PRINTED: 02/28/2020

Division o	of Health Service Regul	ılation			FORM	1 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/1	1/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
THE IVY A	AT CLEMMONS		NDOWBROOK N NS, NC 27012	MALL COURT		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETE DATE		
D 000	Initial Comments		D 000			
	complaint investigatio and on February 10, 2	sure Section conducted a on on February 6-7, 2020 2020 with an exit none on February 11, 2020.				
D 137	10A NCAC 13F .0407 Qualifications	′(a)(5) Other Staff	D 137			
	<ul><li>(a) Each staff person shall:</li><li>(5) have no substanti</li></ul>	7 Other Staff Qualifications in at an adult care home stated findings listed on the in Care Personnel Registry 1E-256;				
	facility failed to ensure C) had no substantiat	as evidenced by: ews and interviews, the e 1 of 3 sampled staff (Staff ted findings on the North Personnel Registry (HCPR)				
	The findings are:					

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:

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		1101 024450	B. WING		00/44/0000	
NAME OF P	ROVIDER OR SUPPLIER	HAL034150 STREET AD	DRESS, CITY, STA	TE. ZIP CODE	02/11/2020	
	T CLEMMONS	6010 MEA	DOWBROOK N			
		CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 137	Continued From page	e 1	D 137			
	-She did not know StacheckShe recently became 02/05/20 and she had personnel recordsShe was also assum Business Office Mana Telephone interview v 02/11/20 at 4:00 pm r -He did not know Statcheck completedHe had not complete records and the RCD the BOM at this timeA HCPR check was c 02/10/20, and there w on 02/11/20 at 5:10 p -She was responsible recordsA HCPR check was c and there were no fin -She did not know who	aing the duties of the ager (BOM).  with the Administrator on revealed:  If C did not have a HCPR  and an audit of the personnel was assuming the duties of completed for Staff C on were no findings.  with the former Administrator in revealed:  If or maintaining personnel done for Staff C upon hire				
D 219	10A NCAC 13F .0606	Staffing Chart	D 219			
	10A NCAC 13F .0606	S Staffing Chart				
	following chart specific supervisory and manal eight-hour shift in faci census of 21 or more	S STAFFING CHART The ies the required aide, agement staffing for each ilities with a capacity or residents according to				

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Division of Health Service Regu	ialion			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	HAL034150	B. WING	02/11/2020	
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE		
	6010 MEAD	OWBROOK MALL COURT		

I THE IVY AT CLEMMONS		ADOWBROOK MALL COURT			
		CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE PF REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	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 2		D 219		
D 219	this Subchapter. Bed Count Position Type Shift Third Shift 21 - 30 Aide 16 Supervisor Not Required Administrator/SIC In the button for the supervisor 8* 8* Within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 Supervisor 8* 8* In the supervisor 8* 8* A hor facility/4 hours within 500 feet and available.**  Administrator On call 71-80 Aide 32 32 Supervisor 8 8 4 hor facility/4 hours within 500 feet and available.**  Administrator On call 81-90 Aide 36 36 Supervisor 8 8 4 hor facility/4 hours within 500 feet and available.**  Administrator On call 81-90 Aide 36 36 Supervisor 8 8 4 hor facility/4 hours within 500 feet and available.**	ole. 16 16 In the building, or 16 e building, or within ole.** 16 e building, or within ole.** 24 urs within the nd immediately 24 urs within the nd immediately 24 urs within the nd immediately 26 urs within the nd immediately 27 urs within the nd immediately 28 urs within the nd immediately 29 urs within the nd immediately 29 urs within the nd immediately 29 urs within the nd immediately 20 urs within the nd immediately 20 urs within the nd immediately 21 urs within the nd immediately 22 urs within the nd immediately 24 urs within the nd immediately	D 219		

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THE IVY AT CLEMMONS

Division of Health Service Regu	ialion			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	HAL034150	B. WING	02/11/2020	
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE		
	6010 MEAD	OWBROOK MALL COURT		

CLEMMONS, NC 27012

SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) D 219 D 219 Continued From page 3 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 101-110 Aide 44 44 32 8\*\* Supervisor 8 8 5 days/week: Minimum of 40 Administrator hours. When not in facility, on call. 111-120 Aide 48 48 32 8\*\* Supervisor 8 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 52 52 40 121-130 Aide 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 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call 141-150 60 60 40 Aide Supervisor 8 8 8 5 days/week: Minimum of 40 Administrator 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 68 68 48 Aide Supervisor 16 16 8 5 days/week: Minimum of 40 Administrator hours. When not in facility, on call. 171-180 Aide 72 72 48

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181-190

191-200

Supervisor 16 16 8

hours. When not in facility, on call.

hours. When not in facility, on call.

Aide

16 16 8

Aide

Administrator

Supervisor

Administrator

5 days/week: Minimum of 40

5 days/week: Minimum of 40

76 76 56

80 80 56

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BOILDING.	A. BUILDING.		
		HAL034150	B. WING		02/11	/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		OWBROOK N	IALL COURT		
0.0.15	CHIMMADV CT	ATEMENT OF DEFICIENCIES	S, NC 27012	PROVIDER'S PLAN OF CORRECTIO	N	0.450
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 219	Continued From page	÷ 4	D 219			
	hours. When not in fa 201-210 Aide Supervisor 16 Administrator hours. When not in fa 211-220 Aide Supervisor 16 Administrator hours. When not in fa 221-230 Aide Supervisor 16 Administrator hours. When not in fa	5 days/week: Minimum of 40 acility, on call. 84 84 56 16 8 5 days/week: Minimum of 40 acility, on call. 88 88 64 16 16 5 days/week: Minimum of 40 acility, on call. 92 92 64 16 16 5 days/week: Minimum of 40 acility, on call. 96 96 64 24 16 5 days/week: Minimum of 40				
		as evidenced by:  ns, record reviews and failed to ensure required				
	staffing hours were m	et on first, second and third sus of 61-70 for 12 of 42				
	The findings are:					
	Review of the facility 01/23/20 to 01/31/20 census of 61 resident	revealed there was a				
	Review of staff timeca 01/31/20 revealed: -On 01/24/20, on third	ards from 01/23/20 to				

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DIVISION OF FIGURATION	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	COMPLETED
HAI 034150 B. WING	00/44/0000
HAL034150 B. WING	02/11/2020
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
6010 MEADOWBROOK MALL COURT	
THE IVY AT CLEMMONS  CLEMMONS, NC 27012	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I	(* )
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR	RIATE DATE
DEFICIENCY)	
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.	
.oo nours.	
Review of the facility census record from	
02/01/20 to 02/06/20 revealed there was a	
census of 64 residents.	
concue of a residente.	
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.	

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-On 02/05/20, on third shift there was a total of

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
		HAL034150	B. WING		02/4	1/2020	
		HAL034130			02/	1/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
<b>-</b> 11- 00/4	- aa.	6010 ME	ADOWBROOK N	MALL COURT			
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	) BE	COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE	
				DEI ICIENCT)			
D 219	Continued From page	9 6	D 219				
	16.50 hours of aide of	overage with a shortage of					
	7.50 hours.						
	Intorvious with a staff	on 02/06/20 revealed:					
		short staffed for a couple of					
	months.	i short stailed for a couple of					
		rator fired several staff; not					
	sure why staff had be						
	•	eral staff to call out of work					
	and staff would conta	ct the former Administrator					
	to let her know.						
	-The former Administr	rator would tell staff there					
	was nothing she could	d do about it.					
		sident Care Coordinator					
	(RCC) on 02/06/20 at						
	(02/05/20).	CC position yesterday					
	-It was her understan	ding the former					
		sident Care Director (RCD)					
		staffing the facility and					
	scheduling staff.	oraning and radiiity and					
	_	des (MAs) were also trained					
	as personal care aide						
	-The third shift (02/06	/20) was scheduled to be					
	staffed with 2 MAs an	nd 2 PCAs.					
	-	affing agency to staff the					
	facility as well.						
	Interview with a resid	ent on 02/07/20 at 2:15 pm					
	revealed:	5.11 5.11 52/51/25 at 2.10 pm					
		get medications on time in					
	the mornings.	_					
	-The resident was sup	pposed to get medications					
		received medications					
	before 10:00 am.						
	-There was not enoug	gh staff to give medications					
	on most days.						
		ouple of nights where the					
	staff could not be four	nd in the facility.					

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DIVISION	n Health Service Regu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		HAL034150	B. WING		00/	14/2020
		HAL034150			1 02/1	1/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
THE 00/ A	T 01 FMM0N0	6010 ME	ADOWBROOK N	MALL COURT		
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(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
D 219	Continued From page	e 7	D 219			
	-The resident could no	ot sleep and got out of bed				
		nall to see what staff was				
	working.					
	•	the other floors but did not				
		o the resident went back to				
	bed.	o the resident went back to				
	-The resident could no	ot recall the dates				
	The recident codia in	or rosali tilo datos.				
	Interview with a MA o	n 02/07/20 at 2:30 pm				
	revealed:	·				
	-The MA was usually	late passing medications in				
	-	e there was not enough				
	staff.	J				
		medications on one floor of				
		hared the medication pass				
	on another floor with a	· · · · · · · · · · · · · · · · · · ·				
	-The MA would be res					
		residents between the to 2				
	floors.	residente settreen tre te 2				
		ortage of staff for a while.				
		ionago er elam ter a miller				
		nd MA on 02/10/20 at 9:30				
	am revealed:					
		Care Director (RCD) was				
	responsible for sched	<u> </u>				
		ng at the facility for a couple				
	of weeks.					
		third shift and there had				
		f was short on third shift.				
	• • • • • • • • • • • • • • • • • • • •	osed to be staffed with 2				
	MAs and 1 or 2 PCAs					
	•	en 1 MA and 1 PCA on third				
	shift.					
		when there had been 1 staff				
		ift but did not recall the				
	date.					
		ues or concerns with staff or				
		ere supposed to call the				
	RCD.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/1	1/2020
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE 710 CODE	1 02/1	.,,2020
NAIVIL OI 11	TOVIDER OR SOLT EIER		DOWBROOK N			
THE IVY A	T CLEMMONS		NS, NC 27012	IALL GOOK!		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 219	Continued From page	8	D 219			
	Interview with the Res (RCC) on 02/10/20 at -The schedule should on first shift, 3 MAs at and 2 MAs and 2 PC/-The former Administrand fire staff.  -The former Administrathe RCC became away had left employment a current RCD to ask for hired back as the RC/-The former Administrathed worked here for seall the staff remaining and there were no exthem and to train there.  Interview with a third revealed:  -She usually worked for the seal of the staff on seal of the staff	sident Care Coordinator in 10:07 am revealed: I reflect 3 MAs and 3 PCAs and 2 PCAs on second shift. As on third shift. I rator would come to work arator had fired her and when the facility, she called the facility, she called the factor her job back and was Courator fired several staff who several years. If years are the facility were new perienced staff to assist an on the facility processes.  MA on 02/10/20 at 11:25 am first shift. I say when she had left the factor or the factor or the factor of the tay until second shift staff.  I be someone to hand off the factor of the factor				
		en there was not enough				

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-She had never come to work or left work when

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DIVISION C	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	A. BUILDING:		ETED
			7. 501251110.			
		HAL034150	B. WING		02/1	1/2020
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE NAVA	T OLEMMONO	6010 MEA	DOWBROOK M	IALL COURT		
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012			
	CUMMADV CT			DROVIDEDIC DI ANI OF CORRECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
			+			
D 219	Continued From page	<del>9</del> 9	D 219			
		4 4 66 11 6 111				
	there was no staff or	1 staff in the facility working.				
	Interview with a fourth	h 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				
		another staff were the only				
	staff on third shift to c	•				
		to be 2 MAs and 1 or 2				
	_	hift; there had been a few				
	times recently only 1					
	scheduled to work on					
	-If staff called out, she	e called the RCC, or RCD.				
	-There always had to	be a MA on duty to give the				
	medication cart keys					
	- 					
	Interview with the RC	D on 02/10/20 at 5:15 pm				
	revealed:	D 011 02, 10,20 at 3.10 p				
		e for scheduling staff to work				
		Hor scheduling Stan to work				
	in the facility.	1505 00/00/00				
		osition of RCD on 02/06/20.				
		of any staff shortages at the				
	facility.					
		east 3 MAs and 3 PCAs on				
	first shift, 3 MAs and	2 PCAs on second shift, and				
	2 MAs and 2 PCAs or	n third shift.				
	Interview with the forr	mer Administrator on				
	02/11/20 at 11:50 am					
	-Her last day of work					
	01/31/20.	at the facility was on				
		to cover staff by manyidina				
		to cover staff by providing				
	MA duties due to staff	_				
	-She fired a few staff,					
	experienced staff just	quit.				
	-She wanted to staff v	with agency staff, but the				
		pay for agency staff to work				
		nad to do the best we could				
	, at the lability 30 We i	iad to do the best we could				

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-For the regular staffing pattern, she only needed

do".

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
D WING						
		HAL034150	B. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	T CLEMMONS	6010 MEA	DOWBROOK N	IALL COURT		
	T CELMINIONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 219	Continued From page	e 10	D 219			
ם איני איני איני איני איני איני איני אינ	2 staff for each floor, -The usual staffing pa supposed to be, on fit and 2 PCAs, on seco and 3 PCAs, and on the and 2 PCAsMost of the time the MAs and 3 PCAs on the on second shift, and 2 shift.  Interview with the form 12:20 pm revealed: -Her last day of work 01/30/20She was responsible -There were a lot of shiftThere were staff shough and there was not enough facilityThere were staff quit, and there was no staff to the there was no staff to	2 MAs per floor.  Intern for the facility was rest shift there were 3 MAs and shift there were 3 MAs shird shift there were 3 MAs shird shift there were 3 MAs shird shift there were 3 MAs facility was staffed with 2 first shift, 2 MAs and 3 PCAs 2 MAs and 2 PCAs on third  The recommendation of the staff schedule.  In the staff schedule.  In the staff were fired and take their places.  In to use agency to staff on re were too many staff  In the staff anyway despite aid.  In the facility was 3 and 4 staff the facility.  In the dule for the facility was 3 and 4 shower staff on first shift, and second shift, 2 MAs and 2 and only be 2 MAs and 1 PCA or third shift; the owner told see agency staff for staffing				
	-If she could not get fa agency staff to work,	acility staff to work or she would come back in to				

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work the shift herself.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		_		
	HAL034150	B. WING		02/11/2020
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE IVY AT CLEMMONS		DOWBROOK N S, NC 27012	IALL COURT	
OVA ID SUMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	d 0/5)
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 219 Continued From page	<del>:</del> 11	D 219		
at 12:15 pm revealed: -There were not enouse. She lived on the four staff during the night such a staff who responds as a staf	gh staff in the facility. th floor and there were no shift on the fourth floor. medication aides (MAs) ght shift for the past 4 or 5 anything during the night  r fourth-floor resident on revealed: gh staff in the facility and d a PCA because some reded assistance some of the same staff in the building on third the supposed to have a PCA acility.  y member on 02/06/20 at ad resided at the facility for the call bell for assistance for ook "forever" for staff to			

Division of Health Service Regulation

STATE FORM 6899 69Q011 If continuation sheet 12 of 150

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	HAL034150	B. WING		02/1	1/2020	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
THE IVY AT CLEMMONS		OWBROOK N	IALL COURT			
		S, NC 27012				
PREFIX (EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 219 Continued From page	12	D 219				
because staff stated the request.  -When staff left again, minutes before they resolve the lack of staff.  -The baths were supposed wednesdays, and Friebath was not always of the family member with dressed for bed at 6:3 staffing he placed herestaff were able to attest of the lack	ney needed help with the it may be another 30 eturned. baths were delayed due to osed to be on Mondays, days, but it seemed that her done on Mondays. as usually changed and 0 pm, but due to low in the bed at 6:30 pm until and to her later in the shift.  arth floor on 02/10/20 at the were no staff on the floor of fourth-floor resident on the evealed: the fourth floor after breakfast ff on the floor for the past ovas in the dining room the and staff had ice in a fout to residents.  INCAC 13 F .0901(a) the approximate the province of the past ovas in the dining room of the past ovas in the dining room of the and staff had ice in a fout to residents.  INCAC 13 F .0901(b) Health on)]					

Division of Health Service Regulation

The facility's failure to provide adequate staffing

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE NAVA	T CL EMMONE	6010 MEAD	OWBROOK N	IALL COURT		
INEIVIA	T CLEMMONS	CLEMMON	S, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	ETE
D 219	Continued From page	e 13	D 219			
	for 61-64 residents for delayed medication a not administered as of the fourth floor for thir throughout the day ar response to call bells; provided related to she clothing, and a reside clean clothes and line incontinence care, and dirty toenails, dry skin PCAs scheduled for 6 and third shifts; failed equipment company at to obtain colostomy be failed to contact the Hadminister medication residents. This failure	r 12 of 42 shifts resulting in dministration, medications ordered, no direct staff on rd shift and at other periods and evening shifts; delayed; a delay in personal care nowers and change of ent who was blind not having ens, not receiving d foot care resulting in long, a, and foul odors and two 61-64 residents on second to notify the medical and/or home health agency ags for a resident and and dome Health agency to so by injection for 2 was detrimental to the elfare of residents and				
	CORRECTION DATE	131 D-34 on 02/06/20.				
D 269	10A NCAC 13F .0901 Supervision	(a) Personal Care and	D 269			
	care to residents according plans and attend to a	staff shall provide personal ording to the residents' care ny other personal care be unable to attend to for				

Division of Health Service Regulation

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		NDOWBROOK N	MALL COURT	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ON (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 269	Continued From page	e 14	D 269		
	This Rule is not met	as evidenced by:			
	TYPE B VIOLATION				
	Based on observation	ns, interviews and record			
		iled to assure staff provided			
	l -	nce for 2 of 6 sampled regarding a resident not			
		are (#2), and a resident			
	requiring extensive as	ssistance with personal care			
	(#9).				
	The findings are:				
	1. Review of Residen 02/26/19 revealed:	t #2's current FL2 dated			
		congestive heart failure			
	(CHF), schizophrenia psychosis and mood				
	-Resident #2 was am				
	-Resident #2 had a co				
	Review of Resident #	#2's hospital discharge			
	summary dated 08/20				
		nitted for a small bowel			
	obstruction on 08/14/	19. ned his ostomy had not			
		ned his ostomy had not creased appetite due to			
	stomach pain.	or agon appoints and to			
	-Resident #2's small t	powel obstruction was			
		management; rest and no			
	surgery was needed.				
	Review of Resident #	5's Colon Rectal Clinic visit			

Division of Health Service Regulation

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Division of He	ealth Service Regu	lation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		DATE SURVEY COMPLETED	
		HAL034150	B. WING			02/11/2020
NAME OF PROVID	DER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
THE NOVATION	EMMONE	6010 ME	ADOWBROOK M	MALL COURT		
THE IVY AT CL	.EMMONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 269 Co	ntinued From page	<del>)</del> 15	D 269			
-Re 200 -Re a s required his -Th the the car Re well available review -Re bat hyg -Re eat Re Progress - Re iled -Re rec door Re 11/	esident #2 was recomall bowel obstructionall bowel obstructionall bowel obstructional bowel obstructional bowel obstructional bowel obstance was some reductional and would brapy (Home Health etc.  View of Resident #2 required thing, grooming, dragiene.  esident #2 required thing, grooming, dragiene.  esident #2 required thing, ambulation a sesident #2 required thing and toileting.  View of Resident #2 required thing and toileting.	ently seen in the hospital for ection with no surgery  ag for his ileostomy taped to ave an underlying wafer. Undant abrasions around be referred for enterostomal h) for help with ileostomy  2's record revealed there aspital discharge summaries  2's care plan dated 03/30/19  di extensive assistance with ressing and personal  di extensive assistance with and transfers. di extensive assistance with (LHPS) dated 01/27/20  lished colostomy or mented as a marked task, ages and follow-up et the resident's needs was				

Division of Health Service Regulation

(RCD) and staff was told the former RCD would

STATE FORM 6899 69Q011 If continuation sheet 16 of 150

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	DENTIFICATION NUMBER:			COMPLETED	
			A. BOILDING			
		HAL034150	B. WING		02/1	1/2020
					•	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE 00/ A	T 01 FMM0N0	6010 ME	ADOWBROOK M	IALL COURT		
THE IVY A	T CLEMMONS	CLEMMO	ONS, NC 27012			
	CUMMADV CT	ATEMENT OF DEFICIENCIES		DDOVIDEDIC DI ANI OF CODDECTIO		
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
170		,	170	DEFICIENCY)		ı
D 269	Continued From page	∍ 16	D 269			1
						ı
	get colostomy bags to	omorrow (11/12/19).				ı
						ı
	Review of Resident #	2's December 2019				ı
	progress notes revea					ı
		pm, Resident #2 would not				ı
		·				ı
	let staff change his co					ı
		0 am, Resident #2 was				ı
		d the colostomy bag was				ı
	removed. Resident #2	2 was cleaned up and a new				ı
	colostomy bag was a	pplied. The resident refused				ı
		at had bowel movement				ı
	(BM) on it.	20 Hade 20 Ho				ı
	, ,	e documented), Resident #2				ı
		•				ı
	refused to let staff cha					ı
		e documented), Resident #2				ı
		ange his colostomy bag.				ı
	-On 12/13/19 at 2: 50	pm and on 12/15/19 (no				ı
	time documented), re	sident refused personal				1
	, .	ed to let staff check his				1
	colostomy bag.					1
		pm, Resident #2 refused to				1
	let staff change his co					1
						1
		0 pm and on 12/22/19 (no				1
	, ,	esident #2 refused personal				1
	care and refused to le	et staff change his colostomy				1
	bag.					1
		m to 7:00 am, Resident				1
	· ·	e and did not sleep all night.				1
	•	pm to 11:00 pm, Resident				1
	#2 would not let staff					1
						1
		e documented), Resident #2				1
	refused to let staff che	•				1
	-On 12/30/19 at 2:00	pm, resident refused				I
	personal care.					1
	-On 12/31/19 at 11:00	pm to 7:00 am, resident				I
		e and refused to put on				I
	clothes.	zana roladda to pat on				1
	Ciotiles.					1
	i					1

Division of Health Service Regulation

notes revealed:

Review of Resident #2's January 2020 progress

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
			B. WING			
		HAL034150	B. WING		02/	11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
		6010 ME	ADOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012	IALL GOOK!		
			N3, NC 27012	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR		DATE
			,,,,,	DEFICIENCY)		
D 269	Continued From page	e 17	D 269			
	-On 01/01/20 (no time	e documented), resident #2				
		e and would not let staff				
		re. Resident #2 stated staff				
	would "mess up" his					
		e documented), Resident #2				
	,	•				
	•	e and would not let staff				
	-	or change his clothes.				
		aff were "undercover", and				
	medication was "pois					
	-On 01/03/20 and 01/	•				
	•	nt refused personal care and				
		eck his colostomy or change				
	his clothes.					
		pm to 11:00 pm, resident				
	refused colostomy ca					
	-On 01/07/20 at 3:00	pm to 11:00 pm, resident				
	refused colostomy ca	re.				
		e documented), resident				
		e and would not let staff				
	check his colostomy.					
	-On 01/11/20 at 3:00	pm to 11:00 pm, resident				
	refused colostomy ca	re.				
	-On 01/13/20 at 7:00	pm to 7:00 am, resident				
	refused colostomy ca	re and got angry at staff.				
		e documented), Resident #2				
	was yelling and screa	aming. Staff tried to calm him				
		ng at staff. Resident was				
	•	ital by Emergency Medical				
	Services.	a. zy =e.geeyea.ea.				
		e documented), resident				
		nospital but was still agitated				
	and having behaviors					
	•	opm, resident let staff				
		nd check his colostomy.				
	•	•				
		to change his shirt with BM				
		put a clean shirt over his				
	dirty shirt.					
		pm to 11:00 pm, resident				
	back in the hospital.					

