2 mg 1 tablet twice daily. -Cogentin 2 mg was dispensed on 01/17/20 and on 02/01/20 for 60 tablets each date. -There was an order dated 12/12/19 for Cogentin 1 mg daily at lunch. -Cogentin 1 mg was dispensed on 01/04/20 and on 01/30/20 for 30 tablets each date. Interview with Resident #2's primary care provider (PCP) on 02/07/20 at 8:55 am revealed: -She knew Resident #2 was noncompliant with his medications and he had a lot of mental health issues. -She was at the facility on 01/08/20 and noticed Resident #2 was not being administered his anti-psychotic medications. Interview with Resident #2's mental health provider (MHP) on 02/07/20 at 11:10 am revealed: -She visited Resident #2 every two weeks. -She had ordered Cogentin for Resident #2. -She was aware that Resident #2 was not receiving his antipsychotic medications as ordered. -The facility did not make her aware, she had discovered this by reviewing the MARs on 01/24/20. -The MHP was so concerned about Resident #2 not getting the correct medications, correct doses and missed medications because Resident #2 was compliant, stable, had decreased behaviors and less resistance to care if he received his anti-psychotic medications. -Resident #2 was currently in the hospital in an acute psychiatric unit.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 105 Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 10:07 am revealed: -Some medications were just discontinued on the MARs because the MAs did not have the medications on the medication carts, or the MAs thought the residents needed a new prescription. -The MAs did not know what to do. -The MAs were responsible for placing the medications received in the medication carts but thought that was not being done because the MAs did not know to do that. -She did not think medication orders were being sent to the pharmacy, so medications were not being sent to the facility. -All the staff working was new and there was no experienced staff left to show the new staff what to do. Interview with a medication aide (MA) on 02/10/20 at 11:15 am revealed: -She administered medications to Resident #2. -Staff initials circled on the MARs meant the medications were not administered, or could not be given for some reason, resident refused the medication or medication was not available in the medication cart. -She had not contacted Resident #2's PCP or MHP because they both were aware of Resident #2 medications and they were both in the facility seeing residents every two weeks. Attempted telephone interviews with Resident #2's Guardian on 02/06/20 at 5:00 pm and on 02/11/20 at 10:00 am was unsuccessful. Attempted telephone interview with the mental health provider for Resident #2 at the local hospital on 02/10/20 at 3:30 pm was unsuccessful.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 106 Refer to interview with the previous Administrator on 02/11/20 at 9:30 am. 5. Review of Resident #3's current FL-2 dated 07/19/20 revealed diagnoses included unsteadiness on feet, muscle weakness, lack of coordination, history of falls, vascular dementia, abnormal gait, and hypertension. a. Review of Resident #3's current FL-2 dated 07/19/20 revealed there was a medication order for amlodipine 5 mg (used to treat high blood pressure) daily. Review of Resident #3's hospital discharge paperwork dated 11/26/19 revealed: -Resident #3 was hypertensive and her systolic blood pressure upon admission was in the 200's. -Resident #3's amlodipine was increased to 10 mg daily from 5 mg daily, upon discharge on 11/26/19. Review of Resident #3's hospital discharge paperwork dated 01/31/20 revealed: -Resident #3 had complaints of a headache that started at the base of her neck and extended over the top of her head. -Resident #3 was previously admitted to the hospital on 11/25/19 and her amlodipine was increased to 10 mg daily at discharge on 11/26/19. Review of Resident #3's subsequent physician orders revealed there was an order dated 01/31/20 amlodipine 5 mg take two tablets daily. Review of Resident #3's December 2019 medication administration record (MAR) revealed: -There was an entry for amlodipine 2.5 mg one	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 107	D 358		

tablet daily, scheduled at 8:00 am.
-There was documentation of administration 12/01/19 to 12/22/19 at 8:00 am and from 12/29/19 to 12/31/19 at 8:00 am.
-There was no documentation from 12/23/19 to 12/28/19 at 8:00 am.

Review of Resident #3's January 2020 MAR revealed:
-There was an entry for amlodipine 2.5 mg one tablet daily, scheduled at 8:00 am.
-There was documentation of administration 01/01/20 to 01/31/20 at 8:00 am.

Review of Resident #3's February 2020 MAR revealed:
-There was a handwritten entry for amlodipine 10 mg take one tablet daily, scheduled at 8:00 am.
-There was documentation of administration from 02/01/20 to 02/06/20 at 8:00 am.

Observation of Resident #3's medications on hand on 02/07/20 at 2:43 pm revealed:
-There was one bubble package with 30 amlodipine 2.5 mg tablets dispensed on 01/30/20.
-There were no amlodipine 10 mg tablets available for administration.

Review of Resident #3's hospital discharge paperwork dated 01/31/20 revealed:
-Resident #3 had complaints of a headache that started at the base of her neck and extended over the top of her head.
-Resident #3 was previously admitted to the hospital on 11/25/19 and her amlodipine was increased to 10 mg daily at discharge on 11/26/19.

Interview with a first shift medication aide (MA) on 02/07/20 at 2:45 pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 108 -She administered the dose of amlodipine available on the cart. -She did not know when Resident #3's dose of amlodipine changed, because she only worked part-time. Telephone interview with a Pharmacist at the facility contracted pharmacy on 02/07/20 at 10:20 am revealed: -Resident #3 had an order for amlodipine 5 mg daily dated 07/19/19. -There were 30 tablets of amlodipine 5 mg dispensed on 07/30/19, 8/30/19, 09/10/19, and 10/10/19. -Then a new order was written dated 10/29/19 for amlodipine 2.5 mg daily and a 16 day supply was sent on 10/30/19. -There were 30-day supplies of amlodipine 2.5 mg dispensed on 11/11/19, 12/04/19, 01/06/20, and 01/30/20. -The pharmacy did not have an amlodipine 10 mg order in the computer system for Resident #3. Telephone interview with Resident #3's physician on 02/07/20 at 9:15 am revealed: -She saw Resident #3 on 02/04/20. -Resident #3 was admitted to the hospital on 01/31/20 due to her blood pressure. -Resident #3's amlodipine was increased from 5 mg to 10 mg in November 2019 after her hospitalization. -She requested to see Resident #3's February MARs on 02/04/20 and amlodipine 2.5 mg was on the MAR. -She discovered Resident #3 after two hospitalizations was still not receiving amlodipine 10 mg daily. -She sent Resident #3's prescription for amlodipine 10 mg daily to the pharmacy again on 02/04/20.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 109	D 358		

-Resident #3 had amlodipine 10 mg prescribed to treat hypertension.

Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 4:04 pm revealed:
-She did not know about Resident #3's inaccurate amlodipine dose.
-She had worked at the facility a year ago and she was just hired again on 02/05/20.
-She did not know Resident #3 was admitted in January 2020 due to high blood pressure.

Interview with the Resident Care Director (RCD) on 02/10/20 at 4:41 pm revealed:
-She began working at the facility on 02/05/20 and she was still learning each resident.
-She was not familiar with Resident #3's medication.
-She would have expected the MAs to transcribe the amlodipine order from the hospital discharge paperwork.

Interview with the Administrator on 02/10/20 at 5:20 pm revealed:
-He was hired on 02/05/20 and was not familiar with Resident #3.
-He did not know she was receiving the wrong dose of amlodipine.

b. Review of Resident #3's current FL-2 dated 07/19/20 revealed there was a medication order for carvedilol 12.5 mg (used to treat high blood pressure) twice daily.

Review of Resident #3's December 2019 medication administration record (MAR) revealed:
-There was an entry for carvedilol 12.5 mg twice daily, scheduled at 8:00 am and 8:00 pm.
-There was documentation of administration of carvedilol 12.5 mg from 12/01/19 to 12/22/19 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 110 8:00 am, from 12/30/19 to 12/31/19 at 8:00 am, from 12/01/19 to 12/13/19 at 8:00 pm, 12/18/19 at 8:00 pm, 12/21/19 at 8:00 pm, and from 12/28/19 to 12/31/19 at 8:00 pm. Review of Resident #3's January 2020 MAR revealed: -There was an entry for carvedilol 12.5 mg twice daily, scheduled at 8:00 am and 8:00 pm. -There was documentation of administration of carvedilol 12.5 mg from 01/01/20 to 01/31/20 at 8:00 am and 8:00 pm. Review of Resident #3's February 2020 MAR revealed there was no entry for carvedilol 12.5 mg twice daily. Observation of Resident #3's medications on hand on 02/07/20 at 2:43 pm revealed there was one bubble package with 30 tablets of carvedilol 12.5 mg, dispensed on 01/30/20. Interview with a first shift medication aide (MA) on 02/07/20 at 2:45 pm revealed: -She did not know why Resident #3's carvedilol 12.5 mg was not entered on the February MAR. -She thought she gave Resident #3 carvedilol that morning, 02/07/20, but she was not sure. -She was a part-time MA and was not at the facility daily. -She was not able to provide documentation of administration of carvedilol 12.5 mg. Attempted telephone interviews with a second shift MA on 02/10/20 at 9:53 am and 02/11/20 at 8:29 am were unsuccessful. Telephone interview with a Pharmacist at the facility contracted pharmacy on 02/07/20 at 10:20 am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 111 -Resident #3 had an order for carvedilol 12.5 mg twice daily ordered on 07/19/19 and a 30-day supply was sent on 07/23/19. -There was another prescription sent for Resident #3's carvedilol 12.5 mg twice daily on 08/30/19 and a 21-day supply was sent the same date. -A 30-day supply of carvedilol 12.5 mg was dispensed on 09/10/19, 10/10/19, 11/11/19, 12/04/19, and 01/30/20. Telephone interview with Resident #3's physician on 02/07/20 at 9:15 am revealed: -Resident #3 has been on carvedilol 12.5 mg since admission. -She thought she saw carvedilol 12.5 mg on Resident #3's February 2020 MAR on 02/04/20. -Resident #3 has carvedilol prescribed to treat hypertension and if Resident #3 did not receive carvedilol daily her blood pressure would increase. Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 4:04 pm revealed she did not know Resident #3's carvedilol 12.5 mg was not on the February 2020 MAR. Interview with the Resident Care Director (RCD) on 02/10/20 at 4:41 pm revealed she did not know Resident #3's carvedilol 12.5 mg was not documented on the February 2020 MAR and she was not able to provide documentation of administration. Interview with the Administrator on 02/10/20 at 5:20 pm revealed: -He did not know there was no documentation of administration for Resident #3's carvedilol. -The MAs were responsible for documenting the medications administered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 112 c. Review of Resident #3's subsequent physician orders revealed: -There was a medication order dated 10/11/19 for Seroquel 25 mg (used to treat psychosis) twice daily for psychosis. -There was a medication order dated 10/17/19 for Seroquel 50 mg twice daily. -There was a medication order dated 12/03/19 for Seroquel 75 mg twice daily. -There was a medication order dated 12/12/19 for Seroquel 75 mg every morning and Seroquel 100 mg nightly. -There was a medication order dated 01/23/20 for Seroquel 100 mg twice daily. Review of Resident #3's December 2019 medication administration record (MAR) revealed: -There was a handwritten entry for Seroquel 50 mg twice daily, scheduled for 8:00 am with a line drawn through it. -There was a second handwritten entry for Seroquel 75 mg twice daily, scheduled for 8:00 am and 8:00 pm and discontinued was documented where staff initials would be documented. -There was documentation of administration of Seroquel 75 mg from 12/09/19 to 12/14/19 at 8:00 am and 12/13/19 at 8:00 pm. -There was a printed third entry for Seroquel 100 mg at bedtime, scheduled at 8:00 pm. -There was documentation of administration of Seroquel 100 mg from 12/01/19 to 12/14/19 at 8:00 pm. -There was a printed fourth entry for Seroquel 50 mg every morning, scheduled at 8:00 am. -There was documentation of administration of Seroquel 50 mg from 12/01/19 to 12/14/19 at 8:00 am. -There was a handwritten fifth entry for Seroquel 75 mg daily, scheduled at 8:00 am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 113 -There was documentation of administration of Seroquel 75 mg from 12/16/19 to 12/22/19 at 8:00 am and from 12/30/19 to 12/31/19 at 8:00 am. -There was a handwritten sixth entry for Seroquel 100 mg at bedtime, scheduled at 8:00 pm. -There was documentation of administration of Seroquel 100 mg from 12/14/19 to 12/17/19 at 8:00 pm, 12/20/19 at 8:00 pm, and from 12/22/19 to 12/31/19 at 8:00 pm. Review of Resident #3's January 2020 MAR revealed: -There was a printed entry for Seroquel 100 mg at bedtime, scheduled at 8:00 pm. -There was documentation of administration of Seroquel 100 mg from 01/01/20 to 01/31/20 at 8:00 pm. -There was a second printed entry for Seroquel 50 mg take one and one-half tablets (75 mg) every morning, scheduled at 8:00 am. -There was documentation of administration of Seroquel 50 mg (1.5 tablets) from 01/01//20 to 01/21/20 at 8:00 am. -There was documentation where the staff initials would be that the second entry was rewritten and discontinued on 01/21/19. -There was a third handwritten entry for Seroquel 100 mg twice daily, scheduled at 8:00 am and 8:00 pm. -There was documentation of administration of Seroquel 100 mg from 01/27/20 to 01/31/20 at 8:00 am and 8:00 pm. Review of Resident #3's February 2020 MAR revealed: -There was a printed entry for Seroquel 100 mg twice daily, scheduled at 8:00 am and 8:00 pm. -Thee was documentation of administration of Seroquel 100 mg from 02/01/20 to 02/05/20 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 114 8:00 am and 8:00 pm, and 02/06/20 at 8:00 am. Observation of Resident #3's medications on hand on 02/07/20 at 2:43 pm revealed there was one bubble package with 30 one-half tablets of Seroquel 50 mg. Interview with a first shift medication aide (MA) on 02/07/20 at 2:45 pm revealed: -She did not recall what she administered to Resident #3 related to her Seroquel dose on 02/07/20. -She did not locate any Seroquel 100 mg tablets in the medication storage room. Telephone interview with a Pharmacist at the facility contracted pharmacy on 02/07/20 at 10:20 am revealed: -Resident #3 had an order for Seroquel 100 mg twice daily dated 01/23/20. -There were 60 tablets of Seroquel 100 mg dispensed on 01/23/20 and 60 more tablets were set to be dispensed on 02/12/20. Telephone interview with Resident #3's mental health physician on 02/07/20 at 12:17 pm revealed: -She had continued to increase Resident #3's Seroquel dose to treat her mood and hallucinations. -Resident #3 was prescribed Seroquel 100 mg twice daily on 01/23/20. -She came to the facility on Thursdays to see residents and last saw Resident #3 on 01/23/20. Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 4:04 pm revealed: -She did not know Resident #3's Seroquel 100 mg tablets were not on the medication cart. -She expected the MAs to transcribe orders from	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 115	D 358		