-On 01/24/20 (no time documented), resident

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Division of Health Service Regulation

				DATE SURVEY COMPLETED		
		HAL034150	B. WING		02	2/11/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
THE IVY	AT CLEMMONS		ADOWBROOK MA	LL COURT		
	T		ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 269	back from the hospital change his colostom -On 01/25/20 (no tim #5 still having behavifeces all over him and The resident had bee -On 01/27/20 at 7:00 refused to let staff chis room and changed Review of Resident #February 2020 revea 02/02/20 the resident colostomy care by stime Review of Resident #February 2020 revea 02/02/20 the resident colostomy care by stime Review of Resident #February 2020 revea 02/02/20 the resident colostomy care by stime Review of Resident #February 2020 revea 02/02/20 the resident colostomy care by stime revealed there were for review.  Observation of Resident #February 2020 at 1 the Health N to take care of the colostor -The Home Health N to take care of the colostor -The PCP was told be that Home Health (H#2 from HH services -That was not like Hitheir services.  -The last time she sad January 2020 and she walking around in the	al. Refused to let staff y bag. ed documented), Resident iors and was lying in bed with d refused to be cleaned up. en in the bed all day. am to 3:00 pm, resident lange his clothes but went to ed his clothes by himself.  #2's personal care log for led on 02/01/20 and t was provided a shower and aff.  #2's personal care logs no other personal care logs  dent #2's room (205) in the acility on 02/07/20 at 11:30 ere no colostomy bags  ent #2's primary care provider t 8:55 am revealed: urse (HAHN) was supposed blostomy and to start the my bags in September 2019. y staff in December 2019 H) had "dropped" Resident H to just drop a resident from aw Resident #2 was in ne noticed Resident #2 was e facility with the colostomy s bowel movement (BM) all	D 269			

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	n nealth Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAI 024450	B. WING		00/44/0000
		HAL034150	1		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		6010 MEA	DOWBROOK N	MALL COURT	
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012		
()(1) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 269	Continued From page	19	D 269		
	. •				
	,	20 to make sure to order the			
	colostomy bags for R	esident #2.			
	latamiaitha a saadi	antina nida (NAA) na			
	Interview with a medion 02/07/20 at 10:00 am				
	-Resident #2 was cur				
		nen Resident #2 went to the			
	hospital or which hosp	ad to go to the hospital			
		olostomy bags and he was			
		olostorily bags and ne was			
	having behaviors.	all the date), Resident #2			
	- ,	he hall and went into the			
	•	colostomy bag off and			
	•	r in front of other residents			
	during mealtime.	i in none of other residents			
	•	nd that was all staff did.			
	•	ot let staff assist with his			
	colostomy.	or for stail addict with the			
	•	the hall with no "bag on".			
		lostomy bags a month ago			
	and he would not let				
		ad been coming out to see			
	` '	just dropped him from their			
	services sometime in	• • •			
	-She did not know wh	ny Resident #2 was			
		did not know where to order			
	the colostomy bags fr				
		supposed to supply the			
	colostomy bags, and	she was not sure what			
	happened; "the bags	just stopped coming".			
	-The MA had not calle	ed HH to ask about the			
		use she did not know which			
	HH agency to call.				
	-The colostomy bags	were stored in Resident			
	#2's room.				
	-Staff called Resident	t #2's guardian to see if the			
		e colostomy bags, but the			
	guardian had no idea	where to get the bags.			

Division of Health Service Regulation

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Division of	of Health Service Regu	ulation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		HAL034150	B. WING		02/1	1/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	FE ZIP CODE		
100	William Co. Co. C. L.L.		ADOWBROOK MA			
THE IVY A	AT CLEMMONS		NS, NC 27012	ALL GOOM		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
			+			
D 269	Continued From page	e 20	D 269			
	Interview with a repre	esentative from the HH				
	-	at 11:40 am revealed:				
		urse (HHN) came out to				
		tember 2019 for Resident #2				
		ation related to the care of				
		ion, bag placement and				
	colostomy bag suppli					
		er for the colostomy bags and				
	ordered as many as t					
	according to the resid					
		stomy bags for Resident #2				
		y company on 11/15/19. IN provided the contact				
	· ·	edical supply company to the				
		are Director (RCD) to order				
	the colostomy bags for	, ,				
	, ,	former RCD aware that the				
		onsible for ordering the				
	colostomy bags going					
	-HH services were di	scontinued on 12/12/19 for				
		e HH only provided start-up				
	and education; then t	<u> </u>				
		ving up and ordering the				
		that was the extent of HH				
	services.					
	Interview with the RC	CD on 02/07/20 at 11:45 am				
	revealed:	D 011 02/01/20 at 11.10 am				
		hat happened to Resident				
	#2's colostomy bags.					
		no was responsible for				
	ordering the bags.					
	-"We did not know wh	nat to do about the				
	colostomy bags."					
		HH about the colostomy bags				
		know which HH agency to				
	call.					
ļ	-The former RCD did	not share the information on				

bags. Division of Health Service Regulation

where and how staff were to order the colostomy

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE COMI	
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIP CODE	,
IVANIE OF T	COVIDER OR GOLT EIER		ADOWBROOK N		
THE IVY A	T CLEMMONS		NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 269	Continued From page	21	D 269		
	could not afford to but the resident would no colostomy bags.				
	supply company on 0 revealed:	·			
	-The medical supply company was emailing and faxing information to the facility and Resident #2's primary care provider (PCP) for over 2 monthsThe medical supply company called and emailed the PCP but never gotten a response from the				
	facility or the PCP.  -The PCP had to sign	·			
	_	nent form for the supply			
	company to deliver th	e colostomy bags. ostomy bags had been sent.			
	- That was why no con	ostorny bags had been sent.			
	Second interview with 4:30 pm revealed: -She had located an a	n the RCD on 02/07/20 at			
	02/07/20 from the me	dical supply company in a ormer RCD's office that had			
	the RCD she was on				
	PCP and had not bee	m had not been sent to the n signed.			
	-She knew Resident # she did not know whice admitted to or when the hospital.	nd MA on 02/10/20 revealed: #2 was in the hospital but ch hospital Resident #2 was he resident went to the			
	bags.	Resident #2's colostomy the colostomy bags for			

Division of Health Service Regulation

-Staff was supposed to provide personal and

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Division of Health Service Regulation

STATEMENT	F OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU COMPLE	
		HAL034150	B. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
			ADOWBROOK M			
THE IVY A	T CLEMMONS	CLEMMO	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 269	Continued From page	e 22	D 269			
	colostomy care for Re-Sometimes Resident care and colostomy of trying to help the resident (RCC) on 02/10/20 at -The former Administration to order the colostomy because the former Administration to order the colostomy because the former Administration ordered.  -The former Administration order colostomy because he was havilled.	esident #2.  t #2 would resist personal eare, and staff would keep dent.  sident Care Coordinator t 10:07 am revealed: rator told the former RCD tomy bags for Resident #2 dministrator was going to bags from another supply stomy bags did not get  rator told staff she was not bry bags for Resident #2				
	Interview with a staff revealed: -Resident #2 did not I put onStaff would make co white trash bags and Interview with a medi 02/10/20 at 11:25 am -Staff would make co white trash bags and -Resident #2 had bee a while" and staff did where to order the ba Interview with a perso 02/10/20 at 11:55 am -She knew Resident #2	on 02/10/20 at 10:20 am  have any colostomy bags to lostomy bags out of small tape them on Resident #2.  cation aide (MA) on revealed: lostomy bags out of small tape them on Resident #2. en out of colostomy bags "for not know what to do or rgs from.  onal care aide (PCA) on revealed: #2 was in the hospital and was admitted to the hospital				

Division of Health Service Regulation

-Resident #2 walked around without a colostomy

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034150	HAL034150 B. WING		02/11	/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 MEA	DOWBROOK N	IALL COURT		
	- CELINING IV	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 269	Continued From page 23		D 269			
	bag on and the resident always had BM on his shirtThe PCA did not know if Resident #2 had any colostomy bags or not.					
	pm revealed: -Resident #2 was able -Resident #2's coloste in December 2019Resident #2 would g colostomy bags off ar -Staff did whatever th colostomy bags ran o Resident #2 or tape a Resident #2 from mea -Sometimes Resident personal care and col sometimes he would -The MA was able to colostomy care for Re resident a sandwich of	ey had to do when the ut; tape small trash bags on a cloth on the stoma to keep ssing up his clothes. #2 would let staff provide lostomy care and not. provide personal care and esident #2 by fixing the 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 outShe had ordered the colostomy bags from another (named) medical supply companyHome Health had originally sent the colostomy bags to the facility for Resident #2Resident #2 had money to pay for the colostomy bagsResident #2 had colostomy bags, he just would not let staff provide personal care or colostomy care him.					

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-Resident #2 was independent with personal care and only needed staff assistance with his

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	<del></del>	
		HAL034150	B. WING		02/11/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		6010 MEA	DOWBROOK N	MALL COURT	
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
D 269	Continued From page	e 24	D 269		
	colostomy care.	ake the colostomy bags off			
	Interview with the former RCD on 02/11/20 at 12:30 pm revealed: -Resident #2 was "dropped" for HH services in December 2019Forms were sent from another (named) HH agency for the PCP to sign to order the colostomy				
		tacted another (named) any to order the colostomy			
	bags.				
	-Staff had to go pick t medical supply compa	- ·			
	-Staff would pay for th				
		gned by the PCP and sent			
		(named) medical supply			
	company where HH h	ad set up the order for			
	colostomy bags from.				
	-If the colostomy bags				
		rmer RCD know and then			
	bags from the medica	d go pick up the colostomy			
	_	ot let staff provide personal			
	care or colostomy car	·			
		ot keep the colostomy bags			
		ound with no colostomy bag			
	on and he would have	e BM all over his clothes.			
		l health provider (MHP) and			
		nt resisted personal and			
	,	use the former RCD or staff			
		HP and PCP visited the			
	facility every 2 weeks				
		to redirect the resident, , change his clothes, give			
	I	and provide colostomy			

Division of Health Service Regulation

care.

-Resident #2 would walk around without a

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL034150	B. WING		02/11/2020	
NAME OF PROVIDER OR SUPPLIER  THE IVY AT CLEMMONS	6010 MEA	DRESS, CITY, STA DOWBROOK N NS, NC 27012			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
Resident #2This company was a H a HH agency and did no supplies.  Interview with a represe (named) medical supply 2:30 pm contacted by the Administrator revealed to company closed in January losed in January lateral HH agency on contacted by the former bags for Resident #2 resident #2The HH agency did supply 1:20 to 1:	ance a week. Sent to the hospital if he or if he had behaviors.  It 2:00 pm with another intacted by the former of received any orders for some Care agency and not of provide colostomy  Internative from another of the former RCD and former RCD and former the medical supply former at the medical supply former at the medical supply colostomy of received any orders for poly colostomy bags.  Iterview with Resident #2's on Rectal Clinic on the sunsuccessful.  Iterviews with Resident #2's on Rectal Clinic on the sunsuccessful.  Iterviews with Resident #2's on Rectal Clinic on the sunsuccessful.	D 269			

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blindness.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/202	20
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		02/11/202	20
			DOWBROOK N			
THE IVY A	T CLEMMONS	CLEMMON	IS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COM	(X5) MPLETE DATE
D 269	Continued From page 26		D 269			
	-Resident #9 was incontinent of bladderResident #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 shiftResident #9 was independent of toiletingResident #9 was assisted with clothing and dressing dailyThere was no documentation Resident #9 had a shower.					
		al Care Record for Resident revealed there was no e provided.				
	12:30 to 12:45pm rev -The resident was in I of her bed without clo wearing an incontiner -The resident wore ye feetThe resident's eyes v attempted to remove -When Resident #9 re	her room sitting on the side withing from the waist down hee brief. ellow socks on both of her were closed as she her socks. emoved her socks a strong				
	to attempt to put on a	moved her socks she began				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
			A. BUILDING.			
		HAL034150	B. WING		02	2/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
THE IVY	AT CLEMMONS	6010 ME	ADOWBROOK MA	LL COURT		
INCIVIA	AT CLEIMINIONS	CLEMMO	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 269	Continued From page	e 27	D 269			
	in her faceResident #9's feet hat All of Resident #9's to grown over each toeResident #9's toe nat dark brown appearant -Resident #9 pressed and waited approximates staff came to her roor.  Interview with a Resident 12:30 pm revealed: -The previous Adminity was very short staffed She needed assistant laundry, bath towels, mealsShe wanted to do as herself but, she need clothes and personal she went to the Admistaff when they came requesting them to he Resident #9 was blir of day without asking She was not able to a showerShe would only allow aide (PCA) to assist the The PCAs told her the asked them to help he She was told by the she needed to do as their help.	ad patches of dry flaky skin. toe nails on each foot were touching the floor. tils on 3 of 10 toes had a toe. If her call bell after prompting ately fifteen minutes until m.  Ident #9 on 02/06/20 at Instrator told her the facility d. Ince with getting a bath, clean Ilinens, and assistance to Is much as possible for eed assistance locating her care items. Ininistrator after speaking to Into her room day after day telp her with these tasks. Ind and did not know the time the staff. In recall the last time she had In her favorite personal care ther with her shower. They were too busy when she ter with a shower. In the staff and the Administrator much for herself without Indication aide (MA) on				
	-She was delayed ge 02/06/20 because sh	tting to Resident #9 on e was answering all the call dications while the PCAs				

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STATE FORM 6899 69Q011 If continuation sheet 28 of 150

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN (	LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED	
			1		
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
THE NAVA	THE NOVAT OF EMPONE			IALL COURT	
INEIVIA	T CLEMMONS	CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 269	Continued From page	e 28	D 269		
	their mealsShe needed to find F and socksResident #9 did not I socks to change into  Interview with the per 02/06/20 at 3:10pm re- Resident #9 did not I personal careShe never showered -Resident #9 become attempted to help with -She did not like to go because Resident #9 things from her roomShe told the former F Administrator about F staff to help with bath	rsonal care aide (PCA) on evealed: want anyone to help with  I Resident #9. e very upset when anyone in personal care. o into Resident #9's room accused staff of stealing RCD and former Resident #9's refusal to allow ing and grooming. d her own brief when it was			
	Observation of Resid 8:00am revealed: -Resident #9 was aslinensResident #9 was we and trousers as yeste Observation of Resid 12:00pm revealed: -Resident #9 was sitt linensResident #9 was we and trousers as yeste	ent #9 on 02/07/20 at eep on her bed without aring the same yellow socks erday (02/06/20). ent #9 on 02/07/20 at ing on her bed without aring the same yellow socks			

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room.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 ME	ADOWBROOK N	IALL COURT		
	TO CELIMINO NO	CLEMMO	NS, NC 27012		<u>,                                      </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 269	Continued From page	e 29	D 269			
D 269	Observation of Reside 1:15pm to 2:00pm rev-Resident #9 was sitti a tray food aloneResident #9 had spil-Resident #9 asked for sweetener for her teat -Resident #9 did not good Observation of Reside 4:00pm revealed: -Resident #9 was in high -The MA came into the land socks for Resider -The MA did not find of Resident #9's roomThe MA went to the lifted find clean clothes and Interview with the MA revealed: -She did help Resider Resident Care Director #9 would not allow an needed helpResident #9 allowed needed help, but the (02/07/20) because of Telephone interview word 11:00am in Resident #9 needed would allow the staff in Resident #9 refused medicationsShe did not have a contraction of the sident #9 refused medications.	ent #9 on 02/07/20 from vealed: ing at dining room table with led food onto her lap. or someone to get her some . get sweetener for her tea. ent #9 on 02/07/20 at her room sitting on her bed. he room looking for clothes int #9. clean clothes and socks in leaundry room and did not it socks for Resident #9. In an 02/07/20 at 4:00pm int #9 because the previous for (RCD) told her Resident hyone to help her when she in PCA help her when she PCA left to go home today if a family emergency. With the former RCD on revealed: more help than what she provide. everything even her interest are plan meeting with	D 269			
	-She did not get a cha	Health Provider (MHP). ance to discuss Resident e MHP because she was				

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always on the medication cart passing

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  CO			
			71. 201251110.			
		HAL034150	B. WING		02	2/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
	AT CLEMMONS	6010 ME	ADOWBROOK MA	LL COURT		
THE IVY	AT CLEMMONS	CLEMMO	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 269	Continued From page	∋ 30	D 269			
	medications.					
	Health Provider on 02 -Resident #9 refused but she required assi like providing her with reminders of the time her mealsResident #9 required approach to get her to she needed helpShe did not know Re overgrown and dirtyThe staff was expect overgrown toe nails to risk Resident #9 coul injury her toes.	a lot of help from the staff stance with hands off tasks in clean clothes and linens, of day, and assistance with dia gentle and patient in allow anyone to help when esident #9's toe nails were ted to report Resident #9's in her because there was a diacquire an infection or				
	on 02/11/20 at 9:50ar -Resident #9 was abl -Resident #9 had "no money and swinging something"Resident #9 allowed when she needed he -Resident #9 refused	e "to do for herself". problem counting her her cane when she wanted only one PCA to help her lp. care and swung her cane when she offered to do				
	resulted in a resident supplies and staff have bags or wash clothes the resident's intestin his skin and clothing resident who was blir	sampled residents which not having colostomy ving to resort to taping trash to his skin or nothing while al contents leaked out onto				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 MEAI	OOWBROOK N	IALL COURT		
	- CELINING IV	CLEMMON	IS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 269	Continued From page 31		D 269			
	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 273	10A NCAC 13F .0902	2(b) Health Care	D 273			
	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 TYPE A1 VIOLATION Based on record revie					
	interviews the facility follow-up with health equipment company a 3 of 6 sampled reside #13) regarding colost an order for an antips	failed to ensure referral and care providers, a medical and Home Health agency for ents (Residents #1, #2, and omy bags not obtained and ychotic medication injection a Home Health Nurse				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/1	1/2020
	ROVIDER OR SUPPLIER	6010 MEA	DRESS, CITY, STA DOWBROOK N NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 273	missed doses of med not obtained (#1), and an immunosuppressive administered by a HH. The findings are:  1. Review of Residen 02/26/2019 revealed congestive heart failured anxiety, insomnia, psychological anxiety, insomnia, psychological and the object of the hospital.  Review of Resident dated 01/24/20 reveal (Invega) 156 mg/ml 1 long-acting anti-psychacute and maintenancy action of Resident # January 2020 revealed documented), Reside and was lying in bed refused to be cleaned in the bed all day.  Review of Resident # January 2020 revealed to new medication or Health to administer the to the hospital.  Review of Resident # Medication Administrative revealed:  -There was a handwr	at ordered clozapine with ication due to weekly labs d a resident with an order for we injection to be IN (#13).  It #2's current FL2 dated diagnoses included re (CHF), schizophrenia, ychosis and mood disorder.  It #2's physician's orders led paliperidone injection dose per month (a notic injection used to treat ce therapy for  2's progress notes for red on 01/25/20 (no timed in #5 still having behaviors with feces all over him and it up. The resident had been  2's progress notes for red on documentation related ders, contacting Home he paliperidone injection resident #2 having been sent  2's January 2020	D 273			

Nurse).

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
AND FEAT OF CONTRESTION		A. BUILDING: _		001111		
		HAL034150	B. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 ME	ADOWBROOK N	IALL COURT		
			NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 273	Continued From page	e 33	D 273			
		nentation paliperidone tered in January 2020.				
	revealed:	2's February 2020 MAR				
		itten entry for paliperidone e for 1 dose by Home Health				
	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 administeredShe knew she was not supposed to administer paliperidone injectionsShe did not know it was supposed to be administered by the HHNThe HHN had not come out to administer the paliperidone to Resident #2She 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.					
	Health agency on 02/ the Home Health age	esentative from the Home 106/20 at 11:40 am revealed ency never received an order tions to be administered by t #2.				
	(PCP) on 02/07/20 at	ent #2's primary care provider 8:55 am revealed: order for paliperidone				

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injections on 01/24/20 for 1 injection each month

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL034150	B. WING		02/11/	2020
	ROVIDER OR SUPPLIER	6010 MEA	DRESS, CITY, STA NDOWBROOK N NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 273	health provider (MHP Resident #2 had not rinjectionsResident #2 was adr 02/05/20 to an acute -Resident #2 not receinjections, among oth contributed to his hos Interview with Reside provider (MHP) on 02 revealed: -She had visited the F 01/24/20 and had rev medications on handThere was no palipe on 01/24/20She was so concerngetting the paliperidor Resident #2 was condecreased behaviors he did received his arincluding the paliperid-Resident #2 was adr 02/05/20 to an acute -The reason Resident hospital was likely be anti-psychotic medicapaliperidone injection Interview with a reprecontracted pharmacy revealed:	with Resident #2's mental ) and the MHP told her received paliperidone mitted to the hospital on psychiatric unit. giving his paliperidone er antipsychotic medications pitalization.  Int #2's mental health f/07/20 at 11:10 am  Resident at the facility on iewed the MARs and ridone injection at the facility and about Resident #2 not the injection because appliant, stable, had and less resistant to care if ntipsychotic medications done injection. mitted to the hospital on psychiatric unit. If #2 had to be sent to the cause he did not receive this ations including the  sentative from the on 02/10/20 at 10:50 am  ) 156 mg/mi injection 1 dose rrent order.	D 273			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
711272711	or contraction	IDENTIFICATION NO.	A. BUILDING: _			
		HAL034150	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	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE	
D 273	Continued From page 35		D 273			
	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 dayShe thought the HHN was supposed to be coming to administer paliperidone injections to Resident #2If 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 01/30/20If 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 HHShe had sent the order to another (named) HH agency to give the paliperidone injection to Resident #2If 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 form -The HH agency had Resident #2.	ner RCD revealed: not received any orders for				
	provided in-home per elderly. -This company was n provide Registered N by injection.	ot a HH agency and did not urse services for medication				
	<ul> <li>b. Review of Residen</li> </ul>	t #2's Colon Rectal Clinic				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAI 024450	B. WING		0.	2/44/2020
		HAL034150			02	2/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
THE IVY	AT CLEMMONS	6010 ME	ADOWBROOK MA	LL COURT		
11112117	TO OLEMINIONO	CLEMMO	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pag	e 36	D 273			
	visit dated 09/5/19 re-Resident #2 had init 2018.  -Resident #2 was red a small bowel obstrurequiredResident #2 had a bhis skin but did not h-There was some red the stoma and would therapy (Home Healt care and education.  Observation of Resid floor of the facility on revealed there were Interview with Reside (PCP) on 02/07/20 a -The Home Health N take care of the colos for the colostomy bay-The PCP was told both that Home Health (H#2 from HH services -It was not like HH to their services.  -The last time she say January 2020 and she walking around in the bag off and there wa over the front of his sinch the say of the colost of the colo	evealed: ial colostomy surgery in cently seen in the hospital for ction with no surgery ag for his ileostomy taped to ave an underlying wafer. dundant abrasions around be referred for enterostomal ch) for help with ileostomy  dent #2's room on the second 02/07/20 at 11:30 am no colostomy bags available.  ent #2's primary care provider t 8:55 am revealed: urse (HHN) was supposed to stomy and to start the order gs in September 2019. y staff in December 2019 H) had "dropped" Resident in just drop a resident from aw Resident #2 was in the noticed Resident #2 was the facility with the colostomy to showel movement (BM) all shirt. The mer Resident Care Director 20 to make sure to order the				
		` ,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL034150	B. WING		02 <i>l</i> ·	11/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		6010 ME	ADOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS	CLEMMC	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	÷ 37	D 273			
	was having behaviors	ò.				
	_	ad been coming out to see				
	, ,	discharged him from their				
	services sometime in	December 2019.				
	-She did not know wh	ıy Resident #2 was				
		did not know where to order				
	the colostomy bags fr					
		s supposed to supply the she was not sure what				
		just stopped coming".				
		were stored in Resident				
	#2's room.	Word Stored in reddiadric				
		dian to see if the guardian				
		my bags, but the guardian				
	had no idea where to	get the bags.				
	Interview with a repre	esentative from the HH				
	agency on 02/07/20 a					
		urse (HHN) came out to				
	-	tember 2019 for Resident #2				
	•	ation related to the care of				
		ion, bag placement and				
	colostomy bag suppli	es. er for the colostomy bags in				
		ordered as many as the				
	•	cording to the resident's pay				
		stomy bags for Resident #2				
		y company on 11/15/19.				
		N provided the contact				
		edical supply company to the				
		e Director (RCD) to order the				
	colostomy bags for R					
		former RCD aware that the				
		onsible for ordering the				
	colostomy bags going					
		scontinued on 12/12/19 for				
	and education; then t	HH only provided start-up he facility would be				

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responsible for following up and ordering the

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
THE IVY A	T CLEMMONS		ADOWBROOK M DNS, NC 27012	IALL COURT	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Interview with the RC revealed: -She did not know wh #2's colostomy bagsShe did not know wh ordering the bags"We did not know wh colostomy bags." -She had not contacte know what HH agence for the colostomy bagThe former RCD had on where and how state colostomy bagsStaff were told by the could not afford to but the resident would not colostomy bags.  Interview with a represupply company on 0 revealed: -The medical supply of faxing information to to primary care provider	that was the extent of HH #2.  Don 02/07/20 at 11:45 am nat happened to Resident no was responsible for nat to do about the ed HH because she did not by to contact about the order gs for Resident #2 d not shared the information aff were to order the e former RCD Resident #2 by the colostomy bags and of be getting any more	D 273		
	the PCP but never go or the PCP.  -The PCP had to sign complete an assessm company to deliver th -The PCP did not sign was the reason colos	ot a response from the facility  an authorization and  nent form for the supply			

4:30 pm revealed:

-She located an authorization form on 02/07/20

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STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	T CI EMMONE	6010 MEA	DOWBROOK N	IALL COURT	
INEIVIA	T CLEMMONS	CLEMMOI	NS, NC 27012		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 39	D 273		
		ply company in a stack of			
	been filed.	RCD's office that had never			
		#2's PCP but the PCP told			
	the RCD she was on				
		m had not been sent to the			
	PCP and had not bee	en signed.			
		sident Care Coordinator			
	(RCC) on 02/10/20 at 10:07 am revealed:				
		of colostomy bags about a			
	month ago.	vers to order the calcutemy			
	bags from.	nere to order the colostomy			
	_	ed HH about the colostomy			
		pecause she did not know			
		ical supply company the			
	colostomy had been				
	•	rator told the former RCD			
	not to order the colos	tomy bags for Resident #2			
	because the former A	dministrator was going to			
		pags from another supply			
	company, so the colo ordered.	stomy bags did not get			
		rator told staff she was not			
	going to order colosto	omy bags for Resident #2			
	because he was havi	ng behaviors.			
	Interview with a staff	on 02/10/20 at 10:20 am			
	revealed:				
		have any colostomy bags.			
		lostomy bags out of small			
	white trash bags or gl Resident #2.	loves and tape them on			
	Interview with a medi	cation aide (MA) on			
	02/10/20 at 11:25 am				
		lostomy bags out of small tape them on Resident #2.			

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-Resident #2 had been out of colostomy bags "for

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Division c	<u>of Health Service Regu</u>	lation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	≣TED
		HAL034150	B. WING		02/4	1/2020
		TAL034130			0411	1/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	ΓE, ZIP CODE		
TUE I\/V A	AT CLEMMONS	6010 ME/	ADOWBROOK M	ALL COURT		
INEIVIA	I CLEININIONS	CLEMMC	ONS, NC 27012			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	KEGULATURT ON L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
	<del>                                     </del>		+	<u>,                                      </u>		
D 273	Continued From page	∍ 40	D 273			
	a while" and staff did	not know what to do or				
	where to order the ba					
	Wildig to 0.25. 2.2	.90 110				
	Interview with a perso	onal care aide (PCA) on				
	02/10/20 at 11:55 am					
		around all the time without a				
	colostomy bag on.					
		ow if Resident #2 had any				
	colostomy bags or no					
	Interview with a seco	nd MA on 02/10/20 at 4:30				
	pm revealed:					
		omy bags ran out sometime				
	in December 2019.					
	_	get frustrated and take the				
	colostomy bags off ar					
		ney had to do when the				
	, ,	out; tape small trash bags on				
		a cloth on the stoma to keep				
	Resident #2 from mes	<del>-</del> -				
	-Resident #2 was cur	rently in the hospital.				
	Interview with the for	mar Administrator on				
	Interview with the form 02/11/20 at 11:50 am					
		ostomy bags and ran out				
	because the supply of					
		ags and the colostomy bags				
	ran out.	ys and the colocion, sage				
	-The former Administr	rator had ordered the				
		another medical supply				
		om the supply company set				
	up by HH.	113 1 3				
		ner supply company she had				
	conducted business v					
		ally sent the colostomy bags.				
	-When Resident #2 h	nad colostomy bags, he				
	would not keep the co	olostomy bag on.				
	Interview with the form	mer RCD on 02/11/20 at				

12:30 pm revealed:

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DIVIDION	i Health Service Regu	ı	_		1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	EIED
		HAL034150	B. WING		02/1	1/2020
NAME OF DE	ROVIDER OR SUPPLIER	STREET VL	DRESS, CITY, STA	TE ZIP CODE		
AVAIVIL OI FI	CONDEN ON OUR FEILIN		DOWBROOK M	,		
THE IVY A	T CLEMMONS			IALL COURT		
			NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROF		DATE
				DEFICIENCY)		
D 273	Continued From page	e 41	D 273			
	-Resident #2 was disc	charged from HH services in				
	December 2019.	3				
	-Forms were sent fro	m another (named) HH				
		sign to order the colostomy				
	bags form.	· ·				
	-The former RCD con	itacted another (named)				
	medical supply compa	any to order the colostomy				
	bags sometime in December 2019.					
	-Staff had to go pick the bags up from the					
	medical supply company.					
		gned by the PCP (date				
	unknown) and sent th					
	• •	ply company where (named)				
	•	der for colostomy bags from.				
	-If the colostomy bags	now and then she would go				
	• •	bags from the medical				
	supply company.	bags from the medical				
		ot keep the colostomy bags				
	on.	or keep the colosiomy bags				
	<b>5</b> 11.					
	Interview with a repre	sentative from another				
	•	on 02/11/20 at 2:00 pm				
	contacted by the form					
	-	no orders for Resident #2				
	and had not received	any orders for Resident #2.				
	-This company was a	Home Care agency and not				
		not provide colostomy				
	supplies.					
		sentative from another				
	• •	ply company on 02/11/20 at				
		the former RCD and former				
	Administrator reveale					
	company closed in Ja	anuary 2020.				
	Interview with a repre	sentative from a third				
		on 02/11/20 at 2:05 pm				
		ner RCD to supply colostomy				

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bags revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL034150	B. WING		02/1	1/2020
NAME OF PROVIDER OR SUPPLIER  THE IVY AT CLEMMONS	6010 MEA	DRESS, CITY, STA DOWBROOK M IS, NC 27012			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
bags for Resident #2The agency did not s  Attempted telephone if #2's Guardian on 02/0 02/11/20 at 10:00 am  2. Review of Resident 01/03/20 revealed dia schizoaffective disorder, a unspecific lesion of milling tervealed: -She had not received 02/03/20She was beginning to She was staying in heshe was supposed to before her prescription. Resident #1's labs we She had labs drawn to been given her clozapeshe asked the MAs of for her medicationsSince December 201 her clozapine every dashed in ot take here or two days in a row, is specific dates.  Telephone interview we Health Practitioner (Mirevealed:	upply colostomy bags. interviews with Resident 16/20 at 5:00 pm and on was unsuccessful.  It #1's current FL-2 dated gnoses included er, hypertension, major anxiety disorder, an ucosa.  Int #1 on 02/06/20 at 1:00pm It clozapine twice daily since of feel very anxious. er room to feel better. In have labs drawn weekly In could be refilled. It ere not drawn weekly. In on 02/04/20 but she had not bine. In every shift since 02/04/20  9 she was not administered ay. It clozapine for more than one but she could not remember  It with Resident #1's Mental IHP) on 02/06/20 at 5:03pm  Interviews with Resident #0 on page 1.5.03pm  Interviews with Resident #1's Mental IHP) on 02/06/20 at 5:03pm  Interviews with Resident #1's Mental IHP) on 02/06/20 at 5:03pm  Interviews with Resident #1's Mental IHP) on 02/06/20 at 5:03pm  Interviews with Resident #1's Mental	D 273			

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submitted to registry so clozapine was dispensed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	-	
THE IVV A	T CLEMMONS	6010 MEA	ADOWBROOK N	IALL COURT		
	TI CELIMINIONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 43	D 273			
	by the pharmacyWhen Resident #1 m that was not submitter registry began requiring done weekly.  Review of physician of 01/03/20 revealed and Telephone interview with the facility's contracted department on 02/06/2-They visited the facilial labs ordered for the 1-The lab received ord 11/12/19, 11/26/19, 02-The results were fax. Resident #1's CBC with 11/26/19, 01/07/20, and 11/26/19, 01/07/20, and 01/28/2-Resident #1's CBC Is 11/26/19, 01/07/20, and Resident #1's CBC Is 11/26/19, 01/07/20, and Resident #1's white collimits.  Telephone interview with the facility's contracted 3:15pm revealed: -Resident #1's clozap CBC to the FDA (Foo	nissed a monthly CBC draw d in December 2019 the ng a CBC blood draw to be orders for Resident #1 dated order for CBC weekly.  With a representative from ad lab phlebotomy 20 at 4:25pm revealed: ity every Tuesday to collect e residents.  ers for CBCs drawn on 1/07/20, and 02/04/20.  ed to the facility when as drawn on 11/12/19, and 02/04/20.  a CBC for Resident #1 in the order dated 01/03/20 for and therefore they did not ident #1 on 01/14/02, 20.  ab results on 11/12/19, and 02/04/20 indicated ell count were within normal with a representative from ad pharmacy on 02/06/20 at the required submission of a d and Drug Administration)				
	registry prior to being -Prior to dispensing R registry was checked completed.	lesident #1's clozapine the				

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-He was not capable of reviewing when a CBC

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STATEMENT OF DEPICIENCES AND PLAN OF CORRECTION DEPICE DEPICE DEPICE OF THE IVY AT CLEMMONS    MAIL SUBMINIST   STREET ADDRESS, CITY, STATE, ZIP CODE	Division of	<u>of Health Service Regu</u>	lation			
NAME OF PROVIDER OR SUPPLIER  THE IVY AT CLEMMONS  SITURDATE OF PROVIDER OR SUPPLIER  THE IVY AT CLEMMONS  SUMMARY STATEMENT OF DEFICIENCES  (EACH DEFICIENCY MUST BE PRECEDED BY PLUL PRECH TAG  (EACH DEFICIENCY MUST BE PRECEDED BY PLUL PRECH TAG  (EACH DEFICIENCY MUST BE PRECEDED BY PLUL PRECH TAG  (EACH DEFICIENCY MUST BE PRECEDED BY PLUL PRECH TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCES TO THE APPROPRIATE DATE  D273  Continued From page 44  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 12/21/19 12/17/19. 01/03/20, 01/11/20, 01/12/6/20.  -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 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 is also so the could get her clozapine.  Interview with the RCD on 02/07/20 at 12:00pm revealed:  -She was hired 02/08/20.  -She was hired 02/08/20.  -She was hired 02/08/20.  -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				(X2) MULTIPLE	CONSTRUCTION	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE  610 MEADOWBROOK MALL COURT CLEMMONS, No. 27012  DYA) ID PREFIX TAG  CROUNDERFORM STATEMENT OF DEFICIENCIES I EACH DEFICIENCY MUST BE PRECEDED BY PULL PREFIX TAG  CROSS-REFERRACED TO THA APPROPRIATE ONTE ONTE ONT	AND PLAN (	)F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE  610 MEADOWBROOK MALL COURT CLEMMONS, No. 27012  DYA) ID PREFIX TAG  CROUNDERFORM STATEMENT OF DEFICIENCIES I EACH DEFICIENCY MUST BE PRECEDED BY PULL PREFIX TAG  CROSS-REFERRACED TO THA APPROPRIATE ONTE ONTE ONT						
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE  610 MEADOWBROOK MALL COURT CLEMMONS, No. 27012  DYA) ID PREFIX TAG  CROUNDERFORM STATEMENT OF DEFICIENCIES I EACH DEFICIENCY MUST BE PRECEDED BY PULL PREFIX TAG  CROSS-REFERRACED TO THA APPROPRIATE ONTE ONTE ONT			HAI 024450	B. WING		00/44/0000
CLEMMONS   CLEMMONS			HALU34150			02/11/2020
THE INVAT CLEMMONS  CLEMMONS, NC. 27012  (PA) ID FREFIX IND.  SUMMARY STATEMENT OF DEFICIENCIES  FREFIX IND.  D FROUDT OR LOCATION ONLY BE PRECEDED BY FULL REGULATORY OR LOCATION ONLY DEPRETIX IND.  D 273  Continued From page 44  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.  Interview with a second shift medication aide (MA) on 02/06/20 at 3.55pm revealed:  -Resident #1's 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 contact 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 and her labd an order for a CBC to be drawn weekly.  -She did not know Resident #1 did not have any	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
CLEMMONS, No. 27012   SUMMARY STATEMENT OF DEFICIENCIES   FRONDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTIO	no.	: =:::::::::::::::::::::::::::::::::	6010 ME	ADOWBROOK M	IALL COURT	
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revealed: -She was hired 02/06/20She did not know Resident #1 had an order for a CBC to be drawn weeklyShe did not know Resident #1 did not have any		olozapine.				
revealed: -She was hired 02/06/20She did not know Resident #1 had an order for a CBC to be drawn weeklyShe did not know Resident #1 did not have any		Interview with the RC	D on 02/07/20 at 12:00pm			
-She was hired 02/06/20She did not know Resident #1 had an order for a CBC to be drawn weeklyShe did not know Resident #1 did not have any			2 0.1 02/01/20 at 12.00p			
-She did not know Resident #1 had an order for a CBC to be drawn weeklyShe did not know Resident #1 did not have any			5/20.			
CBC to be drawn weeklyShe did not know Resident #1 did not have any						
-She did not know Resident #1 did not have any						
			,			

-The MAs were expected to notify her of all issues with following up on lab draws.

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Division c	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			B. WING			
		HAL034150	B. WING		02/1	1/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		6010 MF	ADOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS		ONS, NC 27012	IALL GOOK!		
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
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				DEFICIENCY)		
5.070			5.070			
D 273	Continued From page	∍ 45	D 273			
	-The MAs failed to tel	ll her about Resident #1's				
	missing clozapine and					
		a labe.				
	Telephone interview v	with Resident #1's Mental				
		MHP) on 02/06/20 at 5:03pm				
	revealed:	1111 ) 011 02/00/20 at 0.00pin				
		saw Resident #1 she was				
		been drawn since 01/07/20.				
		have a CBC drawn on				
	01/14/20, 01/21/20, a					
		spitalized within the last year				
		d hallucinations and anxiety.				
		at #1 not continuously having				
ļ		ly to get her clozapine could				
		and increased anxiety that				
		urt herself and other people.				
	_	to monitor Resident #1 for				
	• •	hite cell count) which puts				
	Resident #1 at risk fo	r serious and fatal				
	infections.					
	_	required because Resident				
		nanaged by the REMS (Risk				
		ation Strategy) program.				
ļ	. •	was a FDA mandated				
	program implemented	d by the manufacturers of				
	Clozapine.					
	-The REMS program	was intended to help				
	Healthcare Providers	ensure the safety of				
	patients on Clozapine	<b>)</b> .				
	Interview with the Adr	ministrator 02/07/20 at				
	12:30pm revealed:					
	-He was hired yesterd	day (02/06/20).				
		s to ensure all the residents'				
	health care needs we	ere completed.				
	-The MAs should rep	ort any issues to the RCD.				
		yesterday (02/06/20), and				
		opportunity to audit the				
		orders pertaining to all				
,		p	·	1		

referrals and follow ups.

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DIVISION	of Health Service Regu	lation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING			02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
		6010 ME	ADOWBROOK M	IALL COURT			
I HE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 273	Continued From page	÷ 46	D 273				
	O2/11/20 at 10:44am -Her last day of work -Resident #1 knew sh prior to clozapine bein pharmacyResident #1's MHP of drawnThe MHP was respo #1's labs were submit -She had encountered pharmacy caused wit -When Resident #1 m drawn monthly, she re order from the MHPResident #1 was able MAs to have her labs -Because Resident # MAs she did not follow weekly lab order was serviceShe did not audit the orders, and MARs be understaffed, and she medications. 3. Review of Residen 02/26/19 revealed did depression, anxiety, re obstructive pulmonary esophageal reflux dis failure. Review of Resident #	was 01/30/20.  Ite required a CBC drawn and dispensed by the  ordered monthly CBCs to be  misible for ensuring Resident atted to the registry. Ited a lot of errors the facility's In Resident #1's clozapine. Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested a weekly CBC  The to continuously remind the Inissed having her labs requested having her labs requ					

Division of Health Service Regulation

Medication Administration Record (MAR)

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
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		HAL034150	B. WING	<del></del>	02/	11/2020
NAME OF D	DOVIDED OD CURRUED	CTREET AR	DRESS, CITY, STA	TE 710 CODE		
NAME OF PI	ROVIDER OR SUPPLIER		, ,	•		
THE IVY A	T CLEMMONS	6010 MEA	DOWBROOK N	MALL COURT		
		CLEMMOI	NS, NC 27012			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
				DEI ICIENCI)		
D 273	Continued From page	Δ7	D 273			
	. •					
	revealed there was no	o entry for Humira 40mg				
	every 14 days.					
	Review of Resident #	13's January 2020 MAR				
	revealed:					
	-An entry for Humira I	Pen injection 40mg/.4 ml				
	inject 1 pen under the					
	•	9 and 01/28/19 were circled				
	with no initials docum					
		nentation of administration of				
		anation for not administering				
	for the month of Janu					
	ior the month of dana	ury 2020.				
	Review of Resident #	13's February MAP				
	revealed:	135 February WAR				
		Dan inication 40mm/ 4 ml				
		Pen injection 40mg/.4 ml				
	inject 1 pen under the					
		0, 02/02/20, and 02/03/20				
	were initialed and circ	<u> </u>				
	medication was not a					
	•	Iministering the Humira.				
		0, 02/05/20 and 02/06/20				
	were initialed and doo	cumented as administered.				
		nt #13 on 02/07/20 at				
	9:55am revealed:					
	-A doctor had ordered	d the Humira injection for				
	Resident #13's arthrit	is about a month ago.				
	-Resident #13 had no	t received any doses of the				
	Humira injection.					
	Interview on 02/07/20	at 10:20am with the				
	Medication Aide (MA)					
	-She usually administ					
	another floor.					
		ocate the Humira injection for				
	Resident #13.					
	** *	y the Humira injection had				
	not been administere					
	HOLDERH AUTHINSTELE	u to 1153145111 #13.	1			

Division of Health Service Regulation

-The Humira injection would have to be

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Division	of Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
THE IVY A	T CLEMMONS		ADOWBROOK N	MALL COURT		
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D 070	0 " 15	10	D 070			1
D 273	Continued From page	e 48	D 273			
	administered to Resid	dent #13 by a nurse with				
	home health.					
	Interview on 02/07/20	•				
		inator (RCC) revealed:				
	-	he RCC for 2 days and was				
	new to the facility.	:				
	-She did not know Resident #13 had a Humira					
	injection orderedShe had not had the opportunity to review all the					
	resident records, and had not reviewed the record					
	for Resident #13.	nad not reviewed the record				
	ioi resident #10.					
	Interview on 02/07/20	at 12:30pm with the				
	Resident Care Direct	•				
	-She had been the Ro	•				
	-She did not know Re	esident #13 had a Humira				
	injection ordered.					
		e Humira injection had not				
	been administered to	Resident #13.				
	linkami avvividla a aandm					
	Interview with a contr					
	-One pen of the Hum	10/20 at 10:25am revealed:				
	12/20/19.	ila was disperised on				
		ection 40mg/.4 ml pen had				
	not been refilled for R					
		ve to request any refills for				
	the Humira Pen inject					
	-	-				
	Interview with a repre	esentative for the prescribing				
	T	at 10:25am revealed;				
		Resident #13 to start the				
		40mg/.4 ml inject 1 pen				
	under the skin every	_				
		ot know the Humira had not				
	been administered to	Resident #13.				
	The facility failed to a	 nsure referral and follow-up				
		providers concerning missed				
	paidi oaio p		1	j .		1

Division of Health Service Regulation

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		6010 MEAI	OWBROOK N	IALL COURT		
THE IVY A	T CLEMMONS	CLEMMON	S, NC 27012			
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D 273	73 Continued From page 49		D 273			
	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 338	10A NCAC 13F .0909	Resident Rights	D 338			
	all residents guarante	hall assure that the rights of eed under G.S. 131D-21, ents' Rights, are maintained				
	This Rule is not met TYPE A2 VIOLATION					
	facility failed to ensur (Resident #11, #9, #2 neglect resulting in a	ews and interviews the e 3 of 8 sampled residents 2) were free of abuse and resident being physically d by a personal care aide				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020	
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA ADOWBROOK M			
THE IVY A	T CLEMMONS		NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	÷ 50	D 338			
	assistance with activity	dent required extensive ties of daily living (#9), and a adequate colostomy care or £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 feetResident #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 #11The report noted the suspect (Staff D) assaulted victim (Resident #11) by punching.					
	revealed: -There was a simple a between Resident #1	1 and Staff D. suspect (Resident #11)				
	Staff D was in the sec	o/20 at 12:45 pm revealed cond floor common room t residents for the lunch				
	Observation on 02/06	i/20 at 12:50 pm revealed				

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Staff D provided prompting for a resident to

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Division of Health Service Regulation		_				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL034150	B. WING		02/11/2020	
			-		1 02/1	172020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 MEA	DOWBROOK N	MALL COURT		
		CLEMMO	NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
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			+			
D 338	Continued From page	e 51	D 338			
	complete her lunch m	neal.				
	·					
	Observation on 02/06	6/20 at 1:55 pm revealed				
	Staff D was working of	on the second floor and				
	exiting a resident's ro	om after providing personal				
	care assistance to the	e resident and speaking very				
	loudly to the resident.					
	Interview with Staff D on 02/06/20 at 12:05 pm					
	revealed:					
	-She was the Persona	al Care Aide (PCA)				
	supervisor.					
		ssigned to the second floor				
	as the PCA.					
	Interview with Reside	ent #11 on 02/07/20 at				
	12:54pm revealed:	11 # 11 011 02/01/20 at				
	•	fter she moved into the				
		ncident that took place				
	between Resident #1	•				
		attacked by Staff D on				
	01/20/20.	•				
	-She did not why Staf	ff D and the previous				
	Administrator had cor	me at her yelling and telling				
	her to go into her room	m.				
	-She went into her roo	om and closed her door.				
	-Staff D came into Re	esident #11's room and				
		Resident #11 was inside.				
		t #11 began arguing and				
	Staff D physically atta					
		d she was taken to the				
	hospital.					
	-	y injuries as a result of the				
	attack.	or hitting Stoff D				
	-She did not remember	ei nilling Staπ D.				
	Interview with a house	ekeeper on 02/07/20 at				
	10:00am revealed:	0.00pci 011 02/01/20 at				
	. J. J J J J I I I J J J J J J J J J J J		1	1		1

Division of Health Service Regulation

Resident #11 and Staff D.

-She witnessed the incident on 01/20/20 between

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:			COMPL	ETED
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			B. WING			
		HAL034150	D. WING		02/1	1/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
		6010 MF	ADOWBROOK M	ALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012	7.122 GOGN.		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
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				,		
D 338	Continued From page	e 52	D 338			
	Staff D and Davidant	t #11 was valling at each				
		t #11 was yelling at each				
	other when Resident					
	-Resident #11 went in					
		or came up to Resident #11's				
	room.					
		inistrator went into Resident				
	#11's room.					
		inistrator began yelling at				
	Resident #11 calling I					
	-Resident #11 said "I	· -				
		t #11 "you don't know who				
	you're dealing with".					
		ft Staff D in Resident #11's				
		ed the door telling Staff D to				
	deal with Resident #1					
	_	ing and cussing between				
	Resident #11 and Sta					
	-She heard a loud cra	ack and items in the room				
	being thrown.					
	-The police came and	d Resident #11 left in an				
	ambulance.					
		Resident #11's room to				
	clean it Resident #11'	's clothes and personal				
	items were scattered					
	-Resident #11's room	was a mess.				
		r personal care aide (PCA)				
	on 02/07/20 at 10:29a					
		ncident on 01/20/20 between				
	Resident #11 and Sta	= :				
	-Resident #11 hit Stat	ff D when they were having				
	an argument.					
	_	nent from the other end of				
	the hallway.					
	-Staff D was very bos	sy and loud with the				
	residents and cowork	ers.				
	-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

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	VEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	ΞD
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		HAL034150	D. WIIVO		02/11/2	2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		6010 ME	ADOWBROOK N	IALL COURT		
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(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
D 338	Cantinuad Francisco	- 52	D 338			
D 330	Continued From page	= 55	D 336			
	closed.					
	-Resident #11 and Sta	aff D continued to yell at				
	each other with the de	oor closed.				
	-The police and ambu	ılance came to take				
	Resident #11 to the h	ospital.				
	Interview with a resident on 02/07/20 at 10:40am revealed: -She witnessed the incident between Resident #11 and Staff D on 01/20/20Staff D was yelling at Resident #11 on 01/20/20					
	when Resident #11 hi	it Staff D.				
	Interview with the Adr	ministrator on 02/07/20 at				
	12:00pm revealed:					
	-Staff D was a curren	t employee and worked at				
	the facility for approxi	mately eight years.				
	-	ner Administrator on the				
	=	ncident that took place on				
		sident #11 and Staff D today				
	(02/07/20).					
		rator told him Staff D was				
	•	he residents and coworkers.				
		orker so she was able to				
	accept Staff D's beha					
	-	strator did not suspend Staff				
		orm an investigation into the				
	incident that took place	ce on 01/20/20.				
	0 D : (D :1					
		t #9's FL2 dated 09/07/19				
	revealed:	achizanhrania azzl				
	-Diagnoses included	эспідорпіеніа, апо				
	blindness.	ni ambulatary				
	-Resident #9 was sen -Resident #9 was inco					
	-rtesident #9 was inco	ontinent of pladdel.				
	Pavious of Pasidant #	0's care plan dated 12/21/10				
		9's care plan dated 12/31/19				
	revealed Resident #9	requirea extensive				

assistance with eating, toileting, ambulation, bathing, grooming, dressing, and transfers.