the mental health physician and administer medications as ordered.
-She expected the MAs to notify the pharmacy if the correct dose was not available to administer.

Interview with the Resident Care Director (RCD) on 02/10/20 at 4:41 pm revealed:
-She had not reviewed any medications for Resident #3 and she did not know there were no Seroquel 100 mg available to administer to Resident #3.
-She expected the MAs to follow the six rights of drug administration and administer the correct dose of medication.

Interview with the Administrator on 02/10/20 at 5:20 pm revealed:
-He was not aware that Resident #3 did not have the correct dose of Seroquel on the medication cart.
-He expected the MAs to be responsible for contacting the pharmacy or the physician concerning a medication.

d. Review of Resident #3's subsequent physician orders revealed:
-There was a medication order dated 11/07/19 for Eliquis 5 mg (used to treat prevent blood clots) two tablets twice daily for seven days followed by 5 mg twice daily.
-There was a second medication order dated 01/26/20 for Eliquis 5 mg twice daily.

Review of Resident #3's December 2019 medication administration record (MAR) revealed:
-There was a handwritten entry for Eliquis 5 mg take one tablet twice daily, scheduled for 8:00 am and 8:00 pm.
-There was documentation of administration of Eliquis 5 mg from 12/01/19 to 12/22/19 at 8:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 116	D 358		

am, from 12/30/19 to 12/31/19 at 8:00 am, from 12/01/19 to 12/11/19 at 8:00 pm, from 12/17/19 to 12/18/19 at 8:00 pm, from 12/20/19 to 12/22/19 at 8:00 pm, and from 12/28/19 to 12/30/19 at 8:00 pm.

Review of Resident #3's January 2020 MAR revealed:
-There was a handwritten entry for Eliquis 5 mg take one tablet twice daily, scheduled at 8:00 am and 8:00 pm.
-There was documentation of administration of Eliquis 5 mg from 01/01/20 to 01/31/20 at 8:00 am and 8:00 pm.

Review of Resident #3's February 2020 MAR revealed:
-There was a handwritten entry for Eliquis 5 mg take one tablet twice daily, scheduled at 8:00 am and 8:00 pm.
-There was documentation of discontinued where the staff initials would be located.

Observation of Resident #3's medications on hand on 02/07/20 at 2:43 pm revealed there was no Eliquis available for administration.

Interview with a first shift medication aide (MA) on 02/07/20 at 2:46 pm revealed:
-Resident #3 had discontinue written on her February MAR so she thought it was discontinued.
-There must be a discontinue order somewhere for Resident #3's Eliquis if it was on the MAR.
-She had not seen a discontinue order for Resident #3's Eliquis.
-She looked in the storage room where pharmacy delivered medications were placed but she did not find Eliquis for Resident #3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 117 Telephone interview with a Pharmacist at the facility contracted pharmacy on 02/07/20 at 10:20 am revealed: -There was an order for Resident #3's Eliquis 5 mg two tablets daily for 7 days followed by one tablet (5 mg) twice daily for completion of therapy duration dated 11/07/19 and the pharmacy only dispensed the 7 days portion of Eliquis on 11/08/19. -There was no Eliquis dispensed to fulfill the second half of the script and there was no documentation in the computer system indicating the reason. -The amount of Eliquis indicated on the prescription dated 11/07/19 was 74 tablets. -There was another order received for Resident #3's Eliquis 5 mg twice daily dated 01/26/20. -There was a 30-day supply of Eliquis 5 mg dispensed on 01/27/20 for Resident #3. Telephone interview with Resident #3's physician on 02/07/20 at 9:15 am revealed: -Resident #3 was placed on Eliquis after being hospitalized in November 2019 for a deep vein thrombosis (DVT). -She continued the Eliquis for Resident #3 because of the history of DVT and decided she would remain on it for 3 to 6 months. -She thought Eliquis was on the February 2020 MAR when she saw it on 02/04/20. -If Resident #3 did not receive Eliquis as ordered, she was at risk for developing a pulmonary embolus (a blood clot in an artery in the lungs). Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 4:04 pm revealed: -She did not know Resident #3 did not have Eliquis to administer and she did not know why the MAR indicated the medication was discontinued.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 118 -She expected the MAs not to document discontinue for any medication without an order to discontinue the medication. Interview with the Resident Care Director (RCD) on 02/10/20 at 4:41 pm revealed: -She did not know Resident #3 did not have Eliquis to administer. -She expected the MAs to transcribe orders when received from the physician and if the medication was not delivered by the pharmacy to make the RCC or herself aware. Interview with the Administrator on 02/10/20 at 5:20 pm revealed: -He was not aware of Resident #3's Eliquis. -The MAs were responsible for notifying the pharmacy when a medication was not available to administer. Refer to interview with the previous Administrator on 02/11/20 at 9:30 am. 6. Review of Resident #4's current FL-2 dated 10/09/19 revealed diagnoses included psychosis, hypertension, hyperlipidemia, and syncope. a. Review of Resident #4's current FL-2 dated 10/19/19 revealed there was a medication order for olanzapine 10 take one-half tablet twice daily. Review of Resident #4's subsequent physician orders revealed: -There was an order dated 12/03/19 for olanzapine 10 mg daily. -There was another order dated 01/30/20 for olanzapine 10 mg daily. Review of Resident #4's January 2020 medication administration record (MAR) revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 119	D 358		

-There was a handwritten entry for olanzapine 10 mg take one-half tablet (5 mg) twice daily, scheduled at 9:00 am and 9:00 pm.
-There was documentation of administration from 01/24/20 to 01/31/20 at 9:00 am and from 01/23/20 to 01/31/20 at 9:00 pm.