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Division c	of Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
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		HAL034150	B. WING	<del></del>	02/1	1/2020
NAME OF DE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZID CODE		
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THE IVY A	T CLEMMONS		DOWBROOK N	MALL COURT		
		CLEMMO	NS, NC 27012			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
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D 338	Continued From page	- 54	D 338			
2 000	Continued i form page	3 04				
	Interview with Reside	nt #9 on 02/06/20 at				
	12:30pm revealed:				ļ	
	-Resident #9 was blin	nd.			ļ	
	-She needed assistar	nce finding her clothes and			ļ	
					ļ	
	belongings because she was blindShe needed staff to come and remind her of					
	<ul> <li>-She needed staff to come and remind her of meal times.</li> <li>-She had missed meals and wore the same clothes because she couldn't find clean ones in</li> </ul>					
		couldn't lind clean ones in				
	her room.					
	-Staff D told her to do	_				
	•	g Staff D to help her do			ļ	
		e was very loud and mean.			ļ	
	-There was only one	PCA she would allow to help			ļ	
	her when she needed	d help.			ļ	
	Telephone interview v	with the previous			ļ	
	· · · · · · · · · · · · · · · · · · ·	1/20 at 9:50am revealed:			ļ	
	-Resident #9 was able	e to do for herself			ļ	
		problem counting her money				
	and swinging her can					
	something.	e when she wanted			ļ	
		only one PCA to help her				
	when she needed hel	•				
	-Resident #9 refused					
		when she offered to do				
	something for Reside	ent #9.				
	<ol><li>Review of Residen</li></ol>	it #2's current FL2 dated				
	02/26/19 revealed:					
	-Diagnoses included	congestive heart failure				
	(CHF), schizophrenia	i, anxiety, insomnia,				
	psychosis and mood					
	-Resident #2 was am					
	-Resident #2 had a co					
	ROSIGOTIL #2 Had a Cl	olostomy.				
	Review of Resident #	2's December 2019			ľ	
	TOVIOUS OF INCOMORDER	_ 0 D000111001	1	1		i l

Division of Health Service Regulation

progress notes revealed:

-On 12/08/19 at 12:30 am, Resident #2 was

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL034150	B. WING		02/11/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
<b>THE DOCA</b>	- 0	6010 MEA	ADOWBROOK N	IALL COURT		
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 338	Continued From page	÷ 55	D 338			
	cleaned up and a new applied. The resident his shirt that had bow -On 12/09/19 (no time would not let staff characteristics) and on 12/31/19 at 11:00 #2 would not let staff Review of Resident # notes revealed: -On 01/01/20 (no time would not let staff characteristics) and on 1/02/20 (no time would not let staff characteristics) and on 1/03/20 and 01/documented), Resided check his stoma or characteristics and on 1/17/20 at 10:30 let staff change his should not let staff characteristics and BM all over him a change his clothesOn 01/27/20 at 7:00 would not let staff characteristics and not let staff characteristicsOn 01/27/20 at 7:00 would not let staff characteristics with a media 02/07/20 at 10:00 am -Resident #2 went to ago (dated unknown) colostomy bags and reduced the staff characteristics.	w colostomy bag was would not let staff change el movement (BM) on it. el documented), Resident #2 ange his clothes.  I) pm to 7:00 am, Resident change his clothes.  2's January 2020 progress el documented), Resident #2 ange his colostomy bag. aff would "mess up" his el documented), Resident #2 eck his stoma or change his colothes.  I) pm, Resident #2 would not let staff nange his clothes. I) pm, Resident #2 would not nirt with BM on it and put a rty shirt. It documented), Resident #2 and would not let staff nam to 3:00 pm and man t				
	dining room, took his	colostomy bag off and r in front of other residents				

Division of Health Service Regulation

-Staff cleaned it up and that was all staff did.

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6010 MEADOWBROOK MALL COURT  CLEMMONS, NC 27012  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 338  Continued From page 56  -He would not let staff do anything for him; check his colostomyHe had run out of colostomy bags a month ago and he would not let staff help himHe 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							
THE IVY AT CLEMMONS  CLEMMONS, NC 27012    CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   D 338   Continued From page 56   -He would not let staff do anything for him; check his colostomyHe 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 himHe 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			HAL034150	B. WING		02/1	1/2020
CLEMMONS, NC 27012  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 338  Continued From page 56  -He would not let staff do anything for him; check his colostomyHe 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 himHe 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	NAME OF P	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
(X4) ID PREFIX TAG    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   D PREFIX TAG     D PREFIX TAG   D PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   D 338     D 338   Continued From page 56	THE IVY A	AT CLEMMONS			IALL COURT		
-He would not let staff do anything for him; check his colostomyHe 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 himHe 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	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
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	D 338	Continued From page	e 56	D 338			
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.		-He would not let staff his colostomyHe would run around -He had run out of co and he would not let staff his colostomyHe was able to care would check the bag and check the stoma.  Interview with Reside (PCP) on 02/07/20 at -The last time she sar January 2020 and sh walking around in the bag off and there was over the front of his s -She had told the forr (RCD) in January 202 colostomy bags for R  Interview with the Re 02/10/20 at 10:07 am -The previous Admini was not going to order Resident #2 because -Resident #2 because -Resident #2 kept tak or he would not leave -The colostomy bags where to order the bar -The former RCD wor #2 would have BM or Resident #2 alone.  Interview with a hous at 10:20 am revealed -She noticed Resider bowel movement (BM)	If do anything for him; check If the hall with no "bag on". Illostomy bags a month ago staff help him. If or his own colostomy; staff and help to apply the bags Int #2's primary care provider It 8:55 am revealed: If we Resident #2 was in If e noticed Resident #2 was If acility with the colostomy If showel movement (BM) all hirt. If the resident Care Director If the to order the esident #2. It is ident Care Coordinator on the revealed: If the was having behaviors. It is ing the colostomy bags for the was having behaviors. It is ing the colostomy bags on. If an out and no one knew the colostomy bags on. If an out an out				

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staff to leave Resident #2 alone and not clean

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Division c	Division of Health Service Regulation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		
		1141 004450	B. WING		00/44/0000
		HAL034150			02/11/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
THE 00/ A	T 01 F14140110	6010 MEA	ADOWBROOK N	IALL COURT	
THE IVY AT CLEMMONS  CLEMMON		NS, NC 27012			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
D 338	Continued From page	e 57	D 338		
	him un				
	him up.	on Decident #2 went into			
		nen Resident #2 went into			
	•	on the first floor and took			
		threw it in the floor where			
	the other residents we	S .			
	-Housekeeping had to	o come and clean it up.			
	Intorviou with a resid	ont on 02/10/20 at 4:45 nm			
	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.				
		t sure when this happened.			
		ng in the dining room and the			
	resident did not like th	-			
		back out of the dining room			
	and staff went after R				
		n and cleaned up the mess			
	on the floor.	Tana dicanca ap ino moco			
		esident #2 walking around			
		h his clothes and "it did not			
	smell so good either".				
	3				
	Interview with a secon	nd resident on 02/10/20 at			
	4:53 pm revealed:				
		bered Resident #2 came			
	running into the first f	loor dining room, took his			
	colostomy bag off and	d dropped it on the dining			
	room floor while resid				
		Resident #2 and another			
		the colostomy bag off the			
	floor.				
		t able to finish the meal and			
	"that was not right".				
	1-4	idt 00/40/00			
		resident on 02/10/20 at 5:00			
	pm revealed:	manina into the Cost Co			
		unning into the first floor			
		ped a colostomy bag on the ethe resident was eating.			
	anning room noor will	e uie resident was eathig.	1		

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Division c	<u>of Health Service Regu</u>	lation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPI	LETED
	l					
		HAL034150	B. WING		02/	11/2020
NAME OF D		OTDEET		T. 710 0005		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
THE IVY A	AT CLEMMONS		ADOWBROOK MA	ALL COURT		
1			ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 338	Continued From page	÷ 58	D 338			
	another staff came in -This was very disturb	bing. en Resident #2 in the facility				
	02/10/20 at 11:55 am -Resident #2 walked a bag over his colostom -He always had BM o saw the resident walk -Staff would clean Re	around all the time without a ny. on his shirt when the PCA				
	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 shirtWhen Resident #2 resisted staff assistance to get cleaned up, the former Administrator would tell staff to just walk away.					
	care and colostomy care and colostomy care -Resident #2 was inde	revealed: not let staff provide personal				
	12:30 pm revealed: -Resident #2 would not help himResident #2 walked a colostomy bag and we himself.	mer RCD on 02/11/20 at not let staff take care of him around all the time with no would have BM all over ostomy bags, he just took				

the colostomy bag off.

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL034150	B. WING		02/11/2020	
	ROVIDER OR SUPPLIER	6010 MEAD	PRESS, CITY, STA DOWBROOK N IS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	give him a shower.  -About once a week F around the facility with -Staff would try to red personal care, clean I and clean the stoma.  -Resident #2 only need colostomy care.  -Staff would offer food	clean Resident #2 up and Resident #2 would run h no colostomy bag on. lirect Resident #2, do him up, change his clothes	D 338			
	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.					
	CORRECTION DATE	. 131 D-34 on 02/07/20.				
D 358	10A NCAC 13F .1004 Administration	₊(a) Medication	D 358			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
	HAL034150 B. WING			02/1	11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		DOWBROOK N	IALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	NS, NC 27012  ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 60	D 358			
	(a) An adult care hor preparation and admit prescription and non-by staff are in accorda (1) orders by a licens which are maintained (2) rules in this Section and procedures.  This Rule is not met TYPE A2 VIOLATION  Based on observation reviews, the facility farmedications as order (Residents #1, #10, # during the morning medication for schizo bronchodilators (#10) a medication for dry ethinner (#14); and for (Residents #1, #2, #3 review related to a medication (#1) antipsychotic medication (#5).  The findings are:  1. The medication errevidenced by the obsopportunities during ton 02/07/20.	sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by:  Ins, interviews and record illed to administer ed for 4 residents and #14) observed edication pass related to a phrenia (#1), 2 an asthma medication, and eyes (#13) and a blood 5 of 5 sampled residents (#4, and #5) for record edications (#2), and thinner, and two dications (#3), 2 ations (#4), a diuretic				

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02/26/19 revealed:

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Division o	of Health Service Regu	lation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X	X3) DATE SI COMPLE	
ANDIEAN	or contribution	IDENTIFICATION NOWIDER.	A. BUILDING: _			OOWII EE	
		HAL034150	B. WING			02/1	1/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE			
THE NOVA	T OLEMNONO	6010 ME	ADOWBROOK N	MALL COURT			
THE IVY AT CLEMMONS  CLEMMO		NS, NC 27012					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIAT		(X5) COMPLETE DATE
D 358	Continued From page	e 61	D 358				
	-Diagnoses included hypertension, chronic disease (COPD), gas disease (GERD), pair -There were physiciar -Clonazepam 1mg the panic attacks)Advair 1 puff twice de -Artificial Tears 2 drop (used to treat dry eye Observation of a med morning medication prevealed: -The MA prepared an medications to Reside medications to Reside medications schedule the morning medication. The MA did not admit Advair 1 puff and artiff Resident #13.  Review of Resident # Medication Administrative aled: -There was an entry for times daily at 8:00am -Clonazepam 1mg was administered on 02/00-There was an entry for 1 puff twice daily at 7-Advair 250/50mg was administered on 02/00-There was an entry for drops twice daily at 7-drops twice daily at 7-dr	bipolar depression, anxiety, cobstructive pulmonary stroesophageal reflux and kidney failure. In's orders for: ree times daily (used to treat aily (used to treat as thina). In the property of the property o					
	Observation of medic	ations on hand for Resident					

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#13 on 02/07/20 at 9:55 am revealed clonazepam

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		HAL034150	B. WING		02/	11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	NOVIDER OR GOLF EIER		DOWBROOK N	·		
THE IVY A	T CLEMMONS		NS, NC 27012	MALL COURT		
			NS, NC 27012	T		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APP		DATE
				DEFICIENCY)		
D 358	Continued From page	e 62	D 358			
	. •					
	available for administ	and artificial tears were not				
	avaliable for autilities	ration.				
	Interview on 02/27/20	at 9:55 am with the				
	Medication Aide (MA)					
	-There was no clonaz	epam 1 mg available for				
	administration for Res					
		nented as administered was				
	on 02/04/20, three da					
	-There was no Advair					
	administration for Res	Advair 250/50 documented				
	as administered to Re					
	02/06/20.	esiderit #13 was on				
	-There was no artificia	al tears available for				
	administration to Res					
	-The last dose of artif	icial tears documented as				
		dent #13 was on 02/06/20.				
		MA's responsibility to order				
		pharmacy, but she was not				
	usually working on thi	is medication cart.				
	Interview on 02/10/20	at 11:20cm with the				
		representative revealed:				
		quest refills as needed for				
	•	, Advair 250/50 and the				
	artificial tears for Res					
	-The clonazepam 1m	g was dispensed on				
	02/08/20 with 60 table					
	-The clonezepam 1m	<del>-</del>				
	01/04/20 with 45 table	= = = :				
		as dispensed on 10/06/19,				
	with a 30 day supply.	annual de la compansa				
	-No refills had been re the Advair 250/50 for	equested from the facility for				
		resident #13. as dispensed on 10/02/20,				
	with a 30 day supply.					
		equested from the facility for				
	the artificial tears for I					

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DIVISION	n Health Service Negu	ialion					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	COMPLETED	
		HAL034150	B. WING		02/	11/2020	
		11/12004100			1 02/	11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE			
THE IVY A	T CLEMMONS	6010 MEA	DOWBROOK N	MALL COURT			
		CLEMMO	NS, NC 27012				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)	
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL		COMPLETE DATE	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	TOPRIATE	B/IIE	
			+				
D 358	Continued From page	e 63	D 358				
	Interview on 02/10/20	at 10:15 am with Resident					
	#13's primary care pr	ovider (PCP) revealed:					
		cility to keep prescribed					
	medications on hand	for administration and to					
	administer medication	ns as ordered.					
	-The clonazepam 1m	g was prescribed because					
	Resident #13 was ver	ry anxious.					
	-The Advair 250/50 w	as prescribed because					
	Resident #13 had CC	PD.					
	-The artificial tears wa	as prescribed to Resident					
	#13 for dry eyes.						
	-She was not aware t	he clonazepam 1mg, Advair					
	250/50 or the artificial	l tears were not available for					
	administration to Res	ident #13.					
		experience a greater risk of					
		thing difficulty or dry eyes by					
	•	azepam 1mg, Advair 250/50					
	or artificial tears as or	dered.					
	Intomicus with Deside	mt #42 am 02/07/20 at					
		nt #13 on 02/07/20 at					
	2:20pm revealed;	e frequently out of stock and					
		to administer medications					
	as ordered.	to administer medications					
		e facility staff to provide					
	medications as order						
	medications as order	ed by her physician.					
	Refer to telephone int	terview with the previous					
	Administrator on 02/1						
	b. Review of Residen	t #10's current FL2 dated					
	08/22/19 revealed:						
	-Diagnoses included	encephalopathy, chronic					
	pain syndrome, anxie						
		y disease (COPD), muscle					
	weakness and major	, ,					
	-There was a physicia						
	Handihaler 18mcg inh	nale 1 capsule once daily					
	(used to treat COPD)	•					
	-There was a physicia	an's order for Ventolin HFA					

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Division of	of Health Service Regu	lation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL034150	B. WING	B. WING		02/11/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE			
THE NAV A	T OLEMMONE	6010 MEA	ADOWBROOK N	IALL COURT			
THE IVY AT CLEMMONS CLEMMO		NS, NC 27012					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	<del>2</del> 64	D 358				
	inhale 2 puffs into lungs every 6 hours as needed for wheezing (used to treat COPD).						
	morning medication pat revealed:  -During the medication requested the schedulation the as needed ventolicular and the as needed ventolicular and the as needed ventolicular and the spiriva handihale were not administered. The MA was observed medications were not order the medications.  Review of Resident # medication administration administration.  -There was an entry finhale 1 capsule once -Spiriva handihaler was documented as adminiam.  -There was an entry finhale 1 capsule once -Spiriva handihaler was an entry finhale 1 capsu	alled spiriva handihaler and in.  er 18mcg and ventolin HFA d to Resident #10.  ed to tell Resident #10 the available and she would as as soon as possible.  10's February 2020 ation record (MAR) revealed: for spiriva handihaler 18mcg e daily at 7:00 am.  as left blank and not nistered on 02/07/20 at 7:00  for ventolin HFA inhale 2 6 hours as needed for nentation of administration 20.  ations on hand for Resident 15 am revealed neither the mcg nor the ventolin HFA ministration.					
	Medication Aide (MA) -Neither the spiriva haventolin HFA were no for Resident #10.	revealed: andihaler 18mcg nor the					

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cart, but knew it was the MA's responsibility to

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
			B. WING		l	
		HAL034150	B. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE		
			DOWBROOK N			
THE IVY A	T CLEMMONS			MALL COURT		
		CLEMMON	NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	NEGOLATORT OR I	100 IDENTIFY TING IN ONWATION)	TAG	DEFICIENCY)	WAIL	
D 358	Continued From page	e 65	D 358			
	order medications.					
		w long the spiriva handihaler				
	18mcg and the vento					
	unavailable for admin	istration to Resident #10.				
	Interview on 02/10/20					
		representative revealed:				
	•	er 18mcg for Resident #10				
		/25/19 with a 30 day supply.				
		equested any additional				
	refills for the spiriva h	andihaler 18mcg for				
	Resident #10.					
	-The ventolin HFA for	Resident #10 was				
	dispensed on 01/06/2	0 with a 60 dose supply, on				
	12/16/19 with a 60 do	se supply and on 09/25/19				
	with a 60 dose supply	<i>1</i> .				
	Interview on 02/10/20	at 10:15 am with Resident				
	#10's primary care pr	ovider (PCP) revealed:				
		tion the facility staff would				
	keep prescribed medi					
		administer medications as				
	ordered.					
		er and the ventolin HFA were				
	prescribed to Resider					
	diagnosis of COPD.	, 2000000 00				
	•	e spiriva handihaler 18mcg				
	nor the ventolin HFA					
	administration for Res					
		experience a greater risk of				
		not receiving the spiriva				
		the ventolin HFA as ordered.				
	nandinaler formey or	the ventoilli HFA as ordered.				
	Interview with Poolds	nt #10 on 02/10/20 at 1:50				
		111 # 10 011 02/ 10/20 at 1.30				
	pm revealed:	out of hor modication				
		out of her medications.				
		e facility to provide her				
	medications as ordere	ed by her physician.	1			

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Refer to telephone interview with the previous

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE		
	T CLEMMONS	6010 MEA	DOWBROOK N	MALL COURT		
INEIVIA	II CLEIWIWION3	CLEMMOI	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	8 Continued From page 66		D 358			
	Administrator on 02/1	1/20 at 9:30am.				
	12/15/19 revealed: -Diagnoses included accident (CVA), rhabeleukocytosis and facia-There was a physicia 325mg daily (used to Observation of a med morning medication prevealed: -The MA prepared 4 cadministered the medicationsAspirin 325mg was medications.	al weakness.  an's orders for aspirin prevent blood clots).  lication aide (MA) during the bass on 02/07/20 at 9:35am				
	Review of Resident #14's February MAR revealed: -There was an entry for aspirin 325mg daily at 8:00am.					
	-Aspirin 325mg daily not administered on 0	was initialed and circled as 02/07/20 at 8:00am.				
	#14 on 02/07/20 at 9:	ations on hand for Resident 35am revealed aspirin able for administration.				
	revealed: -There was no aspirir administration for Res-She usually worked a	sident #14. a different medication cart, esponsible for ordering				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL034150	B. WING		02/1	1/2020
	ROVIDER OR SUPPLIER	6010 MEAD	RESS, CITY, STA DOWBROOK N S, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	aspirin 325mg for Reson 02/08/20 with a 30 with a 30 day supply.  Interview on 02/10/20 #10's primary care preshe expected the face medications on hand administer medication - The aspirin 325mg w #14 because of the hiracide and revealed: -The facility sometimes but not oftenShe depended on the medications as ordered.  Refer to telephone int Administrator on 02/1  2. Review of Residen 01/03/20 revealed dia schizoaffective disorder, a unspecific lesion of multerview with Reside revealed: -She did not receive 02/03/20 for her clozareshe was beginning to	at 11:30am with the representative revealed the sident #14 was dispensed day supply and on 01/08/20  at 10:15 am with Resident ovider (PCP) revealed: cility to keep prescribed for administration and to as as ordered. The story of a CVA. Experience a greater risk of eiving the aspirin 325 as  at #14 on 02/07/20 at 9:45  as ran out of her medication, the the facility to administer end by her physician.  at #1's current FL-2 dated agnoses included er, hypertension, major anxiety disorder, an according twice daily since apine.	D 358			

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-She was supposed to have labs drawn weekly

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STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING	B. WING		02/11/2020	
NAME OF PROV	IDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE			
THE IVY AT C	I EMMONS	6010 ME <i>F</i>	ADOWBROOK N	IALL COURT			
THEIVIAIC	LEMINONS	CLEMMO	NS, NC 27012				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT		
D 358 Co	ontinued From page	: 68	D 358				
be -S be -S 02 -S he -S or sp a. da cke ev Re mi 02 -T tal 7: do fro to -T to ac Re mi 02 -T tal 7: to ac -T tal 8: mi 02 -T tal 7: to ac -T tal 8: mi 02 -T t	efore her prescription in the had labs drawn of the had labs drawn of the asked the MAs of 2/04/20. Since December 201 the clozapine every dishe did not take her at two days in a row, hereific dates.  Review of physician ated 01/03/20 reveal ozapine (to treat schorery morning.  Review of Resident # dedication administrate 2/07/20 revealed: There was an entry for the were circles and atender of the did at the reason of the were no reason/findicate the reason diministered.  Review of Resident # dedication administrate at the reason of the were no reason/findicate the reason diministered.  Review of Resident # dedication administrate at the reason diministered.  Review of Resident # dedication administrate at the reason diministered.	n could be refilled. on 02/04/20 but she had not bine. on every shift since  9 she was not administered ay. clozapine for more than one but she could not remember  n orders for Resident #1 led a medication order for hizophrenia) 100mg tablet  1's December 2019 ation record (MAR) on or clozapine 100mg tablet morning scheduled at as documented as not ut of 31 opportunities from round the staff initials for tration for the clozapine  9/19, 12/22/19 and 12/25/19  comments for these dates the medication was not					

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-Clozapine 100mg was documented as not

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
	T CLEMMONS	6010 MEA	ADOWBROOK N	MALL COURT	
INCIVIA	TI CLEWINIONS	CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 358	8 Continued From page 69		D 358		
D 336	administered for 10 o 01/01/20 to 01/31/20.  -There were circles a documenting administered for 01/01/20 to 01/0 02/18/20, and 01/27/2.  -The were no reasonate indicate the reasonate indicate indicate indicate indication prevealed:  -The MA prepared 13 administered the medications administered indications administered indications administered in 02/07/20.  Review of Resident # medication administered in 02/07/20 revealed:  -There was an entry fitake one tablet every 7:00am.  -Clozapine 100mg was administered for 5 ou 02/03/20 to 02/07/20.  -There were circles a documenting administerom 02/03/20 to 02/07/20.  -The were no reasonate in the circles and occumenting administerom 02/03/20 to 02/07/20.	round the staff initials for stration for the clozapine 03/20, 01/07/20 to 01/11/20, 20.  //comments for these dates in the medication was not dication aide (MA) during the bass on 02/07/20 at 8:00am  8 oral medications and dications to Resident #1. as not included in the 13 oral ered to Resident #1. as not administered to be morning medication pass  8 1's February 2020 ation record (MAR) on for clozapine 100mg tablet morning scheduled at as documented as not to 7 opportunities from for the staff initials for stration for the clozapine			
	Observation of Resid	ent #1's available on 02/07/20 at 3:00pm			

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revealed there was no clozapine 100mg tablets

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020	
					02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	) BE COMPLETE	
D 358	Continued From page	e 70	D 358			
	available for administ	ration.				
	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.					
	the facility's contracted 3:15pm revealed: -Resident #1 had a cool clozapine 100mg table morning with instruction months beginning 01/2-Resident #1's for closone tablet every morning the facility since 01/20/2-A seven-day supply on 01/03/20, 01/11/20/2-The pharmacy had not request for refillsResident #1's clozapt CBC (complete blood drug association) regidispensedFrom 01/03/20 to 02/20/20/20/20/20/20/20/20/20/20/20/20/2	zapine 100mg tablet take hing was not dispensed to 6/20. was delivered to the facility 0, 01/26/20. hot received additional hine required submission of a 1 count) to the FDA (federal histry prior to being				
	the facility's contracted department on 02/06/ -The lab received an 11/26/19, 01/07/20, a -There was not a star drawn weekly.	20 at 4:25pm revealed: order for CBC on 11/12/19,				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN (	OF CORRECTION	DENTIFICATION NUMBER:	A BUILDING:	A. BUILDING:		COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA				
THE IVY A	T CLEMMONS		ADOWBROOK N	IALL COURT			
	012	CLEMMO	NS, NC 27012				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE	
				DEFICIENCY)			
D 358	Continued From page	71	D 358				
2 333	Continued i form page	271					
	Interview with a secon	nd shift medication aide					
	(MA) on 02/06/20 at 3	3:55pm revealed:					
	-Resident #1 was out	of clozapine 100mg since					
	02/03/20 when she ca	ame into work.					
	-She did not send a re	equest for a refill for					
		ause she was told Resident					
		n prior to getting anymore					
	of the medication.	m phon to gotting anymore					
		d shift MA on 02/04/20 that					
	Resident #1 was out						
		the lab to see if Resident #1					
	had labs drawn or pe	•					
		Resident Care Director					
	, ,	ecause the RCD did not					
	come to work that day	у.					
	Interview with a first s	shift medication aide (MA) on					
	02/07/20 at 10:55am	, ,					
		#1 was out of her clozapine					
	100mg tablets.	, i was out of her slozapine					
		ay and the day before.					
		a refill for Resident #1's					
	·	ause she was told the third					
	shift MA had requeste						
		ed the reliii. a communication book to					
		tion changes, lab request or					
	refill requests.						
	1.4	-1-156 11: - 11: - 11: - 12: - 11: - 12: -					
		shift medication aide (MA)					
	on 02/06/20 at 11:42a						
		en without clozapine 100mg					
	tablets since 02/02/20						
	-	nacy to request a refill and					
		1 required her labs to before					
	the pharmacy could d	lispense it.					
	-She called the lab or	n 02/04/20 to request the lab					
	results and her labs h	ad not been processed.					

-She put the request for refill in the hot box on the

-The RCD was supposed to follow-up on

wall beside the RCD's office.

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STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
		HAL034150	B. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE NOVA	T OL FMMONO	6010 ME	ADOWBROOK M	IALL COURT		
THE IVY A	T CLEMMONS	CLEMMO	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	÷ 72	D 358			
	Resident #1's labs so clozapine.					
	Interview with the RC revealed:	D on 02/07/20 at 12:00pm				
	-She was hired 02/06 quit.	/20 after the previous RCD				
	-The MAs were support					
	pharmacy when a res	ident ran out of their				
	-She did not know Re	esident #1 was out of				
	clozapine.	oldone # 1 was sat of				
	-The previous RCD d	id not use a shift				
		for the MAs to communicate				
	resident's orders and					
	-There was not an eff place to put medication	ective hot box system in				
		n and restock the medication				
	-She did not audit the assess for missing me					
		with Resident #1's Mental MHP) on 02/06/20 at 5:03pm				
		esident #1's last dose of 20.				
		supposed to miss any				
	-Resident #1 had bee	en taking clozapine for many				
	yearsIt was crucial Reside ordered.	ent #1 take clozapine as				
	-Resident #1 required	l assistance with				
	management of her c	llozapine, she expected the ure 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

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			ADOWBROOK N			
THE IVY A	T CLEMMONS		NS, NC 27012	IALL COURT		
		CLEWINO	NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /	
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1710		,	17.0	DEFICIENCY)		
D 250	O	- 70	D 358			
D 358	Continued From page	e /3	D 356			
	increased anxiety tha	t could cause her to hurt				
	herself and other peo					
		ent and missed does of				
	•	ciated with neutropenia (a				
		which puts Resident #1 at				
	risk for serious and fa					
		dication managed by the				
	· ·	on and Mitigation Strategy)				
	program.	FD.4				
	. •	was an FDA-mandated				
		d by the manufacturers of				
	Clozapine.	a. intended to belo				
	-The REMS program					
	Healthcare Providers patients on Clozapine	-				
		uired to have a CBC blood				
		submitted to registry so				
	_	ised by the pharmacy.				
	-When Resident miss					
		er 2019 the registry began				
		d draw to be done weekly.				
	1					
	Interview with the Adr	ministrator 02/07/20 at				
	12:30pm revealed:					
	-He was hired yesterd	day (02/06/20).				
	-He did not know Res	sident #1 was out of				
	clozapine.					
		ed him there was a problem				
	with the current pharr					
		go without medications.				
		what was causing residents				
	to go without medicat					
		s to ensure all the resident's				
	medications were alw					
		ort any issues they had				
	•	medications to the RCD.				
		as hired yesterday, and she				
	did not have an oppo	rtunity to audit resident's	1			

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medications.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING			
		HAL034150	D. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ATE, ZIP CODE		
		6010 ME	ADOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012			
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(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)	ĺ	
D 050	- · · · -	_,	B 050			
D 358	Continued From page	e 74	D 358			
	Telephone interview v	vith 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 sh	ne required a CBC drawn				
	prior to clozapine beir	ng dispensed by the				
	pharmacy.					
	-Resident #1's MHP of	did order monthly CBC's to				
	be drawn.	•				
	-The MHP was respo	nsible for ensuring Resident				
	#1's labs were submit	tted to the registry.				
	-She had encountered	d a lot of errors the facility's				
		h Resident #1's clozapine.				
		nissed having her labs				
	drawn monthly, she re	equested a weekly CBC				
	order from the MHP.					
	-Resident #1 was able	e to continuously remind the				
	MAs to have her labs					
		1 was able to remind the				
	MAs she did not follow	w up the pharmacy when				
	Resident #1 missed h	ner clozapine.				
	-She did not audit the	medication carts, physician				
	orders, and MARs be	cause the facility was				
	understaffed, and she	e was required to pass				
	medications.					
	Refer to telephone int	terview with the previous				
	Administrator on 02/1	1/20 at 9:50am.				
		n orders for Resident #1			ľ	
		led a medication order for				
	clozapine 150mg 1-1/	/2 tablets at bedtime.				
					I	
	Review of Resident #					
		ation record (MAR) on			ĺ	
	02/07/20 revealed:				ľ	
		or clozapine 100mg tablet			ľ	
	take 1-1/2 tablets at b	edtime scheduled at			ĺ	
	8:00pm.				ľ	
		as documented as not			ľ	
	administered for 10 o	ut of 31 opportunities from				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			P WING			
		HAL034150	B. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		ADOWBROOK N	MALL COURT		
			ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page 75		D 358			
D 358	01/01/20 to 01/31/20There were circles at documenting adminis from 01/01/20 to 01/0 01/18/20, and 01/27/2 -The were no reason/ to indicate the reason administered.  Review of the Februa administration record 02/07/20 revealed: -There was an entry f take 1-1/2 tablets at the 8:00pmClozapine 150mg was administered for 5 our 02/02/20 to 02/06/20There were circles at documenting administrom 02/03/20 to 02/06/20The were no reason/ to indicate the reason administered.  Observation of Residemedications on hand revealed there was not tablets available for a Review of Resident # refills of medications of clozapine 150mg 1-1/2000.	round the staff initials for tration for the clozapine 3/20, 01/07/20 to 01/11/20, 20. Comments for these dates the medication was not as documented as not to f7 opportunities from tration for the clozapine 6/20. Comments for these dates the medication was not to f7 opportunities from tration for the clozapine 6/20. Comments for these dates the medication was not the clozapine 150mg 1-1/2	D 356			
	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					

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clozapine 150mg tablet take 1-1/2 tablets at

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Division	of Health Service Regu	liation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
			-				
			D MINO				
		HAL034150	B. WING		02/1	11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE			
TO WILL OF T	NOVIDER OR GOLF EIER						
THE IVY A	T CLEMMONS		NDOWBROOK N	MALL COURT			
		СЕММО	NS, NC 27012				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE	
TAG	REGULATURT UR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	NAIE	DAIL	
						-	
D 358	Continued From page	e 76	D 358				
		ons to be refilled for twelve					
	months beginning 01						
	-Resident #1's clozap	oine 150mg tablet take 1-1/2					
	tablets at bedtime wa	is 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	0, and 01/26/20.					
	-From 01/03/20 to 02						
		but the facility would have					
	required 34 doses du	-					
	Interview with a secon	nd shift medication aide					
	(MA) on 02/06/20 at 3						
		of clozapine 150mg since					
	02/03/20 when she ca	, ,					
	-She did not send a re						
		ause she was told Resident					
	-	vn prior to getting anymore					
	of the medication.						
		d shift MA on 02/04/20 that					
	Resident #1 was out	•					
		the lab to see if Resident #1					
	had labs drawn or pe	•					
	-She did not tell the F	Resident Care Director					
	(RCD) on 02/04/20 be	ecause the RCD did not					
	come to work that day	y.					
	Interview with a first s	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 yesterda	ay and the day before.					
		a refill for Resident #1's					
		ause she was told the third					
	shift MA had requeste						
	-	e a communication book to					
		ition changes, lab request or					
	refill requests.	a.c., onangoo, lab roquest of					
		veician's order to the					
	-When she faxed phy						
	priarmacy, sne piaced	d the order in a hot box on					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I LAN OF GOTTLEGHON	IBENTI TOATION NOWBER.	A. BUILDING: _		OOMI LETED	
	HAL034150	B. WING		02/11/2020	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMMONS		OOWBROOK N	IALL COURT		
	CLEMMON	IS, NC 27012			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 358 Continued From pa	ge 77	D 358			
the wall beside the -The RCD or MA w on the MARThe RCD was sup when it was deliver order and place it of Interview with a thi on 02/06/20 at 11:4 -Resident #1 had be tablets since Mond -She called the pha found out Resident the pharmacy could -She called the lab results and her lab -She put the reque wall beside the RC -RCD was suppose #1's labs so she co Interview with the F revealed: -She was hired 02/ -The MAs were sup pharmacy when a medicationsShe did not know clozapineThe previous RCE communication boo resident's orders at -There was not an place to put medicat location to verify th carts.	RCD's office. ho received the order wrote it  posed to verify the medication ed by the pharmacy with the in the medication cart.  Id shift medication aide (MA) 2am revealed: een without clozapine 150mg ay. Immacy to request a refill and #1 required her labs to before If dispense it. In 02/04/20 to request the lab Is had not been processed. Ist for refill in the hot box on the D's office. Id to follow-up on Resident all get her clozapine.  RCD on 02/07/20 at 12:00pm  06/20. Doposed to contact the esident ran out of their Resident #1 was out of Id did not use a shift ok for the MAs to communicate and refills between shifts. Effective hot box system in ation orders in a central em and restock the medication  the medications carts to				

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Telephone interview with Resident #1's Mental

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
				<del></del>	
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	
IVAIVIL OI II	NOVIDER OR GOLT EIER				
THE IVY A	T CLEMMONS		DOWBROOK N	IALL COURT	
		CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 78	D 358		
D 358	Health Practitioner (Norevealed: -She did not know Reclozapine was 02/02/-Resident #1 was not doses of clozapineResident #1 had been yearsIt was crucial Resided dailyResident #1 required management of her company of the clozapine could lead increased anxiety that herself and other peodincreased anxiety that herself anxiety that her	AHP) on 02/06/20 at 5:03pm esident #1's last dose of 20. Esupposed to miss any en taking clozapine for many ent #1 take clozapine twice If assistance with elozapine, she expected the cure she got clozapine twice espitalized within the last year dhallucinations and anxiety. It #1 not continuously taking ead to hallucinations and it could cause her to hurt exple. Ent and missed does of ciated with neutropenia (asth puts Resident #1 at risk enfections. Idication managed by the on and Mitigation Strategy)  was an FDA-mandated do by the manufacturers of was intended to help ensure the safety of	D 358		
	drawn monthly to be	submitted to registry so			
	-When Resident miss	, ,			
		er 2019 the registry began			
		d draw to be done weekly.			

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Division o	of Health Service Regu	lation			FURINI APPROVE	בט
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		ADOWBROOK N	MALL COURT		
		CLEMMO	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	E
D 358	Continued From page	÷ 79	D 358			
	Interview with the Adr	ministrator 02/07/20 at				
	12:30pm revealed:					
	-He was hired yestero	• ` '				
	<ul> <li>-He did not know Res clozapine.</li> </ul>	ident #1 was out of				
		ed him there was a problem				
	with the current pharr					
		go without medications.				
		what was causing residents				
	to go without medicat					
	medications were alw	s to ensure all the resident's				
		ort any issues they had				
		medications to the RCD.				
		as hired yesterday, and she				
		rtunity to audit resident's				
	medications.					
	Telephone interview v	with the previous Resident				
		on 02/11/20 at 10:44am				
	revealed:					
	-Her last day of work					
		ne required a CBC drawn				
	prior to clozapine beir pharmacy.	ng dispensed by the				
	· ·	ordered monthly CBC's to be				
	drawn.	Addrea memany debag to be				
	-The MHP was respo	nsible for ensuring Resident				
	#1's labs were submit					
		d a lot of errors the facility's				
	· ·	h Resident #1's clozapine.				
		nissed having her labs equested a weekly CBC				
	order from the MHP.	squested a weekly CDC				

-Resident #1 was able to continuously remind the

-She did not audit the medication carts, physician

-Because Resident #1 was able to remind the MAs she did not follow up the pharmacy when

MAs to have her labs drawn weekly.

Resident #1 missed her clozapine.

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
		HAL034150	B. WING		02/	11/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
			ADOWBROOK N			
THE IVY AT CLEMMONS		NS, NC 27012				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
D 358	Continued From page	e 80	D 358			
	orders, and MARs be	-				
		e was required to pass				
	medications.					
	Refer to telephone int	terview with the previous				
	Administrator on 02/1	·				
	2. Daview of Deciden	t #5's current FL-2 dated				
	*	gnoses included history of				
	deep vein thrombosis					
	-	tive heart failure, peripheral				
	, ,	d chronic kidney disease.				
	Interview with Reside	nt #5 on 02/06/20 at				
	12:45pm revealed:					
		rgency room last night and				
	-	after she was treated for				
	fluid overload.	- h - talsin - francasista				
	beginning today.	o be taking furosemide				
		supposed to continue to				
		heart so she can breathe				
	better.					
	Review of physician o	orders for Resident #5 dated				
	02/05/20 revealed a r					
	furosemide 20mg dail					
	3	,				
	Review of the Februa					
		(MAR) for Resident #5 on				
	02/07/20 revealed:					
		ritten entry for furosemide				
	begin on 02/09/20 at	twice daily for 14 days to				
	02/22/20 at 2:00pm.	ι .υυαιτι απα διυμ υπ				
	-Furosemide was not	documented as				
	administered.					
	Observation of Resident	ent #5's available				

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medications on hand on 02/07/20 at 3:00pm

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DIVISION	of Health Service Regu	lation			<del>,</del>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF D	POVIDED OF SURPLIED	OTDEET A	DDDESS CITY STA	TE ZIR CODE	-	
NAIVIE OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
THE IVY A	T CLEMMONS		ADOWBROOK N	IALL COURT		
			ONS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	()	
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		
				DEFICIENCY)		
D 358	Continued From page	81	D 358			
2 000						
		o furosemide 20mg tablets				
		ration on the medication				
	cart.					
	Telephono intonvious	with a representative from				
		ed pharmacy on 02/07/20 at				
	1:31pm revealed:	a pharmacy on 02/01/20 at				
	•	eceived a faxed physician				
		20mg one tablet for fourteen				
	days.	3				
	-The furosemide was dispensed on 02/06/20 to					
	the facility.	·				
	-The furosemide was	delivered to the facility on				
	02/06/20.					
		nd shift medication aide				
	(MA) on 02/06/20 at 3	have furosemide 20mg				
		cation cart because the start				
	date of the order was					
	-Resident #5 asked h					
	furosemide this morn					
		ne furosemide order to verify				
	the start date.	•				
		d her the furosemide was				
	• •	ble from the pharmacy for a				
	few days.					
	-The third shift MA wr					
	02/09/20 on the MAR	 Resident Care Director				
		n delivery from the pharmacy				
		she was told medications				
	took a few days to be					
	-She did not have acc					
		with medications in them.				
	-The RCD opened all					
	-	ions before putting them on				
	the medication cart	,				

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

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DIVISION	n Health Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		HAL034150	B. WING		02/11	1/2020
			1		1 02/11	.,2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 MEA	DOWBROOK N	IALL COURT		
		CLEMMO	NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGOLATORI ORE	100 IDENTIFY TING IN GRANATION)	TAG	DEFICIENCY)	WAI E	
			<del>                          _     _</del>			
D 358	Continued From page	e 82	D 358			
	revealed:					
	-She was hired 02/06	/20 after the former RCD				
	quit.					
	-She did not know Re	esident #5 went to the				
	emergency room for o	congestive heart failure.				
	-She did not know Re	sident #5 had a physician				
	order for furosemide.					
	•	onsible for signing for all				
	pharmacy deliveries.					
	•	cted to open the pharmacy				
		vailable on the medication				
	cart.	armaay daliyary tataa in tha				
		narmacy delivery totes in the				
	Stock room that she d	lid not have time to open.				
	Interview with the Adr	ministrator 02/07/20 at				
	12:30pm revealed:					
	-He was hired yesterd	day (02/06/20).				
		s to ensure all the resident's				
	medications were alw	ays available.				
	-The MAs should repo	ort 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	o audit resident's				
	medications.					
	D ( ) ( ) ( ) ( )					
		terview with the former				
	Administrator on 02/1	1/20 at 9.50am.				
	4 Review of Residen	t # 2's current FL2 dated				
		agnoses included congestive				
		chizophrenia, anxiety,				
	insomnia, psychosis a					
	,,					
	a. Review of Residen	t #2's physician's orders				
		led paliperidone injection				
	(Invega) 156 mg/ml 1					
		notic injection used to treat				
	acute and maintenand					

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schizophrenia).

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (>		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
THE IVV	AT CLEMMONS	6010 MEA	ADOWBROOK N	MALL COURT	
INCIVIA	AT CLEIMINIONS	CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 83	D 358		
	hospital records for re January 2020 or Febi Review of Resident # Professional Support revealed medication a injections was docum medication aide (MA) administered by Hom Review of Resident # Medication Administra revealed: -There was an entry finject once for 1 dose	2's Licensed Health (LHPS) dated 01/27/20 administration through tented as understood by a staff an injection was to be te Health (HH) agency.  2's January 2020 ation Record (MAR)  for paliperidone 156 mg/ml a (Home Health Nurse). the nentation paliperidone was			
	revealed: -There was an entry f inject once for 1 dose (HHN).	ic's February 202 MAR for paliperidone 156 mg/ml by Home Health Nurse mentation paliperidone was			
	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 wh	nat paliperidone was or how ered			

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-She did not know it was supposed to be

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING: _			
	HAL034150	B. WING		02	11/2020
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
THE IVY AT CLEMMONS		NDOWBROOK M NS, NC 27012	ALL COURT		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
to administer the palip-She had not asked a paliperidone, but just medication cart.  Interview with a repre Health agency on 02/0 the Home Health agency for paliperidone inject the HHN.  Interview with Resider (PCP) on 02/07/20 at -She had written the conjections for 1 injections for 1 injections. She worked closely whealth provider (MHP) Resident #2 had not reinjections.  -She was aware Resident moncompliant with tak -Resident #2 was currun acute psychiatric unitShe was very concerdid not receive the pathis was the reason Resident moncompliant with Resident mospital on 02/05/20.  Interview with Resident provider (MHP) on 02 revealed: -Resident #2 had bee about 2 weeks ago ar -Resident #2 was sen because he would not his medications.	the HHN had not come out beridone to Resident #2. Inother MA or staff about the knew it was available in the sentative from the Home 06/20 at 11:40 am revealed ncy never received an order itons to be administered by int #2's primary care provider 8:55 am revealed: order for paliperidone on each month by the HHN. with Resident #2's mental and the MHP told her received paliperidone ingestions. In the hospital in an in the medications are received to the int #2's mental health with the second in the medication and felt in the medic	D 358			

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DIVISION	n Health Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL034150	B. WING	<del></del>	02/11/2020	
NAME OF D	DOVIDED OD SUDDUJED	STDEET ADI	DECC CITY CTA	TE ZID CODE		
NAIVIE OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
THE IVY A	T CLEMMONS		DOWBROOK N	MALL COURT		
		CLEMMON	IS, NC 27012			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	PRIATE DATE	
				DEFICIENCY)		
D 358	Continued From page	. 85	D 358			
D 330	Continued From page	5 00	5 556			
	-She had visited the F	Resident at the facility on				
	01/24/20 and had rev	iewed the MARs and				
	medications on hand	and she could tell Resident				
	#2 was not getting his	s medications.				
	• •	ridone injection at the facility				
	on 01/24/20.	······································				
		ncerned about Resident #2				
		t medications, correct doses				
		ons because Resident #2				
	•	, had decreased behaviors				
		care if he received his				
	anti-psychotic medica	_				
	paliperidone injection					
	-The MHP felt the rea	son Resident #2 was sent				
	to the hospital was be	ecause he had not received				
	his 4 anti-psychotic m	edications including the				
	paliperidone injection					
	,					
	Interview with a repre	sentative from the				
		on 02/10/20 at 10:50 am				
	revealed:	511 527 15725 at 15.55 am				
		) 156 mg/mi injection 1 dose				
	. , ,					
	each month was a cu					
	-One injection syringe	e was dispensed on				
	01/28/20.					
	-Medication orders we					
	. , ,	P and MHP and some orders				
		re written orders sent to the				
	pharmacy by the facil	ity staff.				
	-The pharmacy staff h	nad difficulty getting in touch				
	with the facility.	· · · · · · · · ·				
	•					
	Interview with the Res	sident Care Coordinator				
	(RCC) on 02/10/20 at	: 10:07 am revealed:				
		ns were delivered to the				
	facility twice each day					
	-She thought the HHN					
	_					
	_	paliperidone injections to				
	Resident #2.		1			

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-All the staff working were new and there was no

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Division of	of Health Service Regu	lation			FORM AI	PPROVED
STATEMENT	r of Deficiencies Of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SUR COMPLETE	
		HAL034150	B. WING		02/11/2	2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		ADOWBROOK N	MALL COURT		
		CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	<del>2</del> 86	D 358			
	experienced staff left do.	to train the new staff what to				
	am revealed:	nd MA on 02/10/20 at 11:15				
		D were responsible to send				
	orders to the pharmace -Any hospital dischare	cy. ge summaries were to be				
	reviewed for any orde	rs and those were sent to				
	the pharmacy as wellShe knew Resident #	‡2 was sent to the hospital,				
	but did not know whe	n he went to the hospital or ent #2 was admitted to.				
	Interview with the form 12:30 pm revealed:	ner RCD on 02/11/20 at				
		for a medication that HH er RCD would send the				
	-If HH was supposed	to administer a resident's administering the injection,				
	the MAs were to let the former RCD would fol	e former RCD know and the low-up with HH.				
	another HH agency to	done injections was sent to give the paliperidone				
		opped" from the HH agency,				
	so the former RCD co agency.	ntacted another HH				
	-Resident #2 was not	discharged from HH				
		pped " from HH because he				
	could not pay for HH s					

know.

Resident #2 his injections, the former RCD did not know anything about it; MAs did not let her

Interview on 02/11/20 at 2:05 pm with another HH agency contacted by the former RCD revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B WING		
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		ADOWBROOK N	IALL COURT	
		CLEMMO	ONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 87	D 358		
	Resident #2This company was a a HH agency. Attempted telephone	not received any orders for  Home Care agency and not 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 on 02/11/20 at 9:30 a	h the former Administrator m.			
	dated 12/20/19 revea	nt #2's physician's order alled paliperidone ER 6 mg 1 and to treat dementia related			
	order dated 01/24/20	2's subsequent physician's revealed paliperidone 6 mg et every morning for 30 days.			
		2's physician's orders ue order for paliperidone 6			
	tablet at bedtime school. 8:00 pm. -Paliperidone was no administered from 12	ation Record (MAR) for paliperidone 6 mg ER 1 edule for administration at t documented as			

MAR.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE 00/	T 01 FMM0N0	6010 MEAI	OWBROOK N	IALL COURT	
THE IVY A	AT CLEMMONS	CLEMMON	IS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page 88		D 358		
	revealed: -There was an entry fitablet every morning at 8:00 amThere was a second every morning times administration at 8:00-Paliperidone was not administered from 01.  Review of Resident # revealed: -There was an entry fitablet every morning at 8:00 amThere was administered and on 02/03/20.  Observation of Resident and on 02/06/20 revitablets was administered and on 02/06/20 revitablets was administered and on 02/06/20 revitablets was administration.  Interview with Reside (PCP) on 02/07/20 at administration.  Interview with Resider (PCP) on 02/07/20 at administration and hissuesShe was at the facilities resident #2 was not medicationsShe thought Resider anti-psychotic medications and the state of	t documented as //01/20 to 01/31/20.  2's February 2020 MAR  for paliperidone 6 mg take 1 schedule for administration tation paliperidone 6 mg ered on 02/01/20, 02/02/20  ent #2's medications on ealed there was no olets available for  nt #2's primary care provider 8:55 am revealed: #2 was noncompliant with the had a lot of mental health ely on 01/08/20 and noticed being administered his			

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Interview with Resident #2's mental health

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		HAL034150	B. WING		02/	11/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 MEA	DOWBROOK N	IALL COURT		
	II OLLIMINIONO	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 89	D 358			
	provider (MPH) on 02 revealed: -Resident #2 had bee about 2 weeks ago ar-Resident #2 was ser would not eat, and he medicationsResident #2 became take his medicationsThe MHP visited the and there was no palithe facilityThe MHP was so connot getting the correct and missed medication was compliant, stable and less resistance to antipsychotic medication.	en admitted to the hospital and again recently. In to the hospital because he was not taking his e unstable when he did not facility last week (01/23/20) iperidone tablets available in encerned about Resident #2 at medications, correct doses ons because Resident #2 and decreased behaviors of care if he received his tions.				
	paliperidone tablets h	revealed she thought and been discontinued				
	Interview with a repre contracted pharmacy revealed: -Paliperidone 6 mg ta bedtime was an expe -The pharmacy had n PCP about needing a paliperidone tablets, I was sent to the facility	ablets 6 mg 1 tablet at ensive medication. not contacted Resident #2's a prior authorization form but a prior authorization form by for Resident #2's primary to sign in order to dispense ets.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL034150	B. WING		02	/11/2020
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY	AT CLEMMONS		DOWBROOK N NS, NC 27012	IALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358	paliperidone tablets we facility.  -The pharmacy staff is with the facility and the cooperation dealing we Administrator.  -The PCP changed the different medication (bedtime -used to treat 12/12/19.  Interview with the Reson 02/07/20 at 4:30 peritory.  -The Resident Care Coalled the contracted paliperidone tablets.  -Paliperidone tablets the pharmacy did not profile for paliperidone tablets the pharmacy did not profile for paliperidone tablets.  -Paliperidone tablets the pharmacy did not profile for paliperidone tablets authorization was new PCP or the MHP to coalled the contracted paliperidone tablets the pharmacy did not profile for paliperidone tablets.  -Paliperidone tablets the previous authorization was new PCP or the MHP to coalled the contracted paliperidone tablets.  -The MAB were response to the MAB	sident #2's PCP and the vere never dispensed to the anad difficulty getting in touch are was a lack of vith the previous  see paliperidone order to a Risperidone 3 mg at a touch disorders) on  sident Care Director (RCD) m revealed: Coordinator (RCC) had pharmacy about the  were never sent because have a prescription on a tablets for Resident #2. The prior authorization form at son 02/07/20 in a stack of RCD's office and the prior ver sent to Resident #2's complete and sign.  The Administrator on revealed she did not know ation orders or any PCP to sign.  The RCD on 02/11/20 at the side of the facility.  The side of the side of the facility in sible for processing orders	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL034150	B. WING		02	2/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	-	
			ADOWBROOK MA			
THE IVY A	AT CLEMMONS	CLEMM	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Attempted telephone #2's Guardian on 02/02/11/20 at 10:00 am Attempted telephone health provider for Rehospital on 02/10/20 unsuccessful.  Refer to interview wit on 02/11/20 at 9:30 at c. Review of Resident revealed physician's 01/02/20 for Risperdam at bedtime (used Review of Resident #medication administration at 8:00 -Risperdal 3 mg was administered at 8:00 12/17/19, and on 12/1-1 -There was document on 12/16/19.  There was no entry morning on the MAR Review of Resident #1 December 2019 reversed at 2019 reversed at 201/107/20 revealed and 10/107/20 revealed and 10/107/20 revealed and 10/10/1/20 revealed and 10/10/10/10/10/10/10/10/10/10/10/10/10/1	interviews with Resident 06/20 at 5:00 pm and on a was unsuccessful.  interview with the mental esident #2 at the local at 3:30 pm was  the the previous Administrator am.  It #2's physician's orders orders dated 12/12/19 and al 1 mg every morning and 3 to treat mood disorders).  It becember 2020 atton record (MAR) revealed: for Risperdal 3 mg 1 tablet e scheduled for 0 pm.  In the previous Administrator am.  It #2's physician's orders orders dated 12/12/19 and al 1 mg every morning and 3 to treat mood disorders).  It becomes a for a scheduled for 0 pm.  In the previous Administrator am.  It #2's physician's order dated at 12/12/19 and 12/12/19 to 20/19.  It is progress notes for a scheduled Resident #2 refused at 12/19 and 12/30/19.  It is physician's order dated	D 358	DEFICIENC	CY)	
	Risperdal 2 mg every	morning.  #2's physician's order dated				

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
THE IVY A	AT CLEMMONS		NS, NC 27012	IALL COURT	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	92	D 358		
	tablets every morning	order for Risperdal 1 mg 2 g, discontinue previous continue Risperdal 3 mg at			
	revealed: -There was an entry fevery morning schedu 8:00 amRisperdal 1 mg was administered at 8:00 a 01/14/20 and from 01 01/21/20 to 01/25/20 marked through on the handwritten on the Marked through at 7:00 amRisperdal 2 mg was administered on 01/0 -Discontinued was hare	am from 01/07/20 to 1/17/20 to 01/19/20 and from with the initials circled and ne MAR and "D/C" AR. I entry for Risperdal 2 mg 1 scheduled for administration not documented as 1/20 and 01/28/20. andwritten on the MAR.			
	tablet every night at b administration at 8:00 -Risperdal 3 mg was administered at 8:00 p 01/02/20 to 01/04/20, 01/14/20 and on 01/2 -Risperdal 3 mg docu was left blank on 01/ 01/23/20 and from 01 -"Hospital" was hand 01/15/20, 01/16/20, 0 -There was no docum Risperdal was not add	O pm. documented as not pm by circled initials from , and from 01/06/20 to 25/20. umentation of administration /17/20, from 02/20/20 to			

Review of Resident #2's progress notes for January 2020 revealed Resident #2 refused

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		PLETED
		HAL034150	B. WING		02	/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
THE NAVA	T CI EMMONE	6010 ME	ADOWBROOK N	IALL COURT		
THE IVY	T CLEMMONS	CLEMMO	NS, NC 27012			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	e 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.					
	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 3mgThere 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:					
	his medications and hissuesShe was at the facilit Resident #2 was not medicationsShe thought Resider anti-psychotic medications are resident to an acute psychiatric Interview with Reside provider (MHP) on 02 revealed: -She visited Resident -When she visited on	ations including the I to his recent hospitalization ic unit at a local hospital. ent #2's mental health 2/07/20 at 11:10 am				

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had written an order to discontinue.