Review of Resident #4's February 2020 MAR revealed:
-There was an entry for olanzapine 10 mg take one-half (5 mg) twice daily, scheduled at 9:00 am and 9:00 pm.
-There was documentation of administration from 02/01/20 to 02/06/20 at 9:00 am.
-There was documentation of administration on 02/01/20 at 9:00 pm.
-There were circled staff initials from 02/02/20 to 02/06/20 at 9:00 pm, indicating olanzapine was not administered.

Observation of Resident #4's medications on hand on 02/07/20 at 12:05 pm revealed there was no olanzapine available for administration.

Interview with a first shift medication aide on 02/07/20 at 2:45 pm revealed:
-She knew Resident #4 did not have any olanzapine in stock.
-She planned to reorder olanzapine for Resident #4 at the end of her shift.
-She did not know how long Resident #4 had been out of olanzapine because she worked at the facility part-time.

Telephone interview with Resident #4's mental health physician on 02/07/20 at 12:17 pm revealed:
-She prescribed olanzapine for Resident #4 to treat her psychosis.
-She last saw Resident #4 on 01/30/20 and she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 120	D 358		

was actively hallucinating.
-She needed the olanzapine and her hallucinations would increase without the medication.

Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 4:04 pm revealed:
-She did not know Resident #4 did not have any olanzapine available to administer.
-She did not know the facility's contracted pharmacy did not have Resident #4 on profile in their computer system.
-She expected the MAs to notify her or the RCD if there was an issue with obtaining a resident's medications.

Interview with the Resident Care Director (RCD) on 02/10/20 at 4:41 pm revealed:
-She did not know about Resident #4's medications not being available.
-She expected the MAs to notify the pharmacy when a mediation was not available to administer.

Interview with the Administrator on 02/10/20 at 5:20 pm revealed:
-He did not know about Resident #4's medications not being available.
-He expected the MAs, RCC, and RCD to ensure residents had their medications available to administer.

Attempted telephone interviews with a second shift MA on 02/10/20 at 9:53 am and 02/11/20 at 8:29 am were unsuccessful.

Attempted interview with Resident #4's pharmacy on 02/07/20 at 12:09 pm was unsuccessful.

b. Review of Resident #4's current FL-2 dated 10/09/19 revealed there was an order for Haldol 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 121 mg/ml take 2.5 ml twice daily. Review of Resident #4's subsequent physician orders revealed: -There was an order dated 12/31/19 for Haldol 2.5 mg twice daily. -There was an order dated 01/30/20 to discontinue Haldol. Review of Resident #4's February 2020 medication administration (MAR) revealed: -There was an entry for Haldol 2 mg/ml take 2.5 ml twice daily, scheduled for 9:00 am and 9:00 pm. -There was documentation of administration of Haldol 2.5 ml from 02/01/20 to 02/06/20 at 9:00 am and 9:00 pm. Observation of Resident #4's medications on hand on 02/07/20 at 12:05 pm revealed there was one bubble package with 18 tablets of Haldol dispensed on 01/08/20. Interview with a first shift medication aide on 02/07/20 at 12:06 pm revealed: -She administered medications to Resident #4, and she was not aware of a discontinue order for Resident #4's Haldol. -She administered medications to Resident #4 as it appeared on her MAR. Attempted telephone interview with Resident #4's pharmacy on 02/07/20 at 12:09 pm was unsuccessful. Telephone interview with Resident #4's mental health physician on 02/07/20 at 12:17 pm revealed: -She discontinued Resident #4's Haldol on 01/30/20 because she was prescribed another	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 122	D 358		

anti-psychotic medication olanzapine.
-Resident #4 did not need two anti-psychotic medications.
-The continued usage of Haldol could cause side effects.

Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 4:04 pm revealed:
-She expected the MAs to implement medication orders when the physicians provided the orders.
-She expected the MAs to transcribe and follow the orders.
-She did not know Resident #4's Haldol was discontinued.

Interview with the Resident Care Director (RCD) on 02/10/20 at 4:41 pm revealed:
-MAs were responsible for transcribing orders and then providing a copy to the RCC so that she could check the order transcribed to the MAR.
-She did not know about Resident #4's order to discontinue Haldol.

Interview with the Administrator on 02/10/20 at 5:20 pm revealed:
-He expected the MAs, RCC, and RCD to be responsible for physician orders.
-He was not aware of Resident #4's discontinue order for Haldol.

Refer to interview with the former Administrator on 02/11/20 at 9:30 am.

_____

Telephone interview with the former Administrator on 02/11/20 at 9:30am revealed:
-Her last day of work was 01/31/20.
-The medication aides and RCD faxed orders to the pharmacy.
-They were expected to wait 3-7 days before the pharmacy delivered medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 123 -She had a lot of issues with the pharmacy that never got resolved because the owner changed the pharmacy to another pharmacy that was owned by a family member. -She continuously battled with the MAs to get orders placed on the residents' records, MARS, and processed completely. -She did not follow up the MAs and RCD about missing medications by auditing the medication carts, MARs, and physician's orders. -The facility was understaffed, and she had work as PCA, MA, and Administrator. _____ The facility failed to administer medications as ordered which resulted in Resident #1 not receiving an anti-psychotic medication as ordered resulting in increased anxiety; Resident #2 not receiving an antipsychotic medications resulting in increased behaviors and hospital admission to an acute psychiatric unit; Resident #3 not receiving an anti-psychotic, a blood thinner, and two anti-hypertension medications as ordered resulting in an increased risk of hallucinating, developing a pulmonary embolus and hypertension; Resident #4 not receiving a anti-psychotic medications resulting an increased risk of anxiety and hallucinations; Resident #5 not receiving a diuretic resulting in increased edema and hospital visit for fluid overload; Resident #13 not receiving medications for panic attacks, an asthma medication, and eye drops for dry eyes resulting in an increased risk of panic attacks, difficulty breathing, and dry eyes; Resident #10 not receiving 2 medications for COPD resulting in an increased risk of difficulty breathing; and Resident #14 not receiving a blood thinner resulting in an increased risk of developing blood clots. This failure placed residents at substantial risk for serious harm and serious neglect which constitutes a Type A2 Violation.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 124 The facility provided a plan of protection in accordance with G.S. 131 D-34 on 02/07/20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 12, 2020.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure staff documented on the Medication Administration Record (MAR) the administration of medications immediately following the administration and not prior to the next residents administration of medication for 4 of 4 sampled residents (Residents #15, #14, #13 and #1) during the observation of the morning medication pass on 02/07/20. The findings are:	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 125 a. Review of Resident #15's current FL2 dated 12/04/19 revealed diagnoses included schizophrenia, insulin dependent diabetes mellitus, anxiety and insomnia. Review of Resident #15's current FL2 dated 12/04/19 included physician's orders for: -Lamotrigine 100 mg daily (used to treat mood disorders). -Losartan 50 mg daily (used to treat high blood pressure). -Oxybutynin 10 mg daily (used to treat overactive bladder). -Oyster Shell calcium 500 mg daily (used to treat calcium deficiency). -Perphenazine 4 mg twice daily (used to treat schizophrenia). -Celexa 40 mg daily (used to treat depression). -Deep Sea nasal spray 1 spray, both nostrils, three times daily (used to treat dry or irritated nasal passages). Review of Resident #15's physician's orders revealed: -An order dated 06/18/19 for vitamin B12 1000 mg daily (used to treat vitamin B12 deficiency) . -An order dated 10/11/19 for docusate sodium 100 mg twice daily (used to treat constipation). Observation on 02/07/19 at 9:00am of the morning medication pass revealed the Medication Aide (MA) initialed each of the following medications as administered prior to the actual administration of the medications: -Lamotrigine 100 mg daily. -Losartan 50 mg daily. -Oxybutynin 10 mg daily. -Oyster Shell calcium 500 mg daily. -Perphenazine 4 mg twice daily.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 126	D 366		