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DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			D WING			
		HAL034150	B. WING		02/1	11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
			DOWBROOK N			
THE IVY A	T CLEMMONS			MALL COOK!		
		CLEMINO	NS, NC 27012	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NAIE	D/112
				,		<del> </del>
D 358	Continued From page	94	D 358			
	Decident #2 was ser	at book to the beenitel				
	-Resident #2 was ser					
		eating and he would not take				
	his medications.					
		ncerned about Resident #2				
		t antipsychotic medications,				
	correct doses and mis					
		Resident #2 was compliant,				
	stable, had decrease	d behaviors and less				
		e received his medications.				
	-Resident #2 was cur	rently in the hospital in an				
	acute psychiatric unit	and she felt his admission				
	to the hospital was ca	aused by not receiving his				
	anti-psychotic medica	ations including Risperdal as				
	ordered.	0 1				
	Interview with a medi	cation aide (MA) on				
	02/10/20 at 9:30 am r	` ,				
		#2 was in the hospital but				
		en the resident went to he				
	hospital or which hos					
	admitted to.	pital Nesident #2 was				
		n, care provider would				
	-	y care provider would				
	sometimes send orde					
		cation orders would not be				
	in the residents' recor					
		physician orders to the				
	pharmacy.					
		ns were on a cycle-filled				
	system except for cor					
	-The pharmacy delive	ered medications to the				
	facility daily.					
	Interview with the Res	sident Care Coordinator				
	(RCC) on 02/10/20 at	: 10:07 am revealed:				
	-Some medications w	ere just discontinued on the				[
	MARs because the M					
		edication carts, or the MAs				
		needed a new prescription.				
	-The MAs did not kno					
	-The MAs were respo					
	THE MINDS MALE LESPE	moible for placing the	- 1			1

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Division o	of Health Service Regu	liation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
			B. WING			
		HAL034150	B. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			DOWBROOK M			
THE IVY A	T CLEMMONS			IALL GOOK!		
		CLEMMO	NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	TREGOE TOTAL OTTE	EGG IBENTII TIING INI GIAMBUTON)	TAG	DEFICIENCY)	WIL	
			+			
D 358	Continued From page	e 95	D 358			
		in the medication carts but				
	_	being done because the				
	MAs did not know to					
		dication orders were being				
	sent to the pharmacy	, so medications were not				
	being sent to the facil	lity.				
	-All the staff working v	was new and there was no				
	experienced staff left	to show the new staff what				
	to do.					
	Interview with a secon	nd MA on 02/10/20 at 11:15				
	am revealed:					
	-She knew Resident	#2 was admitted to the				
		ot know when the resident				
	went to the hospital.	ist mon when the resident				
	-She thought Risperd	lal may have been				
		was not sure; discontinued				
	was written on the MA					
		on the MARs meant the				
		administered, or could not				
		ason such as, resident on or medication was not				
	available in the medic					
	·	onsible for contacting the				
	PCP.					
		mer RCD on 02/11/20 at				
	12:30 pm revealed:					
	-The MAs were respon					
	medications were in t					
		onsible for processing orders				
	and sending orders to					
	-The MAs and former	RCD were responsible for				
	creating the MARs; th	ne pharmacy did not provide				
	pre-printed MARs.	•				
		osed to go back to Resident				
		ter his medications when he				
	refused.					
			1			1

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Review of Resident #2's current orders and

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DIVISION	n Health Service Negu	alion					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			_				
		HAL034150	B. WING		02/1	1/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
THE IVY A	T CLEMMONS		ADOWBROOK N	IALL COURT			
	CLEMMO						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 358	Continued From page	96	D 358				
	dispensing records prepharmacy revealed: -There was an order of bedtime dated 12/12/mg tabletsThere was no order of Risperdal 1 mg every -On 01/09/20, an order Risperdal 2 mg every -On 01/09/20, an order Risperdal 3 mg to 2 mg continue Risperdal 3 mg 1 table dispensed on 12/17/1-Risperdal 1 mg 2 table dispensed on 01/10/2-Risperdal 1 mg 1 table dispensed on 01/25/2-All Risperdal orders of 01/30/20.  Attempted telephone #2's Guardian on 02/02/11/20 at 10:00 amg.  Attempted telephone health provider for Research to interview with on 02/11/20 at 9:30 and d. Review of Residen.	ovided by the contracted on file for Risperdal 3 mg at 19 to replace Paliperidone 6 on file dated 01/07/20 for morning and to start morning. er was received to increase g every morning and mg at bedtime. let at bedtime was 9 for 5 tablets. lets each morning was 0 for 60 tablets. let each morning was 0 for 30 tablets. were discontinued on  interviews with Resident 06/20 at 5:00 pm and on was unsuccessful. interview with the mental esident #2 at the local at 3:30 pm was  in the previous Administrator in.  t #2's physician's order led Depakote 250 mg 1					
	Review of Resident #						

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mg twice daily.

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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
	T CI EMMONE	6010 MEA	DOWBROOK N	IALL COURT	
INEIVIA	T CLEMMONS	CLEMMON	IS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 97	D 358		
D 358	Review of Resident # medication administra-There was an entry f twice daily scheduled am and 5:00 pm.  -Depakote was not do at 7:00 am from 12/02/12/31/19.  -There was documen Depakote was not ad 12/05/19, 12/08/19 ar-Discontinued was har "VOID" was handwritt Depakote on the MAF Review of Resident # order dated 01/07/20 twice daily.  Review of Resident # revealed:  -There was an entry f twice daily scheduled am and 5:00 pm.  -Depakote was not do at 7:00 am or 7:00 pmDiscontinued was har	eta's December 2019 ation record (MAR) revealed: for Depakote 250 mg 1 tablet I for administration at 7:00 commented as administered 5/10 to 12/31/19. commented as administered 19 and from 12/05/19 to tation for the reason ministered as refused on and on 12/27/19. andwritten on the MAR and ten over the entry for	D 358		
	7:00 am and 7:00 pm -Depakote was not do at 7:00 am from 01/0 -Depakote 250 mg wa administered at 7:00 01/26/20There was no docum	ocumented as administered 1/20 to 01/31/20. as not documented as pm from 01/01/20 to nentation for the reason			
	Depakote was not ad	ministered as ordered.			

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DIVISION	n Health Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			1	<del></del>		
		HAL034150	B. WING	<del></del>	02/	/11/2020
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZID CODE		
NAIVIE OF PI	ROVIDER OR SUPPLIER					
THE IVY A	T CLEMMONS		DOWBROOK N	MALL COURT		
	CLEMM					
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH	IOULD BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE API	PROPRIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	. 08	D 358			
D 000	Continued From page	: 90	5 330			
	Review of Resident #	2's February 2020 MAR				
	revealed:					
	-There was an entry f	or Depakote 250 mg 1 tablet				
	_	for administration at 7:00				
	am and 7:00 pm.					
	· ·	nented as not administered				
	by circled initials at 7:					
	•					
	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					
		entation for the reason				
	Depakote was not ad	ministered as ordered.				
	Observation of Reside	ent #2's medications on				
	hand on 02/06/20 at 5	5:10 pm revealed:				
	-Depakote 250 mg wa	as available for				
	administration.					
	-There were 2 unoper	ned bubble packs with 30				
	tablets each dispense					
		ster 1 tablet twice daily.				
	mon donono to damini	otor radiot twice daily.				
	Peview of Pecident #	2's current orders and				
		ovided by the contracted				
	pharmacy revealed:	Ovided by the contracted				
		ion Donalista 250 mar tuisa				
		or Depakote 250 mg twice				
	daily dated 01/07/20.					
	-There was no discon	tinue order on tile for				
	Depakote.					
	•	ote 250 mg twice daily was				
	received by the pharm					
	-Depakote was disper	nsed on 01/30/20 for 60				
	tablets.					
	Interview with Reside	nt #2's primary care provider				
	(PCP) on 02/07/20 at					
		‡2 was noncompliant with				
		ne had a lot of mental health				
	issues.	a lot of montal floatin				
	100000.		1	T .		1

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-She was at the facility on 01/08/20 and noticed

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (X3) D.			
			A. BUILDING:			
		HAL034150	B. WING		02	2/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
THE IVV	AT CLEMMONS	6010 ME	ADOWBROOK MA	LL COURT		
INCIVIA	AT CLEWINIONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETE DATE	
D 358	D 358 Continued From page 99		D 358			
	Resident #2 was not antipsychotic medicatShe thought Resider anti-psychotic medicat contributed to his reconcute psychiatric unit.  Interview with Reside provider (MHP) on 02 revealed: -She visited Resident -She had ordered Dehe was supposed to be the was supposed to be the was not taking Depaked by reviewing the MAF was no Depakote in the She knew Resident and medicationsThe MHP was so control getting the correct correct doses and mis medications because stable, had decreased resistance to care if hereident #2 was cur acute psychiatric unit to the hospital was care	being administered his tions.  In #2 not getting his ations including Depakote ent hospitalization to an at a local hospital.  Int #2's mental health #2's mental health #2'o7/20 at 11:10 am  If #2 every two weeks.  If pakote for Resident #2 and be taking Depakote.  If it is a ware Resident #2 and be taking Depakote.  If it is a ware Resident #2 and be taking Depakote.  If it is a ware Resident #2 and be taking Depakote.  If it is a ware Resident #2 and there he facility.				
	(RCC) on 02/10/20 at -Some medications w MARs because the M medications on the m	vere just discontinued on the lAs did not have the ledication carts, or the MAs needed a new prescription.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 02/	
THE IVY A	AT CLEMMONS		OOWBROOK M S, NC 27012	IALL COURT		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 358	thought that was not I MAs did not know to consider the pharmacy being sent to the facilical to the staff working wexperienced staff left to do.  Interview with a medicular new wear to the hospital sent to the hospital but she did nowent to the hospital.  She administered means written on the Marker of the was written on the Marker was written on the Marker without his medication cart.  Interview with the form 02/11/20 at 11:50 am order entries off the Marker of the Marker without his medication.  Interview with the form on 02/11/20 at 12:30  The MAs and the form MHP and the primary went without his medication.  MAs were responsible checking the medicat was not on the cart, the call the pharmacy.	in the medication carts but being done because the do that. dication orders were being a so medications were not ity. Was new and there was no to show the new staff what  cation aide (MA) on revealed: #2 was sent out to the ot know when Resident #2.  te may have been was not sure; discontinued AR. es write discontinued on the cations would not available .  mer Administrator on revealed she would take MARs because she could not  mer Resident Care Director pm revealed: mer RCD would call the care provider if Resident #2 ications for 2 days. when Resident #2 went	D 358			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING	B. WING		02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE			
THE IVY A	T CLEMMONS		DOWBROOK M NS, NC 27012	ALL COURT			
(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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(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 health provider for Rehospital on 02/10/20 aunsuccessful.						
	Refer to interview with on 02/11/20 at 9:30 a	n the previous Administrator m.					
	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).						
	order dated 12/05/19	2's subsequent physician's and 12/12/19 revealed unch combined with 2 mg					
		2's physician's orders discontinue Cogentin 1 mg					
	-There was an entry f scheduled for adminis pm . -Cogentin 2 mg was r administered at 5:00	ation record (MAR) revealed: for Cogentin 2 mg twice daily stration at 7:00 am and 5:00					

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12/31/19.

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  ### OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  ### OF MICHADOWBROOK MALL COURT  ### CEMMONS    CAMPIE   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREPIX   RESULATORY OR LSC IDENTIFYING INFORMATION    PREPIX   TAG   PROVIDER'S PLAN OF CORRECTTION ADOLD BE CROSS-REFERENCED TO THE APPROPRIATE DATE    D 358	STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  THE IVY AT CLEMMONS  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 102 -There was an entry for Cogentin 1 mg at lunch time scheduled for administration at 11:30 amCogentin 1 mg 1 tablet at lunch was not documented as and 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 amCogentin 1 mg was not documented as administered as ordered.  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 amCogentin 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 01/125/20 to 01/27/20 on 01/29/20 and on 01/23/20, from 01/125/20 to 01/27/20 on 01/29/20 and on 01/30/20.							
THE IVY AT CLEMMONS  CLEMMONS, NC 27012    (X4)   ID PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (IDENTIFYING INFORMATION)   D PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    D 358			HAL034150	B. WING		02/11/2020	
CLEMMONS, NC 27012    CAJID   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLANOF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CLEMMONS, NC 27012  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 358  Continued From page 102  -There was an entry for Cogentin 1 mg at lunch time scheduled for administration at 11:30 amCogentin 1 mg 1 tablet at lunch was not documented as administered at 11: 30 am from 12/20/19 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 amCogentin 1 mg was not documented as administered at 11:30 am from 01/01/20 to 01/18/20, 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.	THE IVY A	AT CLEMMONS	6010 ME	ADOWBROOK M	IALL COURT		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 12/19/19, 12/19/19, 12/19/19 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 01/13/20, from 01/19/20 to 01/27/20 on 01/29/20 and on 01/30/20.	CLEMMON			NS, NC 27012			
-There was an entry for Cogentin 1 mg at lunch time scheduled for administration at 11:30 amCogentin 1 mg 1 tablet at lunch was not documented as administered at 11: 30 am from 12/05/19 to 12/19/19, 12/21/19, 12/28/19, 12/29/19 and on 12/31/19There 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 amCogentin 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.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLET	E
time scheduled for administration at 11:30 amCogentin 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 12/31/19There 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 amCogentin 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.	D 358	Continued From page	e 102	D 358			
-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.	D 336	-There was an entry f time scheduled for accogentin 1 mg 1 tab documented as admin 12/05/19 to 12/19/19, 12/29/19 and on 12/3 -There was no documented as not administered at 11:30 amCogentin 1 mg was readministered at 11:30 amThere was an entry from 01/19/01/25/20 to 01/27/20 01/30/20Discontinued was hear there was an entry from 101/25/20 to 01/27/20 01/30/20Discontinued was hear there was an entry from 101/06/20, from 01/08/20, "Hospital" was writte 01/16/20, 01/19/20 arrogentin 2 mg was readministered at 5:00 MAR from 01/08/20 to	for Cogentin 1 mg at lunch diministration at 11:30 am. let at lunch was not nistered at 11: 30 am from 12/21, 12/23/19, 12/28/19, 1/19. Inentation for the reason ministered as ordered.  12's progress notes for aled Resident #2 refused /19 and 12/30/19.  12's January 202 MAR  15 or Cogentin 1 mg 1 tablet led for administration at led for administration at led for o1/23/20, from on 01/29/20 and on andwritten on the MAR. for Cogentin 2 mg twice daily stration at 7:00 am and 5:00 and from 01/02/20 to 01/20/20, from and on 01/27/20. In on the MAR for 01/15/20, and 01/20/20. documented as not pm by circled initials on the o 01/14/20, on 01/17/20, and	D 336			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/1	1/2020
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
	T CLEMMONS	6010 MEAD	OWBROOK N	IALL COURT		
INCIVIA	T CLEWINIONS	CLEMMON	S, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 103	D 358			
	January 2020 revealed medications on 01/02 01/08/20, and on 01/02 Review of Resident # revealed: -There was an entry f scheduled for administration pmCogentin 2 mg was of	2's February 2020 MAR or Cogentin 2 mg twice daily stration at 7:00 am and 5:00				
	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 ed there were no progress				
	hand 02/07/20 at 10:1 -Cogentin 2 mg tablet were available for adr -There were 2 unoper Cogentin 2 mg tablets bubble pack and disp instructions to adminisurance -There was 1 unopen 1 mg tablets with 30 t	is and Cogentin 1mg tablets ministration. ned bubble packs of swith 30 tablets in each ensed on 02/01/20 and ster twice daily. ed bubble pack of Cogentin ablets in the bubble pack /30/20 and instructions to				

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Review of Resident #2's current orders and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02	/11/2020
NAME OF PROVIDER OR S	UPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMMON	ıs		ADOWBROOK NO 27012	MALL COURT		
PREFIX (EAC	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLETE DATE
dispensing pharmacy -There wa 2 mg 1 tab -Cogentin on 02/01/2 -There wa 1 mg daily -Cogentin on 01/30/2 Interview (PCP) on -She knew his medical issuesShe was Resident # anti-psych Interview (provider (Prevealed: -She visite -She had of -She was receiving Provider (Prevealed: -The facility discovered 01/24/20The MHP not getting and misse was compand less reanti-psych -Resident	revealed: s an order s an order solet twice da 2 mg was o 20 for 60 tal s an order at lunch. 1 mg was o 20 for 30 tal with Reside 02/07/20 at r Resident at the facilit 2 was not otic medica with Reside MHP) on 02 d Resident ordered Co aware that his antipsyo y did not m d this by rev was so co the correct d medicatio liant, stable esistance to otic medica	dated 12/12/19 for Cogentin aily. dispensed on 01/17/20 and olets each date. dated 12/12/19 for Cogentin dispensed on 01/04/20 and olets each date. dispensed on 01/04/20 and olets each date. Int #2's primary care provider 8:55 am revealed: #2 was noncompliant with the had a lot of mental health are h	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			1	<del></del>	
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		6010 MEA	DOWBROOK N	MALL COURT	
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012		
(V4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	)N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 358	8 Continued From page 105		D 358		
	Interview with the Re	sident Care Coordinator			
	(RCC) on 02/10/20 at				
	, ,	vere just discontinued on the			
	MARs because the M				
		edication carts, or the MAs			
	thought the residents	needed a new prescription.			
	-The MAs did not know what to doThe 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				
		dication orders were being			
	_	, so medications were not			
	being sent to the facil				
	_	was new and there was no			
	to do.	to show the new staff what			
	io do.				
	Interview with a medi	cation aide (MA) on			
	02/10/20 at 11:15 am				
	-She administered me	edications to Resident #2.			
	-Staff initials circled o	n the MARs meant the			
	medications were not	administered, or could not			
	_	ason, resident refused the			
	medication or medica	tion was not available in the			
	medication cart.				
		ed Resident #2's PCP or			
		oth were aware of Resident			
		hey were both in the facility			
	seeing residents ever	y two weeks.			
	Attempted telephone	interviews with Resident			
	I	06/20 at 5:00 pm and on			
	02/11/20 at 10:00 am				
	Attempted telephone	interview with the mental			
	health provider for Re				
	hospital on 02/10/20				
	unsuccessful.	•			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02	2/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
THE IVY A	AT CLEMMONS		ADOWBROOK M. DNS, NC 27012	ALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLETE DATE
D 358		h the previous Administrator	D 358			
	07/19/20 revealed dia unsteadiness on feet	, muscle weakness, lack of of falls, vascular dementia,				
	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.					
	paperwork dated 11/2 -Resident #3 was hyp blood pressure upon -Resident #3's amlod	f3's hospital discharge 26/19 revealed: pertensive and her systolic admission was in the 200's. lipine was increased to 10 aily, upon discharge on				
	paperwork dated 01/3 -Resident #3 had constarted at the base of over the top of her he-Resident #3 was pre-	mplaints of a headache that f her neck and extended ead. eviously admitted to the and her amlodipine was				
	orders revealed there 01/31/20 amlodipine	5 mg take two tablets daily.				
	Review of Resident #	#3's December 2019				

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-There was an entry for amlodipine 2.5 mg one

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING	B. WING		1/2020
	ROVIDER OR SUPPLIER	6010 ME	DDRESS, CITY, STA Adowbrook N NS, NC 27012	,	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 358	tablet daily, schedule -There was documen 12/01/19 to 12/22/19 12/29/19 to 12/31/19 -There was no docum 12/28/19 at 8:00 am.  Review of Resident # revealed: -There was an entry f tablet daily, schedule -There was documen 01/01/20 to 01/31/20  Review of Resident # revealed: -There was a handwr mg take one tablet da -There was documen 02/01/20 to 02/06/20  Observation of Resid hand on 02/07/20 at 2 -There was one bubb amlodipine 2.5 mg tal -There were no amlor available for administ  Review of Resident # paperwork dated 01/3 -Resident #3 had con started at the base of over the top of her he -Resident #3 was pre hospital on 11/25/19 a increased to 10 mg d 11/26/19.	d at 8:00 am. tation of administration at 8:00 am and from at 8:00 am. hentation from 12/23/19 to  3's January 2020 MAR  or amlodipine 2.5 mg one d at 8:00 am. tation of administration at 8:00 am.  3's February 2020 MAR  itten entry for amlodipine 10 aily, scheduled at 8:00 am. tation of administration from at 8:00 am.  ent #3's medications on 2:43 pm revealed: le package with 30 blets dispensed on 01/30/20. dipine 10 mg tablets ration.  3's hospital discharge 81/20 revealed: hplaints of a headache that her neck and extended ad. viously admitted to the and her amlodipine was	D 358			

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02/07/20 at 2:45 pm revealed:

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	_ETED
		1141 024450	B. WING		00/	44/0000
		HAL034150			021	11/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THE NAVA	T CLEMMONE	6010 MEA	DOWBROOK N	MALL COURT		
I TE IV I A	T CLEMMONS	CLEMMON	NS, NC 27012			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THI DEFICIENCY)		DATE
				BEI IGIEITO I		
D 358	Continued From page	e 108	D 358			
	-She administered the	e dose of amlodipine				
	available on the cart.					
	-She did not know wh	en Resident #3's dose of				
	amlodipine changed,	because she only worked				
	part-time.	•				
	Telephone interview v	vith a Pharmacist at the				
	facility contracted pha	armacy 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 tablet	s of amlodipine 5 mg				
	dispensed on 07/30/1 10/10/19.	9, 8/30/19, 09/10/19, and				
	-Then a new order wa	as written dated 10/29/19 for				
		ily and a 16 day supply was				
		supplies of amlodipine 2.5				
		11/19, 12/04/19, 01/06/20,				
	-The pharmacy did no	ot have an amlodipine 10 mg				
	order in the computer	system for Resident #3.				
	•	with Resident #3's physician				
	on 02/07/20 at 9:15 a					
	-She saw Resident #3					
		nitted to the hospital on				
	01/31/20 due to her b					
		ipine was increased from 5				
	mg to 10 mg in Nover	mber 2019 after her				
	hospitalization.					
	-She requested to see	e Resident #3's February				
		nd amlodipine 2.5 mg was				
	on the MAR.					
	-She discovered Resi					
		still not receiving amlodipine				
	10 mg daily.					
	-She sent Resident #3					
	amlodipine 10 mg dai	lly to the pharmacy again on				

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02/04/20.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		1101 004450	B WING		00/44/000	
		HAL034150	B. WIITO		02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
THE IVY A	T CLEMMONS		NDOWBROOK N NS, NC 27012	IALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COM	K5) PLETE ATE
D 358	Continued From page	÷ 109	D 358			
	treat hypertension.  Interview with the Res	odipine 10 mg prescribed to sident Care Coordinator 4:04 pm revealed:				
	<ul> <li>(RCC) on 02/10/20 at 4:04 pm revealed:</li> <li>-She did not know about Resident #3's inaccurate amlodipine dose.</li> <li>-She had worked at the facility a year ago and she was just hired again on 02/05/20.</li> </ul>					
	-She did not know Resident #3 was admitted in January 2020 due to high blood pressure.					
	on 02/10/20 at 4:41 p -She began working a and she was still learn -She was not familiar medicationShe would have expense.	at the facility on 02/05/20 ning each resident.				
	5:20 pm revealed: -He was hired on 02/0 with Resident #3.	ministrator on 02/10/20 at 05/20 and was not familiar was receiving the wrong				
	07/19/20 revealed the	t #3's current FL-2 dated ere was a medication order l (used to treat high blood				
	-There was an entry f daily, scheduled at 8:	ation record (MAR) revealed: for carvedilol 12.5 mg twice				

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carvedilol 12.5 mg from 12/01/19 to 12/22/19 at

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING	7. BOILDING.			
	HAL034150	B. WING		02	/11/2020	
NAME OF PROVIDER OR SUPPLI	ER STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE			
THE IVY AT CLEMMONS		ADOWBROOK M DNS, NC 27012	ALL COURT			
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
from 12/01/19 to 8:00 pm, 12/21 to 12/31/19 at 8 Review of Resi revealed: -There was an daily, schedule -There was doc carvedilol 12.5 8:00 am and 8: Review of Resi revealed there mg twice daily.  Observation of hand on 02/07/one bubble pace 12.5 mg, dispersion of hand on 02/07/20 at 2:4 -She did not kn 12.5 mg was not a she thought si morning, 02/07 -She was a particulity dailyShe was not a administration of Attempted teleps shift MA on 02/8:29 am were used.	12/30/19 to 12/31/19 at 8:00 am, to 12/13/19 at 8:00 pm, 12/18/19 at 8:00 pm, and from 12/28/19 8:00 pm.  Ident #3's January 2020 MAR  Bentry for carvedilol 12.5 mg twice to at 8:00 am and 8:00 pm.  Bumentation of administration of the grown on 1/01/20 to 01/31/20 at 00 pm.  Ident #3's February 2020 MAR  Ident #3's February 2020 MAR  Ident #3's February 2020 MAR  Ident #3's medications on 20 at 2:43 pm revealed there was elage with 30 tablets of carvedilol nised on 01/30/20.  In first shift medication aide (MA) on 5 pm revealed:  In why Resident #3's carvedilol on the February MAR.  In gave Resident #3 carvedilol that 1/20, but she was not sure.  It-time MA and was not at the ble to provide documentation of of carvedilol 12.5 mg.  In the provide documentation of the carvedilol 12.5 mg.  In the provide documentation of the carvedilol 12.5 mg.	D 358				

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		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
THE NOVA	T OI EMMONO	6010 MEA	DOWBROOK N	IALL COURT	
THE IVY AT CLEMMONS CLEMMO			NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 111	D 358		
	-Resident #3 had an a twice daily ordered or supply was sent on 0 -There was another p #3's carvedilol 12.5 m and a 21-day supply 2-A 30-day supply of c dispensed on 09/10/1 12/04/19, and 01/30/2 Telephone interview on 02/07/20 at 9:15 a -Resident #3 has bee since admissionShe thought she saw Resident #3's Februal-Resident #3 has care	order for carvedilol 12.5 mg in 07/19/19 and a 30-day 7/23/19. Orescription sent for Resident ing twice daily on 08/30/19 was sent the same date. Arvedilol 12.5 mg was 19, 10/10/19, 11/11/19, 20.  With Resident #3's physician im revealed: Or carvedilol 12.5 mg on ary 2020 MAR on 02/04/20. Or wedilol prescribed to treat in esident #3 did not receive			
	(RCC) on 02/10/20 at	sident Care Coordinator t 4:04 pm revealed she did 3's carvedilol 12.5 mg was 2020 MAR.			
	on 02/10/20 at 4:41 p know Resident #3's c	sident Care Director (RCD) om revealed she did not carvedilol 12.5 mg was not cebruary 2020 MAR and she de documentation of			
	5:20 pm revealed: -He did not know ther administration for Res	onsible for documenting the			

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	JF CURRECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COIVIFLI	=1ED
		HAL034150	B. WING		02/1	1/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE 00/ A	T 01 511110110	6010 MEA	DOWBROOK M	IALL COURT		
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
IAG		,	IAO	DEFICIENCY)		
D 358	Continued From page		D 358			
		t #3's subsequent physician				
	orders revealed:	tion order dated 10/11/19 for				
		d to treat psychosis) twice				
	daily for psychosis.	u to treat psychosis, twice				
	, ,	tion order dated 10/17/19 for				
	Seroquel 50 mg twice					
		tion order dated 12/03/19 for				
	Seroquel 75 mg twice					
		tion order dated 12/12/19 for				
	mg nightly.	y morning and Seroquel 100				
	, ,	tion order dated 01/23/20 for				
	Seroquel 100 mg twice					
		, , , ,				
	Review of Resident #					
		ation record (MAR) revealed:				
		ritten entry for Seroquel 50				
	mg twice daily, sched drawn through it.	duled for 8:00 am with a line				
	-There was a second	handwritten entry for				ı
		e daily, scheduled for 8:00				
	am and 8:00 pm and	-				
	documented where st					
	documented.					
		tation of administration of				
		12/09/19 to 12/14/19 at				
	8:00 am and 12/13/19	9 at 8:00 pm. third entry for Seroquel 100				
	mg at bedtime, sched					
		Itation of administration of				
		n 12/01/19 to 12/14/19 at				
	8:00 pm.					
		fourth entry for Seroquel 50				
	mg every morning, so					
		tation of administration of				1
	Seroquel 50 mg from 8:00 am	12/01/19 to 12/14/19 at				1

-There was a handwritten fifth entry for Seroquel 75 mg daily, scheduled at 8:00 am. Division of Health Service Regulation

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
			B. WING			
		HAL034150	B. WING		02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			ADOWBROOK N			
THE IVY A	T CLEMMONS			MALL COOK I		
	Г		ONS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		.
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		•
IAG	TREGOLATION ON	EGG IDEITTI TING III GIUMMITON,	IAG	DEFICIENCY)	W. (12	
						_
D 358	Continued From page	e 113	D 358			
	There was deciman	tation of administration of				
		tation of administration of				
		12/16/19 to 12/22/19 at				
		/30/19 to 12/31/19 at 8:00				
	am.					
		itten sixth entry for Seroquel				
	100 mg at bedtime, s	•				
		tation of administration of				
		n 12/14/19 to 12/17/19 at				
		8:00 pm, and from 12/22/19				
	to 12/31/19 at 8:00 pr	m.				
	Review of Resident #	3's January 2020 MAR				
	revealed:					
	-There was a printed	entry for Seroquel 100 mg				
	at bedtime, schedule					
	-There was documen	tation of administration of				
	Seroquel 100 mg fror	n 01/01/20 to 01/31/20 at				
	8:00 pm.					
	•	printed entry for Seroquel				
		one-half tablets (75 mg)				
	every morning, sched					
	, ,	tation of administration of				
		tablets) from 01/01//20 to				
	01/21/20 at 8:00 am.	tablots) from 0 1/0 1//20 to				
		tation where the staff initials				
		cond entry was rewritten and				
	discontinued on 01/2					
		indwritten entry for Seroquel				
		cheduled at 8:00 am and				
	8:00 pm.	cheduled at 0.00 am and				
		tation of administration of				
		m 01/27/20 to 01/31/20 at				
	8:00 am and 8:00 pm	I.				
	Povious of Posidorst #	22's Eshruary 2020 MAD				
		3's February 2020 MAR				
	revealed:					
		entry for Seroquel 100 mg				
	twice daily, scheduled	d 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

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DIVISION	of Health Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			_		
			D 14/11/0		
		HAL034150	B. WING		02/11/2020
NAME OF D		CTDEET AS	DRESS, CITY, STAT	FF 71D CODE	
NAIVIE OF P	ROVIDER OR SUPPLIER		, ,	,	
THE IVY A	T CLEMMONS	6010 ME	ADOWBROOK M	ALL COURT	
11121417	II OLLIIIIIOITO	CLEMMO	NS, NC 27012		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(*)
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 350	0	. 44.4	D 358		
D 358	Continued From page	9 114	D 336		
	8:00 am and 8:00 pm	, and 02/06/20 at 8:00 am.			
	o.oo am ana o.oo pm	, and 02/00/20 at 0.00 am.			
	Observation of Reside	ent #3's medications on			
	•	2:43 pm revealed there was			
		•			
		with 30 one-half tablets of			
	Seroquel 50 mg.				
		hift medication aide (MA) on			
	02/07/20 at 2:45 pm r	evealed:			
	-She did not recall wh	at she administered to			
	Resident #3 related to	her Seroquel dose on			
	02/07/20.	•			
	-She did not locate ar	ny Seroquel 100 mg tablets			
	in the medication stor				
	iii iiio iiioaloatioii otoi	ago room.			
	Telephone interview v	vith a Pharmacist at the			
		armacy on 02/07/20 at 10:20			
	•	annacy on 02/07/20 at 10.20			
	am revealed:				
		order for Seroquel 100 mg			
	twice daily dated 01/2				
		s of Seroquel 100 mg			
	dispensed on 01/23/2	0 and 60 more tablets were			
	set to be dispensed o	n 02/12/20.			
	Telephone interview v	vith Resident #3's mental			
	health physician on 0	2/07/20 at 12:17 pm			
	revealed:	•			
	-She had continued to	increase Resident #3's			
	Seroquel dose to trea				
	hallucinations.				
		scribed Seroquel 100 mg			
	twice daily on 01/23/2				
		lity on Thursdays to see			
	residents and last sav	v Resident #3 on 01/23/20.			
		sident Care Coordinator			
	(RCC) on 02/10/20 at				
	-She did not know Re	sident #3's Seroquel 100			

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mg tablets were not on the medication cart.
-She expected the MAs to transcribe orders from

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		HAL034150	B. WING		02/1	1/2020
NAME OF D		OTREETA		FF. 7ID 00DF		
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
THE IVY A	AT CLEMMONS		ADOWBROOK M	ALL COURT		
			ONS, NC 27012			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
D 358	Continued From page	e 115	D 358			
	the mental health phy	ysician and administer				
	medications as order					
		As to notify the pharmacy if				
	-	not available to administer.				
		sident Care Director (RCD)				
	on 02/10/20 at 4:41 p					
		ed any medications for did not know there were no				
		allable to administer to				
	Resident #3.	illable to autilities to				
	i	As to follow the six rights of				
	-	and administer the correct				
	dose of medication.					
	Interview with the Adr	ministrator on 02/10/20 at				
	5:20 pm revealed:					
	-He was not aware th	nat Resident #3 did not have				1
	the correct dose of Secart.	eroquel on the medication				
		s to be responsible for				1
	contacting the pharma					1
	concerning a medicat	tion.				
	d. Review of Residen	nt #3's subsequent physician				
	orders revealed:					ı
	-There was a medica	tion order dated 11/07/19 for				ı
	, ,	treat prevent blood clots)				ı
	_	y for seven days followed by				ı
	5 mg twice daily.	lucadiaatiau audau datad				ı
	01/26/20 for Eliquis 5	medication order dated				ı
	0 1/20/20 101 Eliquis 3	ing twice daily.				
	Review of Resident #	43's December 2019				ı
	medication administra	ation record (MAR) revealed:				ı
	-There was a handwr	ritten entry for Eliquis 5 mg				ı
	take one tablet twice	daily, scheduled for 8:00 am				ı
	and 8:00 pm.					ı
	-There was documen	itation of administration of				ı

Eliquis 5 mg from 12/01/19 to 12/22/19 at 8:00

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
	T CLEMMONE	6010 MEA	DOWBROOK N	IALL COURT	
INEIVIA	T CLEMMONS	CLEMMON	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 116	D 358		
	am, from 12/30/19 to 12/01/19 to 12/11/19 12/18/19 at 8:00 pm,	12/31/19 at 8:00 am, from at 8:00 pm, from 12/17/19 to from 12/20/19 to 12/22/19 at 2/28/19 to 12/30/19 at 8:00			
	revealed: -There was a handwr take one tablet twice and 8:00 pmThere was documen	3's January 2020 MAR itten entry for Eliquis 5 mg daily, scheduled at 8:00 am tation of administration of 01/20 to 01/31/20 at 8:00			
	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 pmThere was documentation of discontinued where the staff initials would be located.				
	hand on 02/07/20 at 2 no Eliquis available for Interview with a first s 02/07/20 at 2:46 pm r -Resident #3 had disc	shift medication aide (MA) on revealed: continue written on her			
	for Resident #3's Eliq -She had not seen a Resident #3's Eliquis. -She looked in the sto	continue order somewhere uis if it was on the MAR. discontinue order for orage room where pharmacy s were placed but she did			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL034150	B. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMMONS			DOWBROOK M	IALL COURT		
			NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 117	D 358			
	facility contracted pha am revealed:  -There was an order of mg two tablets daily for tablet (5 mg) twice da duration dated 11/07/ dispensed the 7 days 11/08/19.  -There was no Eliquis second half of the scr documentation in the the reason.  -The amount of Eliquis prescription dated 11/17- There was another of #3's Eliquis 5 mg twice -There was a 30-day dispensed on 01/27/20	s dispensed to fulfill the ript and there was no computer system indicating s indicated on the 707/19 was 74 tablets. Index received for Resident red daily dated 01/26/20. Supply of Eliquis 5 mg red for Resident #3.				
	-Resident #3 was place hospitalized in Noven thrombosis (DVT)She continued the Electric residual re	ced on Eliquis after being nber 2019 for a deep vein liquis for Resident #3 y of DVT and decided she				
	MAR when she saw it -If Resident #3 did no she was at risk for de	was on the February 2020 t on 02/04/20. t receive Eliquis as ordered, veloping a pulmonary in an artery in the lungs).				
	(RCC) on 02/10/20 at -She did not know Re	sident #3 did not have and she did not know why				

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discontinued.

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Division of	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL034150	B. WING		02/1	1/2020
					1 02/	172020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		DOWBROOK N	MALL COURT		
		СLЕММО	NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
170		,	IAG	DEFICIENCY)		
D 250	0 (; 15	440	D 250			
D 358	Continued From page	e 118	D 358			
	-She expected the MA	As not to document				
	discontinue for any m	nedication without an order to				
	discontinue the medic	cation.				
		sident Care Director (RCD)				
	on 02/10/20 at 4:41 p					
		esident #3 did not have				
	Eliquis to administer.					
	=	As to transcribe orders when				
		sician and if the medication				
	RCC or herself aware	the pharmacy to make the				
	NOC OF Hersell aware	<del>.</del>				
	Interview with the Adr	ministrator on 02/10/20 at				
	5:20 pm revealed:					
	-He was not aware of	f Resident #3's Eliquis.				
	-The MAs were respon	onsible for notifying the				
	pharmacy when a me	edication was not available to				
	administer.					
		h the previous Administrator				
	on 02/11/20 at 9:30 a	m.				
	6 Paviou of Posidon	it #4's current FL-2 dated				
	-	agnoses included psychosis.				
		pidemia, and syncope.				
	Tryportonion, Tryporn	praema, and syncope.				
	a. Review of Residen	it #4's current FL-2 dated				
	10/19/19 revealed the	ere was a medication order				
	for olanzapine 10 take	e one-half tablet twice daily.				
	Review of Resident #	4's subsequent physician				
	orders revealed:					
	-There was an order					
	olanzapine 10 mg dai	-				
		order dated 01/30/20 for				
	olanzapine 10 mg dai	ııy.				
	Review of Resident #	4'e January 2020				
		ation record (MAR) revealed:				
	modiodion duministr	anon robbia (ivi) ii i) robbalca.	1			[

Division of Health Service Regulation

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Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	T CLEMMONS	6010 MEA	DOWBROOK N	IALL COURT	
INEIVIA	II CLEIWINIONS	CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 119	D 358		
	-There was a handwr mg take one-half table scheduled at 9:00 am -There was documen 01/24/20 to 01/31/20 01/23/20 to 01/31/20 Review of Resident # revealed: -There was an entry f one-half (5 mg) twice and 9:00 pm. -There was documen 02/01/20 to 02/06/20 -There was documen 02/01/20 at 9:00 pm. -There were circled si	itten entry for olanzapine 10 et (5 mg) twice daily, n and 9:00 pm. tation of administration from at 9:00 am and from at 9:00 pm.  E4's February 2020 MAR for olanzapine 10 mg take daily, scheduled at 9:00 am tation of administration from			
	hand on 02/07/20 at 2 no olanzapine availab  Interview with a first s 02/07/20 at 2:45 pm r -She knew Resident s olanzapine in stockShe planned to reord #4 at the end of her s	shift medication aide on revealed: #4 did not have any der olanzapine for Resident shift.			
	been out of olanzapin the facility part-time.  Telephone interview whealth physician on 0 revealed:	w long Resident #4 had he because she worked at with Resident #4's mental 2/07/20 at 12:17 pm zapine for Resident #4 to			

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-She last saw Resident #4 on 01/30/20 and she

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL034150	B. WING		02/11/2020	
					1 02/11//2020	_
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
THE IVY A	T CLEMMONS		ADOWBROOK N	IALL COURT		
		CLEMMO	NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	( - /	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
17.0		,	170	DEFICIENCY)		
D 350	0 " 15	100	D 250			$\neg$
D 358	Continued From page	9 120	D 358			
	was actively hallucina	iting.				
	-She needed the olan	zapine and her				
	hallucinations would i	ncrease without the				
	medication.					
		sident Care Coordinator				
	(RCC) on 02/10/20 at					
		esident #4 did not have any				
	olanzapine available					
	-She did not know the	•				
	· ·	re Resident #4 on profile in				
	their computer system					
		As to notify her or the RCD if ith obtaining a resident's				
	medications.	in obtaining a resident's				
	medications.					
	Interview with the Res	sident Care Director (RCD)				
	on 02/10/20 at 4:41 p	, ,				
	-She did not know ab					
	medications not being	g available.				
	-She expected the MA	As to notify the pharmacy				
	when a mediation wa	s not available to administer.				
		ninistrator on 02/10/20 at				
	5:20 pm revealed:	1.D. 1.1.1.11				
	-He did not know abo					
	medications not being	•				
	•	s, RCC, and RCD to ensure edications available to				
	administer.	edications available to				
	dariiiiiotor.					
	Attempted telephone	interviews with a second				
		at 9:53 am and 02/11/20 at				
	8:29 am were unsucc					
	Attempted interview v	vith Resident #4's pharmacy				
		pm was unsuccessful.				

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

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· , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		HAL034150	B. WING		02/1	1/2020
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
THE IVY	AT CLEMMONS		.DOWBROOK N NS, NC 27012	IALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	58 Continued From page 121		D 358			
	mg/ml take 2.5 ml twi	ce daily.				
	Review of Resident # orders revealed: -There was an order of 2.5 mg twice dailyThere was an order of discontinue Haldol.  Review of Resident # medication administration administration administration and twice daily, schedulemThere was document Haldol 2.5 ml from 02 am and 9:00 pm.  Observation of Resident on 02/07/20 at 20 one bubble package was an order of twice daily.	4's subsequent physician dated 12/31/19 for Haldol dated 01/30/20 to  4's February 2020 ation (MAR) revealed: for Haldol 2 mg/ml take 2.5 alled for 9:00 am and 9:00 tation of administration of //01/20 to 02/06/20 at 9:00  ent #4's medications on 12:05 pm revealed there was with 18 tablets of Haldol				
	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 HaldolShe 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:					

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01/30/20 because she was prescribed another

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Division of	<u>of Health Service Regu</u>	lation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
THE IVY A	AT CLEMMONS		ADOWBROOK MA ONS, NC 27012	ALL COURT		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	÷ 122	D 358			
	medications.	ation olanzapine. need two anti-psychotic e of Haldol could cause side				
	(RCC) on 02/10/20 at -She expected the M/ orders when the phys -She expected the M/ the orders.	sident Care Coordinator t 4:04 pm revealed: As to implement medication sicians provided the orders. As to transcribe and follow esident #4's Haldol was				
	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.					
	5:20 pm revealed: -He expected the MA: responsible for physic	ministrator on 02/10/20 at as, RCC, and RCD to be cian orders.				
	Refer to interview with on 02/11/20 at 9:30 a	h the former Administrator nm.				
	on 02/11/20 at 9:30ar -Her last day of work -The medication aided the pharmacy.					

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pharmacy delivered medications.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02	2/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
	T CI EMMONS	6010 ME	ADOWBROOK MA	LL COURT		
I HE IV I A	T CLEMMONS	CLEMMO	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 123	D 358			
D 358	-She had a lot of issu never got resolved be the pharmacy to anot owned by a family me-She continuously bar orders placed on the and processed compleshe did not follow up missing medications I carts, MARs, and phy-The facility was undeas PCA, MA, and Addreshe and the facility failed to a ordered which resulter receiving an anti-psycresulting in increased receiving an anti-psycresulting in an increased developing a pulmonal hypertension; Reside anti-psychotic medicarisk of anxiety and har receiving an diuretic reand hospital visit for finot receiving medicat asthma medication, a resulting in an increase difficulty breathing, and increase difficulty breathing, and owners and the summer of the process of the part of the	es with the pharmacy that cause the owner changed her pharmacy that was ember. Ittled with the MAs to get residents' records, MARS, etely. In the MAs and RCD about by auditing the medication resician's orders. Iterstaffed, and she had work ministrator.  Indications as and in Resident #1 not chotic medication as ordered anxiety; Resident #2 not chotic medications resulting and hospital admission to unit; Resident #3 not chotic, a blood thinner, and medications as ordered sed risk of hallucinating, ary embolus and attions resulting an increased actions resulting an increased actions; Resident #5 not sulting in increased dema aluid overload; Resident #13 ions for panic attacks, and eye drops for dry eyes sed risk of panic attacks, and dry eyes; Resident #10	D 358			
	resulting in an increase difficulty breathing, ar not receiving 2 medic in an increased risk on Resident #14 not receivesulting in an increase clots. This failure place	sed risk of panic attacks, and dry eyes; Resident #10 cations for COPD resulting of difficulty breathing; and ceiving a blood thinner sed risk of developing blood ced residents at substantial and serious neglect which				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034150	B. WING		02/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
<b>THE 00/</b>	- aa.	6010 ME	ADOWBROOK N	IALL COURT	
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 358	Continued From page 124		D 358		
	CORRECTION DATE	. 131 D-34 on 02/07/20.			
D 366	D 366 10A NCAC 13F .1004 (i) Medication Administration		D 366		
	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.				
	reviews, the facility fa documented on the M Administration Record of medications immediadministration and no administration of medications (Residents)	ns, interviews and record hiled to ensure staff Medication d (MAR) the administration			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPI	EIED
		HAL034150	B. WING		02/	11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		DOWBROOK N NS, NC 27012	MALL COURT		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETE DATE
D 366	Continued From page	e 125	D 366			
	a. Review of Residen 12/04/19 revealed dia schizophrenia, insulir mellitus, anxiety and	dependent diabetes				
	12/04/19 included phy-Lamotrigine 100 mg disorders)Losartan 50 mg daily pressure)Oxybutynin 10 mg dabladder)Oyster Shell calcium calcium deficiency)Perphenazine 4 mg schizophrenia)Celexa 40 mg daily (Deep Sea nasal sprathree times daily (use	r15's current FL2 dated ysician's orders for: daily (used to treat mood or (used to treat high blood aily (used to treat overactive soon mg daily (used to treat twice daily (used to treat used to treat depression).  ay 1 spray, both nostrils, and to treat dry or irritated				
	revealed: -An order dated 06/18 mg daily (used to treat-An order dated 10/17 100 mg twice daily (used to treat-An order dated 10/17 100 mg twice daily (used to treat-An order dated 10/17 100 mg medication particularly medications as admir administration of the standard transcrigine 100 mg -Losartan 50 mg daily -Oxybutynin 10 mg daily	pass revealed the Medication such of the following histered prior to the actual medications: daily.				
	-Oyster Shell calcium -Perphenazine 4 mg					

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
		HAL034150	B. WING		02/1	11/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		ADOWBROOK M	MALL COURT		
			ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 366	Continued From page	e 126	D 366			
	three times dailyVitamin B12 1000 mg -Docusate sodium 10 Refer to the interview with the MA.					
	with the Resident Care Coordinator (RCC).					
	Refer to the interview with the Resident Car	on 02/07/20 at 12:30pm re Director (RCD).				
	Refer to the interview with the Administrator	on 02/11/20 at 11:15am r.				
	12/15/19 revealed dia cerebral vasculr accid	at #14's current FL2 dated agnoses included history of dent, Rhabdomyolysis, s and facial weakness.				
	12/15/19 included phy -Amlodipine 10 mg da pressure). -Baclofen 10 mg twice	e14's current FL2 dated ysician's orders for: aily (used to treat high blood e daily (used to treat muscle				
	excess stomach acid	twice daily (used to treat). laily (used to treat anxiety).				
		pass revealed the MA pollowing medications as the actual administration of				

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-Baclofen 10 mg twice daily.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
		-	A. BUILDING: _			
		HAL034150	B. WING		02/11	/2020
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		DOWBROOK M	IALL COURT		
CLEMMON		NS, NC 27012				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 366	Continued From page	: 127	D 366			
	-Pantoprazole 40 mg -Escitalopram 5 mg d	-				
	Refer to the interview with the MA.	on 02/07/20 at 10:20am				
	Refer to the interview with the RCC.	on 02/07/20 at 12:10pm				
	Refer to the interview on 02/07/20 at 12:30pm with the RCD.					
	Refer to the interview with the Administrator	on 02/11/20 at 11:15am				
	02/26/19 revealed dia depression, anxiety, h	/ disease, gastroesophageal				
	02/26/19 included phy-Gavi-lax 17 gm mixe (used to treat constipation-Tramadol 50 mg four pain).	d in 6 ounces of liquid daily				
	D deficiency)Duloxetine 60 mg two depression)Latuda 120 mg daily disorder).	ice daily (used to treat				
	constipation)Tizanidine 4 mg twice spasticity).	e daily (used to treat e daily (used to treat muscle every 6 hours as needed				

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(used to treat nausea).