-Celexa 40 mg daily.
-Deep Sea nasal spray 1 spray, both nostrils, three times daily.
-Vitamin B12 1000 mg daily.
-Docusate sodium 100 mg twice daily.

Refer to the interview on 02/07/20 at 10:20am with the MA.

Refer to the interview on 02/07/20 at 12:10pm with the Resident Care Coordinator (RCC).

Refer to the interview on 02/07/20 at 12:30pm with the Resident Care Director (RCD).

Refer to the interview on 02/11/20 at 11:15am with the Administrator.

b. Review of Resident #14's current FL2 dated 12/15/19 revealed diagnoses included history of cerebral vasculr accident, Rhabdomyolysis, diabetes, leukocytosis and facial weakness.

Review of Resident #14's current FL2 dated 12/15/19 included physician's orders for:
-Amlodipine 10 mg daily (used to treat high blood pressure).
-Baclofen 10 mg twice daily (used to treat muscle spasticity).
-Pantoprazole 40 mg twice daily (used to treat excess stomach acid).
-Escitalopram 5 mg daily (used to treat anxiety).

Observation on 02/07/19 at 9:35am of the morning medication pass revealed the MA initialed each of the following medications as administered prior to the actual administration of the medications:
-Amlodipine 10 mg daily.
-Baclofen 10 mg twice daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 127	D 366		

-Pantoprazole 40 mg twice daily.
-Escitalopram 5 mg daily.

Refer to the interview on 02/07/20 at 10:20am with the MA.

Refer to the interview on 02/07/20 at 12:10pm with the RCC.

Refer to the interview on 02/07/20 at 12:30pm with the RCD.

Refer to the interview on 02/11/20 at 11:15am with the Administrator.

c. Review of Resident #13's current FL2 dated 02/26/19 revealed diagnoses included bipolar depression, anxiety, hypertension, chronic obstructive pulmonary disease, gastroesophageal reflux disease, pain and kidney failure.

Review of Resident #13's current FL2 dated 02/26/19 included physician's orders for:
-Gavi-lax 17 gm mixed in 6 ounces of liquid daily (used to treat constipation).
-Tramadol 50 mg four times daily (used to treat pain).
-Vitamin D 2000 units daily (used to treat vitamin D deficiency).
-Duloxetine 60 mg twice daily (used to treat depression).
-Latuda 120 mg daily (used to treat bipolar disorder).
-Senna Plus 8.6/50 mg twice daily (used to treat constipation).
-Tizanidine 4 mg twice daily (used to treat muscle spasticity).
-Promethazine 25 mg every 6 hours as needed (used to treat nausea).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 128	D 366		

Review of Resident #13's physician's orders revealed no documentation of a signed physician's order for the hydroxychloroquine 200 mg (used to treat arthritis) and nodocumentation of a signed physician's order for the vitamin B12 500 mg daily (used to treat vitamin B12 deficiency).

Observation on 02/07/19 at 9:55am of the morning medication pass revealed the MA initialed each of the following medications as administered prior to the actual administration of the medications:
-Gavi-lax 17 gm mixed in 6 ounces of liquid daily.
-Tramadol 50 mg four times daily.
-Vitamin D 2000 units daily.
-Duloxetine 60 mg twice daily.
-Latuda 120 mg daily.
-Senna Plus 8.6/50 mg twice daily.
-Tizanidine 4 mg twice daily.
-Promethazine 25 mg every 6 hours as needed.
-Hydroxychloroquine 200 mg daily.
-Vitamin B12 500 mg daily.

Interview on 02/10/20 ar 11:00am with the RCC revealed she was unable to locate the signed physician orders for Resident #13's hydroxychloroquine 200 mg or the vitamin B12 500 mg daily.

Refer to the interview on 02/07/20 at 10:20am with the MA.

Refer to the interview on 02/07/20 at 12:10pm with the RCC.

Refer to the interview on 02/07/20 at 12:30pm with the RCD.

Refer to the interview on 02/11/20 at 11:15am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 129	D 366		

with the Administrator.

d. Review of Resident #1's current FL-2 dated 01/03/20 revealed diagnoses included schizoaffective disorder, hypertension, major depressive disorder, anxiety disorder, an unspecific lesion of mucosa.

Review of Resident #1's current FL2 dated 01/01/20 included physician's orders for:
-Gavi-lax 17 gms in 6 ounces of of water daily (used to treat constipation).
-Clonazepam 0.5 mg three times daily (used to treat panic disorders).
-Amitiza 8 mcg twice daily (used to treat constipation).
-Amlodipine 5 mg daily (used to treat high blood pressure).
-Atenolol 50 mg twice daily (used to treat high blood pressure).
-Celecoxib 200 mg daily (used to treat inflammation).
-Centrum chewable daily (used to treat vitamin deficiency).
-Vitamin D 5000 U daily (used to treat vitamin D deficiency).
-Vitamin E 200 U twice daily (used to treat vitamin E deficiency).
-Losartan 50 mg daily (used to treat high blood pressure).
-Lithium carb 300 mg twice daily (used to treat bipolar disorder).
-Singulair 10 mg daily (used to treat asthma).
-Senna Plus 8.6 - 50 mg twice daily (used to treat constipation).

Observation on 02/07/19 at 10:10am of the morning medication pass revealed the MA initialed each of the following medications as administered prior to the actual administration of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 130	D 366		

the medications:
-Gavi-lax 17 gms in 6 ounces of of water daily.
-Clonazepam 0.5 mg three times daily.
-Amitiza 8mcg twice daily.
-Amlodipine 5 mg daily.
-Atenolol 50 mg twice daily.
-Celecoxib 200 mg daily.
-Centrum chewable daily.
-Vitamin D 5000 U daily.
-Vitamin E 200 U twice daily.
-Losartan 50 mg daily.
-Lithium carb 300 mg twice daily.
-Singulair 10 mg daily.
-Senna Plus 8.6 - 50 mg twice daily.

Refer to the interview on 02/07/20 at 10:20am with the MA.

Refer to the interview on 02/07/20 at 12:10pm with the RCC.

Refer to the interview on 02/07/20 at 12:30pm with the RCD.

Refer to the interview on 02/11/20 at 11:15am with the Administrator.

_____

Interview on 02/07/20 at 10:20am with the MA revealed:
-She usually administered medications on another floor in the facility.
-She always signed the MARs when she punched the medication into the medication cup, and not after the medication was administered.
-She was trained to never leave a blank spot on a MAR when administering medication.

Interview on 02/07/20 at 12:10pm with the RCC revealed:
-She had only been the RCC for 2 days and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D 366	Continued From page 131 new to the facility. -She had not had the opportunity to observe an entire medication administration pass. -MAs should initial the MAR after the medication had been administered, not before. Interview on 02/07/20 at 12:30pm with the RCD revealed: -She had been the RCD for 2 days. -She had noticed MAs working on the medication carts, but she had not had the opportunity to observe a medication administration pass. -The MAs should not initial the MARs before the medication was administered. Interview on 02/11/20 at 11:15am with the Administrator revealed: -The RCD was responsible for proper and correct administration of medication as it was ordered by the physician for the facility. -This included accurate documentation for medication administration.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 132 (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure accuracy of the Medication Administration Records for 4 of 5 sampled residents (Resident #13, #10, #14, and #4) related to documenting the administration of an arthritis medication (Resident #13), documenting the administration of a stool softener and oxygen (Resident 10) ,a blood thinner (Resident 14), and a vitamin (Resident #4) as ordered by the physician. The findings are: 1. Review of Resident #13's current FL2 dated 02/26/19 revealed diagnoses included bipolar depression, anxiety, hypertension, chronic obstructive pulmonary disease, GERD, pain and kidney failure. Review of Resident #13's physician's orders revealed an order dated 12/19/19 for Humira	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 133 40mg injection every 14 days (used to treat arthritis). Review of Resident #13's December 2019 Medication Administration Record (MAR) revealed there was not an entry for Humira 40mg every 14 days. Review of Resident #13's February MAR revealed: -An entry for Humira Pen injection 40mg/.4ml inject 1 pen under the skin every 14 days. -The dates of 02/01/20, 0202/20, and 02/03/20 were initialed and circled indicating the medication was not administered. . -The dates of 02/04/20, 02/05/20 and 02/06/20 were initialed as administered. Interview on 02/07/20 at 10:20am with the MA revealed: -She did not administer the Humira injection. -She was unable to locate the Humira injection for Resident #13. -She had been taught to never leave a medication administration entry blank, so she initialed the entry. -She did not document the Humira injection as an exception on the MAR. Interview on 02/07/20 at 12:10pm with the Resident Care Coordinator (RCC) revealed: -She had only been the RCC for 2 days and was new to the facility. -She did not know Resident #13 had a Humira injection ordered. -She had not had the opportunity to review all the resident MARs, and had not reviewed the MARs for Resident #13. -The entry on the MARs should only be initialed after a medication was administered.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

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THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D 367	Continued From page 134	D 367		

-The entry on the MARs should be initialed and circled if the medication was not administered, then the reason the medication was not given should be logged on the back of the MAR.

Interview on 02/07/20 at 12:30pm with the Resident Care Director (RCD) revealed:
-She had been the RCD for 2 days.
-She did not know Resident #13 had a Humira injection ordered.
-She did not know medication staff had initialed the MAR as if the Humira had been administered.
-The medication staff should initial the medication entry on the MAR after a medication was administered.
-If a medication was not administered as ordered, the entry on the MAR should be initialed and circled, then the reason the medication was not given should be logged on the back of the MAR.

Interview with a pharmacy representative on 02/10/20 at 10:25am revealed;
-The Humira Pen injection 40mg/.4ml inject 1 pen under the skin every 14 days was dispensed on 12/20/19.
-The Humira Pen injection 40mg/.4ml pen had not been refilled.
-The facility would have to request any refills for the Humira Pen injection 40mg/.4ml.

Interview with Resident #13 on 02/07/20 at 9:55am revealed:
-Resident #13 had not received any doses of the Humira injection.

2. Review of Resident #10's current FL2 dated 08/22/19 revealed diagnoses included encephalopathy, chronic pain syndrome, anxiety disorder, chronic obstructive pulmonary disease (COPD), muscle weakness and major depressive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 135 disorder. a. Review of Resident #10's record revealed a signed physician's orders dated 08/29/19 for lactulose 10gm/15 give 30 cc daily (used to treat constipation). Review of Resident #10's December 2019 Medication Administration record (MAR) revealed: -An entry for lactulose 10gm/15 give 30 cc once daily for constipation. -The entry was documented as administered daily at 7:00am, except for 12/21/19 through 12/24/19 when Resident #10 was hospitalized. Review of Resident #10's January 2020 MAR revealed: -An entry for lactulose 10gm/15 give 30 cc once daily for constipation. -The entry was documented as administered daily at 7:00am, except for 01/01/20 and 01/29/20 which were initialed and circled. -The entry on the back of the MAR for 01/01/20 was documented "Resident didn't want". -The entry on the back of the MAR for 01/29/20 was documented "Held due to loose stool". Review of Resident #10's February 2020 MAR revealed: -An entry for lactulose 10gm/15 give 30 cc once daily for constipation. -The entry was documented as administered daily at 7:00am from 02/01/20 through 02/07/20. Interview with a Medication Aide (MA) on 02/10/20 at 10:15 am revealed: -She worked both first and second shifts as a MA. -Resident #10 often refused the lactulose. -She had worked on Resident #10's medication cart yesterday and Resident #10 refused the 7:00	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 136	D 367		

am dose of lactulose 30cc once daily for constipation.

Interview on 02/11/20 at 1:15 pm with a pharmacy representative revealed:
-The pharmacy had an order dated 08/29/19 for lactulose 10gm/15 give 30 cc once daily for constipation, which had never been dispensed.
-The lactulose had never been dispensed because the facility had never requested the medication.

Interview with the prescribing provider on 02/10/20 at 10:15 am revealed:
-Resident #10 had an order dated 08/29/19 for lactulose 10gm/15 give 30 cc daily.
-Resident #10 could refuse the medication if she did not need to take it.

Interview with Resident #10 on 02/10/20 at 1:50 pm revealed:
-She usually refused the lactulose 30cc.
-She did not need to take the lactulose.

b. Review of Resident #10's January 2020 MAR revealed:
-An entry for lactulose 45cc take 45cc (used to treat constipation) X 1 day at 8:00pm.
-The entry was dated 01/07/20.
-The entry was documented as administered from 01/10/20 through 01/19/20, from 01/21/20 through 01/26/20 and from 01/28/20 through 01/31/20.
-The entry for 01/09/20 was initialed and circled.
-The entry on the back of the MAR was documented "Waiting on annual".
-The entries for 01/20/20 and 01/27/20 were blank.

Review of Resident #10's February 2020 MAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D 367	Continued From page 137	D 367		

revealed:
-An entry for lactulose take 45cc X 1 day at 8:00pm.
-The entry was documented as administered from 02/01/20 through 02/06/20.

Review of Resident #10's record revealed no order for lactulose 45cc take 45cc X 1 day at 8:00pm.

Interview on 02/11/20 at 1:15pm with a pharmacy representative revealed:
-The pharmacy had an order dated 01/07/20 for lactulose 45cc by mouth every day X 1 day, giving dose today-constipation.
-Lactulose 45cc was dispensed on 01/08/20 and none had been dispensed since.
-The order was a one time dose of lactulose 45cc every day X 1 day and would not need a refill.

Interview with the prescribing provider on 02/10/20 at 10:15am revealed:
-The order dated 01/07/20 for lactulose 45cc every day X 1 day, giving dose today-constipation was a one time only order.
-She expected the staff to document accurately on the MARs.

Interview with the Resident Care Coordinator (RCC) on 02/11/20 at 11:20 am revealed:
-She could not locate the order for dated 01/07/20 for lactulose 45cc every day X 1 day, giving dose today.

Interview with Resident #10 on 02/10/20 at 1:50pm revealed she usually refused the lactulose 45cc.

c. Review of Resident #10's current FL2 dated 08/22/19 revealed an order for oxygen at 3 liters

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

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THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 138 per minute (lpm) continuously. Review of Resident #10's December 2019 Medication Administration Record (MAR) revealed: -An entry for oxygen at 3 lpm continuously. -The entry had no documented administrations from 12/01/19 through 12/31/19. -There was no documentation the oxygen had been monitored or administered by facility staff. Review of Resident 10's January 2020 MAR revealed: -An entry for oxygen at 3 lpm continuously. -Documentation of administration by staff for 83 of 93 opportunities from 01/01/20 through 01/31/20. -There were 10 of 93 opportunities for administration left blank from 01/01/20 through 01/31/20. Review of Resident #10's February MAR revealed: -An entry for oxygen 3/lpm continuously. -Documentation of administration by staff for 16 of 19 opportunities from 02/01/20 through 02/07/20. -There were 3 of 19 opportunities for administration left blank from 02/01/20 through 02/07/20. Observation on 02/07/20 at 9:15am revealed Resident #10 had oxygen at 3/lpm via nasal cannula being administered. Interview with the Medication Aide (MA) on 02/07/20 at 9:20 am revealed the MA should initial the entry for the oxygen administration for Resident #10.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 139 Interview with the prescribing provider on 02/10/20 at 10:15 am revealed: -Resident #10 has an order for oxygen at 3/lpm continuously. -Facility staff were expected to monitor the oxygen use and administer as needed. 3. Review of Resident #4's current FL-2 dated 10/09/19 revealed: -Diagnoses included psychosis, hypertension, hyperlipidemia, and syncope. -There was a medication order for vitamin D2 1.25 mg take one tablet once a week on Monday. Review of Resident #4's January 2020 medication administration record (MAR) revealed: -There was an entry for vitamin D2 50,000 units take one capsule weekly on Monday, scheduled at 9:00 am. -There was documentation of administration of vitamin D2 on 01/27/20 at 9:00 am. Review of Resident #4's February 2020 MAR revealed: -There was an entry for vitamin D2 50,000 units take one capsule weekly on Monday, scheduled for 9:00 am. -There was documentation of administration of vitamin D2 from 02/01/20 to 02/07/20 at 9:00 am. Observation of Resident #4's medications on hand on 02/07/20 at 12:05 pm revealed there was no vitamin D2 available for administration. Attempted telephone interview with Resident #4's pharmacy on 02/07/20 at 12:09 pm was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 4:04 pm revealed:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 140 -She had not reviewed residents' MARs yet, so she did not know the MAs were signing for Resident #4's vitamin D2 daily. -She expected the MAs to not sign for a medication that was not available to administer. -She expected the MAs to read the MAR and not just sign it. -She held the MAs and herself responsible for ensuring the MARs were accurate. Interview with the Resident Care Director (RCD) on 02/10/20 at 4:41 pm revealed: -She was not aware MAs were signing daily for Resident #4's weekly vitamin D2. -She expected MAs to read the MAR entries before administering medications. -She thought the MAs were signing the MAR without reading the entry. Interview with the Administrator on 02/10/20 at revealed: -He was not aware that the MAs were signing daily for Resident #4's weekly vitamin D2. -He held the MAs, RCC, and RCD responsible for the accuracy of the MARs.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

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THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D912	Continued From page 141 received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulation related to staffing, and implementation. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to ensure required staffing hours were met on first, second and third shifts based on a census of 61-70 for 12 of 42 shifts sampled from 01/23/20 to 02/05/20. [Refer to Tag D0219, 10 NCAC 13F .0606 Staffing Chart (Type B Violation)] 2. Based on recommendations, interviews, and record reviews, the previous Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care, health care, medication administration (Resident #13), resident rights, and staffing. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents were protected from abuse, and neglect as	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 142 related to Personal Care and Supervision, Health Care, Resident Rights and Medication Administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure staff provided personal care assistance for 2 of 6 sampled residents (#2 and #9) regarding a resident not receiving colostomy care (#2), and a resident requiring extensive assistance with personal care (#9). [Refer to Tag D0269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 2. Based on record reviews, observations and interviews the facility failed to ensure referral and follow-up with health care providers, a medical equipment company and Home Health agency for 3 of 6 sampled residents (Residents #1, #2, and #13) regarding colostomy bags not obtained and an order for an antipsychotic medication injection to be administered by a Home Health Nurse (HHN) (#2), a resident ordered clozapine with missed doses of medication due to weekly labs not obtained (#1), and a resident with an order for an immunosuppressive injection to be administered by a HHN (#13). [Refer to Tag D0273, 10A NCAC 13F .0902 (b) Health Care (Type A1 Violation)] 3. Based on record reviews and interviews the facility failed to ensure 3 of 8 sampled residents (Resident #11, #9, #2) were free of abuse and neglect resulting in a resident being physically and verbally assaulted by a personal care aide (Staff D) (#11), a resident required extensive assistance with activities of daily living (#9), and a resident not provided adequate colostomy care or	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D914	Continued From page 143 colostomy supplies (#2). [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)] 4. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 4 residents (Residents #1, #10, #13 and #14) observed during the morning medication pass related to a medication for schizophrenia (#1), 2 bronchodilators (#10) an asthma medication, and a medication for dry eyes (#13) and a blood thinner (#14); and for 5 of 5 sampled residents (Residents #1, #2, #3, #4, and #5) for record review related to a medication for schizophrenia (#1) antipsychotic medications (#2), an anti-psychotic, a blood thinner, and two anti-hypertension medications (#3), 2 anti-psychotic medications (#4), a diuretic medication (#5). [Refer to Tag D0358, 10A NCAC 13F .1004 a Medication Administration (Type A2 Violation)]	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on recommendations, interviews, and	D980		

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	HAL034150	A. BUILDING: _____ B. WING _____	02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT CLEMMONS	6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012

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D980	Continued From page 144 record reviews, the former Administrator failed to ensure the management, operations, and policies of the facility were implemented and rules were maintained for personal care, health care, medication administration (Resident #13), resident rights, and staffing. The findings are: Interview with the Housekeeping Supervisor on 02/07/20 at 9:30am revealed: -The former Administrator walked out of the building approximately one week ago. -She went to the previous Administrator to discuss hiring maintenance staff. -Housekeeping was responsible for maintenance duties and housekeeping tasks because the maintenance manager and staff quit in the past 3 months. -The former Administrator ordered the housekeeping staff to removed resident's furniture and belongings to relocate them to another room or storage. -She attempted to negotiate additional help because housekeeping was behind with laundry and daily housekeeping tasks in December. -The previous Administrator became very angry, at that time she no longer approached her with housekeeping concerns. -After her attempt to negotiate additional help nothing changed. -Resident's laundry, rooms and common areas were not routinely cleaned. Interview with the Dietary Manager on 02/07/20 at 9:50am revealed: -The previous Administrator had a very poor attitude. -The previous Administrator hired any person that placed an application to work in the kitchen.	D980		

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D980	Continued From page 145	D980		

-When new hires would come to work a few days and leave he approached the previous Administrator requesting to screen new hires more closely.
-The previous Administrator delayed hiring anyone to replace staff that quit in the beginning of December.
-He attempted to resolve issues with resident's diet orders when he was not receiving updates to diet changes or new admission diets.
-The previous Administrator and Resident Care Director ignored his request for an improved process to ensure residents were getting their ordered diets.
-After he continuously made attempts to resolve dietary issues he gave up and did not approach management with them.

Interview with a housekeeper on 02/07/20 at 10:00am revealed:
-She reported housekeeping issues with keeping up with daily housekeeping tasks related to the facility not having enough staff to assists residents with personal care needs.
-Resident's laundry and rooms were not being cleaned daily because the housekeeping staff was ordered to move resident's furniture and personal items out of rooms to another room or storage.
-She did not approach the previous Administrator because she was rude and used foul language.

Interview with a representative from the contracted pharmacy on 02/10/20 at 10:50 am revealed:
-The pharmacy staff had difficulty getting in touch with the facility when the pharmacy had questions about medications or the facility staff needed to contact residents' PCP about medications.
-There was a lack of cooperation dealing with the

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D980	Continued From page 146	D980		

former Administrator.

Interview with a PCA on 02/10/20 at 11:55 am revealed she reported any concerns with residents to the MAs, and then the MAs reported those concerns to the RCD.

Interview with the former Resident Care Director (RCD) on 02/11/20 at 12:30 pm revealed:
-The former Administrator controlled everything at the facility.
-The personal care aides (PCAs) were responsible to tell the medication aides (MAs) of any issues or concerns with the residents. The MAs were supposed to tell the former RCD of any concerns with the residents or residents' medications and the former RCD was responsible to tell the former Administrator.
-The former RCD was responsible for scheduling staff at the facility.

Interview with the former Administrator on 02/11/20 at 11:50 am revealed:
-The former RCD was responsible for MAs, medication process and orders, and to assure staff were performing work duties.
-The former RCD was responsible to let her know of any issues or concerns with staff or residents.
-The former Administrator and the former RCD were responsible for staffing the facility.

Interview with a MA on 02/10/20 at 9:30 am revealed:
-If the MA had any concerns with residents or staff called out of work, she reported it to the former RCD and former Administrator.
-Reporting staff shortages did not change, there were still staff shortages especially on second and third shifts.
-The former Administrator would tell staff there

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D980	Continued From page 147 was nothing the former Administrator could do about staff shortages. Non-compliance was identified in the following rule areas at the violation level: 1. Based on record reviews, observations and interviews the facility failed to ensure referral and follow-up with health care providers, a medical equipment company and Home Health agency for 3 of 6 sampled residents (Residents #1, #2, and #13) regarding colostomy bags not obtained and an order for an antipsychotic medication injection to be administered by a Home Health Nurse (HHN) (#2), a resident ordered clozapine with missed doses of medication due to weekly labs not obtained (#1), and a resident with an order for an immunosuppressive injection to be administered by a HHN (#13). [Refer to Tag D0273, 10A NCAC 13F .0902 (b) Health Care (Type A1 Violation)] 2. Based on record reviews and interviews the facility failed to ensure 3 of 8 sampled residents (Resident #11, #9, #2) were free of abuse and neglect resulting in a resident being physically and verbally assaulted by a personal care aide (Staff D) (#11), a resident required extensive assistance with activities of daily living (#9), and a resident not provided adequate colostomy care or colostomy supplies (#2). [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)] 3. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 4 residents (Residents #1, #10, #13 and #14) observed	D980		

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D980	Continued From page 148 during the morning medication pass related to a medication for schizophrenia (#1), 2 bronchodilators (#10) an asthma medication, and a medication for dry eyes (#13) and a blood thinner (#14); and for 5 of 5 sampled residents (Residents #1, #2, #3, #4, and #5) for record review related to a medication for schizophrenia (#1) antipsychotic medications (#2), an anti-psychotic, a blood thinner, and two anti-hypertension medications (#3), 2 anti-psychotic medications (#4), a diuretic medication (#5). [Refer to Tag D0358, 10A NCAC 13F .1004 a Medication Administration (Type A2 Violation)] 4. Based on observations, record reviews and interviews, the facility failed to ensure required staffing hours were met on first, second and third shifts based on a census of 61-70 for 12 of 42 shifts sampled from 01/23/20 to 02/05/20. [Refer to Tag D0219, 10 NCAC 13F .0606 Staffing Chart (Type B Violation)] 5. Based on observations, interviews and record reviews, the facility failed to assure staff provided personal care assistance for 2 of 6 sampled residents (#2 and #9) regarding a resident not receiving colostomy care (#2), and a resident requiring extensive assistance with personal care (#9). [Refer to Tag D0269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. _____ The facility failed to ensure responsibility for the overall management, administration, supervision and operation of the facility which resulted in staffing hours below the required hours needed to provide care for 61-64 residents for 12 of 42 shifts; a resident was not administered antipsychotic medications resulting in increased	D980		

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D980	Continued From page 149 behaviors and admission to an acute psychiatric unit and the same resident not receiving adequate colostomy care and colostomy bags were not obtained for the resident and walking about the facility with intestinal contents on his skin and clothes; personal care was not provided to a resident who required extensive assistance; missed doses of an antipsychotic medication due to weekly labs not obtained, a resident was not administered an immunosuppressive injection and medications not administered as ordered to 7 residents; two residents who were physically and/or verbally assaulted by Staff D. This failure placed residents at risk of serious physical harm and serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 02/07/20. CORRECTION DATE FOR THE TYPE 12 VIOLATION SHALL NOT EXCEED MARCH 12, 2020.	D980		