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			D. WING				
		HAL034150	B. WING		02/1	1/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
THE IVY A	T CLEMMONS		OWBROOK M	IALL COURT			
			S, NC 27012				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 366	Continued From page	<del>≥</del> 128	D 366				
	Review of Resident # revealed no document physician's order for the grade of the signed physician's foot may be deficiency.  Observation on 02/07 morning medication provided in the medications:  -Gavi-lax 17 gm mixe -Tramadol 50 mg four -Vitamin D 2000 units -Duloxetine 60 mg twi -Latuda 120 mg daily -Senna Plus 8.6/50 mr -Tizanidine 4 mg twice -Promethazine 25 mg -Hydroxychloroquine -Vitamin B12 500 mg Interview on 02/10/20 revealed she was unaphysician orders for Fred the interview with the MA.  Refer to the interview with the RCC.	et13's physician's orders nation of a signed the hydroxychloroquine 200 natitis) and nodocumentation is order for the vitamin B12 of treat vitamin B12 of tr					
		on 02/07/20 at 12:30pm					

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

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Division of	Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
		HAL034150	B. WING		02/11/2020		
NAME OF D	DOVIDED OD SUDDIJED	CTDFFT A	DDBESS CITY STA	TE ZID CODE			
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA				
THE IVY A	T CLEMMONS		ADOWBROOK N DNS, NC 27012	IALL COURT			
			JN3, NC 27012				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPF  DEFICIENCY)	BE COMPLETE		
D 366	Continued From page	÷ 129	D 366				
	with the Administrator						
	d. Review of Resident 01/03/20 revealed dia	t #1's current FL-2 dated					
		er, hypertension, major					
	depressive disorder, a	* ·					
	unspecific lesion of m						
	Daview of Desident #	Ala august FLO datad					
	Review of Resident # 01/01/20 included phy						
		ounces of of water daily					
	(used to treat constipa						
	•	three times daily (used to					
	-Amitiza 8 mcg twice						
	constipation).	ly (used to treat high blood					
	pressure).	y (abba to a bat mgm blood					
		daily (used to treat high					
	blood pressure).						
	-Celecoxib 200 mg da	ally (used to treat					
	inflammation).	aily (used to treat vitamin					
	deficiency).	any (used to treat vitainin					
	-Vitamin D 5000 U da	ily (used to treat vitamin D					
	deficiency).						
		e daily (used to treat vitamin					
	E deficiency).	(used to treat high blood					
	pressure).	(used to treat high blood					
	-	twice daily (used to treat					
	bipolar disorder).	, ,					
		(used to treat asthma).					
	-Senna Plus 8.6 - 50 constipation).	mg twice daily (used to treat					

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

STATE FORM 6899 69Q011 If continuation sheet 130 of 150

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/	11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE	, ZIP CODE		
			EADOWBROOK MA			
THE IVY A	AT CLEMMONS	CLEMM	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 366	Continued From page	= 130	D 366			
	-Clonazepam 0.5 mg -Amitiza 8mcg twice of -Amlodipine 5 mg dainor and twice of -Celecoxib 200 mg dainor and twice of -Celecoxib 200 mg dainor and twice of the interview with the RCC.  Refer to the interview with the RCC.  Refer to the interview with the RCC.	daily. da				
	Interview on 02/07/20 revealed:	at 10:20am with the MA				

revealed:

another floor in the facility.

-She always signed the MARs when she punched the medication into the medication cup, and not

-She was trained to never leave a blank spot on a

Interview on 02/07/20 at 12:10pm with the RCC

-She had only been the RCC for 2 days and was

after the medication was administered.

MAR when administering medication.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7.1. 20122			
		HAL034150	B. WING		02/1	1/2020
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		DOWBROOK N	IALL COURT		
I			NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 366	Continued From page	e 131	D 366			
	entire medication adn -MAs should initial the had been administered Interview on 02/07/20 revealed: -She had been the RO -She had noticed MAs carts, but she had not observe a medication -The MAs should not medication was admin Interview on 02/11/20 Administrator reveale -The RCD was respon	e MAR after the medication ed, not before.  D at 12:30pm with the RCD  CD for 2 days. Is working on the medication of the the opportunity to administration pass. Initial the MARs before the nistered.  D at 11:15am with the d: Insible for proper and correct lication as it was ordered by facility. It documentation for				
D 367	10A NCAC 13F .1004 Administration	I(j) Medication	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					

Division of Health Service Regulation

documenting the resulting effect on the resident;

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) DA' A. BUILDING:		
		1141 004450	B. WING			2/44/0000
		HAL034150	5		02	2/11/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
THE IVY	AT CLEMMONS		ADOWBROOK MA	LL COURT		
	OLIMANA DV. OT		ONS, NC 27012	DDO//IDEDIO DI ANI OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO TO THE PROPERTY OF THE PROVIDER OF	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 132	D 367			
	omission, including re (8) name or initials of the medication or trea signature equivalent	any omission of nents and the reason for the efusals; and, the person administering atment. If initials are used, a to those initials is to be ntained with the medication				
	reviews, the facility fathe Medication Admir sampled residents (R#4) related to docume an arthritis medication documenting the admisoftener and oxygen thinner (Resident 14) #4) as ordered by the The findings are:  1. Review of Resident 02/26/19 revealed diadepression, anxiety, I	ns, interviews and record iiled to ensure accuracy of histration Records for 4 of 5 desident #13, #10, #14, and tenting the administration of in (Resident #13), hinistration of a stool (Resident 10), a blood in, and a vitamin (Resident is physician.  It #13's current FL2 dated agnoses included bipolar				
		:13's physician's orders ted 12/19/19 for Humira				

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STATE FORM 6899 69Q011 If continuation sheet 133 of 150

Division of Health Service Regulation						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
THE IVY A	AT CLEMMONS		ADOWBROOK M	ALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	e 133	D 367			
	40mg injection every arthritis).	14 days (used to treat				
	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 daysThe dates of 02/01/20, 0202/20, and 02/03/20 were initialed and circled indicating the medication was not administeredThe dates of 02/04/20, 02/05/20 and 02/06/20 were initialed as administered.					
	revealed: -She did not administ -She was unable to lo Resident #13She had been taugh medication administra initialed the entry.	ation entry blank, so she nt the Humira injection as an				
	-She had only been the new to the facilityShe did not know Resinjection orderedShe had not had the	O at 12:10pm with the dinator (RCC) revealed: the RCC for 2 days and was esident #13 had a Humira e opportunity to review all the had not reviewed the MARs				

-The entry on the MARs should only be initialed

after a medication was administered.

STATE FORM 6899 69Q011 If continuation sheet 134 of 150

PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 134  -The entry on the MARs should be initialed and		NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
THE IVY AT CLEMMONS  CLEMMONS, NC 27012  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 134  -The entry on the MARs should be initialed and			HAL034150	B. WING		02/11/2020	
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 134  -The entry on the MARs should be initialed and			6010 MEAL	OWBROOK N			
-The entry on the MARs should be initialed and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETE DATE
icricled 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 daysShe did not know Resident #13 had a Humira injection orderedShe did not know medication staff had initialed the MAR as if the Humira had been administeredThe medication staff should initial the medication entry on the MAR after a medication was administeredIf 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 12/20/19The Humira Pen injection 40mg/.4ml pen had not been refilledThe 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 #15 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	D 367	-The entry on the MA circled if the medicati then the reason the m should be logged on Interview on 02/07/20 Resident Care Direct -She had been the Reshe did not know me the MAR as if the Hullenth entry on the MAR after administered.  -If a medication was if the entry on the MAR circled, then the reasing given should be logged Interview with a pharmon on the MAR circled, then the reasing interview with a pharmon on the MAR circled, then the reasing interview with a pharmon on the market in the Humira Pen inject on the Humira injection.	aRs should be initialed and ion was not administered, nedication was not given the back of the MAR.  O at 12:30pm with the or (RCD) revealed: CD for 2 days. Esident #13 had a Humira  edication staff had initialed mira had been administered. If should initial the medication er a medication was  not administered as ordered, a should be initialed and on the medication was not ed on the back of the MAR.  Imacy representative on revealed; Estion 40mg/.4ml inject 1 pen 14 days was dispensed on ection 40mg/.4ml pen had have to request any refills for the tion 40mg/.4ml.  Each #13 on 02/07/20 at the treceived any doses of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once the staff of the mass of the initialed and once	D 367			

Division of Health Service Regulation

(COPD), muscle weakness and major depressive

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Division of Health Service Regulation

DIVISION	n nealth Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
			_			
		HAL034150	B. WING		02	/11/2020
NAME OF D	DOVIDED OD CURRUED	CTDEET AD	DDECC CITY CTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
THE IVY A	T CLEMMONS	6010 MEA	DOWBROOK N	MALL COURT		
		CLEMMOI	NS, NC 27012			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO		DATE
			1	DEFICIEN	C1)	
D 367	Continued From page	135	D 367			
	Continuou i rom page	7 100				
	disorder.					
	a. Review of Residen	t #10's record revealed a				
	signed physician's ord	ders dated 08/29/19 for				
		e 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.						
	_	nented as administered daily				
		12/21/19 through 12/24/19				
	when Resident #10 w	as hospitalized.				
	Review of Resident #	10's January 2020 MAR				
	revealed:					
	-An entry for lactulose	e 10gm/15 give 30 cc once				
	daily for constipation.					
		nented as administered daily				
	_	01/01/20 and 01/29/20				
	which were initialed a					
		k of the MAR for 01/01/20				
	•					
	was documented "Re					
	•	k of the MAR for 01/29/20				
	was documented "He	ld due to loose stool".				
		#10's February 2020 MAR				
	revealed:					
	<ul> <li>-An entry for lactulose</li> </ul>	e 10gm/15 give 30 cc once				
	daily for constipation.					
	-The entry was docum	nented as administered daily				
	at 7:00am from 02/01	•				
		-				
	Interview with a Medi	cation Aide (MA) on				
	02/10/20 at 10:15 am	* *				
		t and second shifts as a MA.				
	-Resident #10 often re					
		Resident #10's medication				
	-one had worked off f	CONCERT # 10 3 INCUIDATION	1	1		

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cart yesterday and Resident #10 refused the 7:00

STATE FORM 6899 69Q011 If continuation sheet 136 of 150

Division of Health Service Regulation							
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		UAI 024450	B. WING		02/11/2020		
		HAL034150			02/1	1/2020	
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STA				
THE IVY A	T CLEMMONS		ADOWBROOK N NS, NC 27012	IALL COURT			
	0.18.44.51.07			DDGU/DEDIG DI AM OF CODDECTION			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 367	Continued From page	e 136	D 367				
	am dose of lactulose 30cc once daily for constipation.						
	representative reveals -The pharmacy had a lactulose 10gm/15 giv constipation, which ha -The lactulose had ne because the facility ha medication.  Interview with the pre 02/10/20 at 10:15 am -Resident #10 had an lactulose 10gm/15 giv	n order dated 08/29/19 for ve 30 cc once daily for ad never been dispensed. ever been dispensed ad never requested the scribing provider on revealed:					
	pm revealed: -She usually refused: -She did not need to	the lactulose 30cc. take the lactulose.  It #10's January 2020 MAR  A 45cc take 45cc (used to 1 day at 8:00pm.  O1/07/20. Inented as administered from 19/20, from 01/21/20 Ifrom 01/28/20 through  O was initialed and circled.  It was the lactulose.					

blank.

Review of Resident #10's February 2020 MAR

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020	
	ROVIDER OR SUPPLIER	6010 MEA	DRESS, CITY, STA DOWBROOK N NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	8:00pmThe entry was docur 02/01/20 through 02/01/20 through 02/01/20 through 02/01/20 through 02/01/20 through 02/01/20 through 02/11/20 the pharmacy had a lactulose 45cc by modose today-constipation -Lactulose 45cc was none had been disperate order was a one every day X 1 day and Interview with the precedent of the order dated 01/01/20 at 10:15am through of the MARs.  Interview with the Resident of the MARs.  Interview with the Resident of lactulose 45cc evertoday.  Interview with Resident 1:50pm revealed she lactulose 45cc.	e take 45cc X 1 day at mented as administered from 06/20.  10's record revealed no cc take 45cc X 1 day at  1 at 1:15pm with a pharmacy ed: In order dated 01/07/20 for uth every day X 1 day, giving on. Idispensed on 01/08/20 and insed since. It time dose of lactulose 45cc id would not need a refill.  1 scribing provider on revealed: 107/20 for lactulose 45cc ving dose today-constipation order. 11:20 am revealed:	D 367			

Division of Health Service Regulation

08/22/19 revealed an order for oxygen at 3 liters

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		02/11/2020	
	ROVIDER OR SUPPLIER	6010 MEA	DDRESS, CITY, STA ADOWBROOK N NS, NC 27012	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
D 367	from 12/01/19 through -There was no documbeen monitored or ad Review of Resident 1 revealed: -An entry for oxygen and -Documentation of according of 93 opportunities from 01/31/20There were 10 of 93 administration left blam 01/31/20.  Review of Resident # revealed: -An entry for oxygen and -Documentation of according of 19 opportunities from 02/07/20There were 3 of 19 of administration left blam 02/07/20.  Observation on 02/07 Resident #10 had oxygen and part of 19 opportunities from 02/07/20.  Observation on 02/07 Resident #10 had oxygen and part of 19 opportunities from 02/07/20.	inuously.  210's December 2019 ation Record (MAR)  at 3 lpm continuously. cumented administrations in 12/31/19. Inentation the oxygen had liministered by facility staff.  O's January 2020 MAR  at 3 lpm continuously. Iministration by staff for 83 om 01/01/20 through  opportunities for ink from 01/01/20 through  210's February MAR  33/lpm continuously. Iministration by staff for 16 om 02/01/20 through  opportunities for ink from 02/01/20 through  opportunities for ink from 02/01/20 through  opportunities for ink from 02/01/20 through	D 367			

Division of Health Service Regulation

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DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL034150	B. WING		02/11/2020	
NAME OF D	ROVIDER OR SUPPLIER	CTDEET AD	DRESS, CITY, STA	TE ZID CODE	•	
NAME OF PI	ROVIDER OR SUPPLIER					
THE IVY AT CLEMMONS		DOWBROOK N	MALL COURT			
		CLEMMO	NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD	( -/	_
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		-
				DEFICIENCY)		
D 367	Continued From page	130	D 367			
D 301			D 307			
	Interview with the pre	<b>.</b>				
	02/10/20 at 10:15 am revealed:					
		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:	t #4 5 Current i L-2 dated				
	-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				
		ation record (MAR) revealed:				
		for vitamin D2 50,000 units				
	•	ekly on Monday, scheduled				
	at 9:00 am.	<i>3</i> ,				
	-There was documen	tation of administration of				
	vitamin D2 on 01/27/2	20 at 9:00 am.				
	Review of Resident #	4's February 2020 MAR				
	revealed:	101 Colucity ZOZO IVIAIN				
		or vitamin D2 50,000 units				
	•	ekly on Monday, scheduled				
	for 9:00 am.	3.				
	-There was documen	tation of administration of				
	vitamin D2 from 02/01	1/20 to 02/07/20 at 9:00 am.				
	Observation of Pacid	ent #4's medications on				
	-	ent #4's medications on 12:05 pm revealed there was				
	no vitamin D2 availab	•				
	no vitariiii DZ avallab	no ioi administration.				
	Attempted telephone	interview with Resident #4's				
	pharmacy on 02/07/2					
	unsuccessful.	•				
	Interview with the Res	sident Care Coordinator				

Division of Health Service Regulation

(RCC) on 02/10/20 at 4:04 pm revealed:

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
		HAL034150	B. WING		02/11/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE	•		
			ADOWBROOK MALL COURT				
THE IVY A	T CLEMMONS		NS, NC 27012				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE		
D 367	Continued From page	± 140	D 367				
	-She had not reviewe she did not know the Resident #4's vitamin -She expected the Mandication that was respected the Majust sign itShe held the MAs are ensuring the MARs we Interview with the Reson 02/10/20 at 4:41 preshe was not aware Massident #4's weekly -She expected MAs to before administering the Resident #4's weekly -She expected MAs to before administering the Resident #4's weekly -She expected MAs to before administering the Resident #4's weekly -She expected MAs to before administering the Resident #4's weekly -She expected MAs to before administering the Resident #4's vitamin and the Resident #4's weekly -She expected MAs to before administering the Resident #4's vitamin and the Resident #4's weekly -She expected MAs to before administering the Resident #4's vitamin -She expected the Majust sign in the Resident #4's weekly -She expected MAs to before administering the Resident #4's weekly -She expected MAs to be some the Resident #4's wee	d residents' MARs yet, so MAs were signing for D2 daily. As to not sign for a not available to administer. As to read the MAR and not and herself responsible for were accurate.  Sident Care Director (RCD) am revealed: MAs were signing daily for vitamin D2. or read the MAR entries medications. s were signing the MAR					
	revealed: -He was not aware th daily for Resident #4's	CC, and RCD responsible for					
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912				
	Every resident shall h 2. To receive care an adequate, appropriate	ration of Residents' Rights have the following rights: nd services which are e, and in compliance with state laws and rules and					
		as evidenced by: ns, record reviews, and failed to ensure residents					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
		HAL034150	B. WING		02	2/11/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
THE IVY A	T CLEMMONS		ADOWBROOK M DNS, NC 27012	ALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D912	appropriate and in confederal and state law related to staffing, and The findings are:  1. Based on observation interviews, the facility staffing hours were manifest based on a central shifts based on a central shifts sampled from to Tag D0219, 10 NC (Type B Violation)]  2. Based on recommercord reviews, the proposition to assure the manage policies of the facility were maintained for predication administration.	rvices which were adequate, impliance with relevant is and rules and regulation id implementation.  Itions, record reviews and in failed to ensure required interest on first, second and third issus of 61-70 for 12 of 42 in 1/23/20 to 02/05/20. [Refer AC 13F .0606 Staffing Chart is endations, interviews, and in revious Administrator failed in ement, operations, and in were implemented and rules in the property of the property o	D912			
D914	G.S. 131D-21 Declar Every resident shall h 4. To be free of menta neglect, and exploitate This Rule is not met	as evidenced by:	D914			
	interviews, the facility	ns, record reviews, and r failed to assure residents abuse, and neglect as				

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NAME OF PROVIDER OR SUPPLIER  THE IVY AT CLEMMONS  SUMMARY STATEMENT OF DEFICIENCES (CLEMMONS, NC 27012  [(A4) ID PROVIDER SPLAN OF CORRECTION MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6010 MEADOWBROOK MALL COURT  CLEMMONS, NC 27012   (X4) ID PREFIX TAG  (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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				A. BUILDING: _			
### CLEMMONS    Clemmons			HAL034150	B. WING		02/1	1/2020
CLEMMONS, NC 27012    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH OBRICEINCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   D914      D914   Continued From page 142   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	NAME OF P	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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	THE IVY	AT CLEMMONS			IALL COURT		
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	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
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	D914	related to Personal C Care, Resident Rights Administration.  The findings are:  1. Based on observat reviews, the facility fapersonal care assistaresidents (#2 and #9) receiving colostomy or requiring extensive as (#9). [Refer to Tag DC .0901(a) Personal Ca Violation)].  2. Based on record reinterviews the facility follow-up with health equipment company a 3 of 6 sampled reside #13) regarding colost an order for an antips to be administered by (HHN) (#2), a resident missed doses of med not obtained (#1), and an immunosuppressivadministered by a HHD0273, 10A NCAC 13 (Type A1 Violation)]  3. Based on record refacility failed to ensure (Resident #11, #9, #2 neglect resulting in a and verbally assaulte	are and Supervision, Health is and Medication  ions, interviews and record ailed to assure staff provided ince for 2 of 6 sampled regarding a resident not eare (#2), and a resident easistance with personal care 10269, 10A NCAC 13F are and Supervision (Type B reviews, observations and failed to ensure referral and care providers, a medical and Home Health agency for ents (Residents #1, #2, and only bags not obtained and eychotic medication injection of a Home Health Nurse at ordered clozapine with ication due to weekly labs at a resident with an order for the injection to be service injection to be service injection to be service and interviews the end of 8 sampled residents 2) were free of abuse and resident being physically displacements and interviews and interviews the end of 8 sampled residents 2) were free of abuse and resident being physically displacements and resident are aide.	D914			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL034150	B. WING		02/11/2020	
NAME OF PR	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	, , ,	
THE IVY A	T CLEMMONS		OWBROOK N S, NC 27012	IALL COURT		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D914	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 Implem G.S. 131D-25 Implem		D980			
	this Article shall rest v facility. Each facility s	lementing the provisions of with the administrator of the shall provide appropriate lement the declaration of ded in G.S. 131D-21.				
	This Rule is not met a					
	Based on recommend	dations, interviews, and				,

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DIVISION	or riealin Service Negu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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HAL034150						
		B. WING	<del></del>	02/1	1/2020	
NAME OF D		OTDEET AD	DEGG OITY OTA	TE 710 000E		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
THE IVY A	T CLEMMONS	6010 MEA	DOWBROOK N	MALL COURT		
		CLEMMON	NS, NC 27012			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG REGULATORY OR I		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
D980	Continued From page	144	D980			
		ormer Administrator failed to				
	ensure the managem	ent, operations, and policies				
	of the facility were imp	plemented and rules were				
	maintained for persor	nal care, health care,				
	medication administra					
	resident rights, and st	· · ·				
		·-······9·				
	The findings are:					
	The imanige 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 agoShe went to the previous Administrator to discuss hiring maintenance staff.					
		esponsible for maintenance				
		oing tasks because the				
	maintenance manage	er and staff quit in the past 3				
	months.					
	-The former Administr					
	housekeeping staff to					
	furniture and belongir	ngs to relocate them to				
	another room or stora	ige.				
	-She attempted to negotiate additional help					
	because housekeeping was behind with laundry					
	and daily housekeeping tasks in December.					
		strator became very angry,				
		nger approached her with				
	housekeeping concer					
	-After her attempt to negotiate additional help nothing changedResident's laundry, rooms and common areas					
	were not routinely cle	aned.				
	Intervious with the Dia	ton, Managar on 02/07/20 of				
		tary Manager on 02/07/20 at				
	9:50am revealed:					
	-	strator had a very poor				
	attitude.					
-The previous Administrator hired any person that						

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placed an application to work in the kitchen.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL034150		B. WING		02/11/2020		
NAME OF D			I OTA	FF 71D 00DF	1 02/11/2020	
NAME OF PI	ROVIDER OR SUPPLIER		DOWRESS, CITY, STAT			
THE IVY A	T CLEMMONS		NS, NC 27012	ALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D980	Continued From page	e 145	D980			
D980	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 145  -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		D980			
with the facility when the pharmacy had questions about medications or the facility staff needed to contact residents' PCP about medications.						

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-There was a lack of cooperation dealing with the

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STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COM	LLILD	
		HAL034150	B. WING		02	/11/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE			
THE IVY A	T CLEMMONS		DOWBROOK M	ALL COURT			
			NS, NC 27012				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D980	Continued From page	e 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 facilityThe 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 AdministratorThe former RCD was responsible for scheduling staff at the facility.						
	medication process a staff were performing -The former RCD was of any issues or cond	revealed: s responsible for MAs, and orders, and to assure work duties. s responsible to let her know erns with staff or residents. rator and the former RCD					
	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D. WING			
HAL034150		B. WING		02/11/2020		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		ADOWBROOK M	IALL COURT		
			ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D980	Continued From page	e 147	D980			
	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)]					
	facility failed to ensure (Resident #11, #9, #2 neglect resulting in a and verbally assaulte (Staff D) (#11), a resident assistance with activity resident not provided colostomy supplies (#	eviews and interviews the e 3 of 8 sampled residents 2) were free of abuse and resident being physically d by a personal care aide dent required extensive ties of daily living (#9), and a adequate colostomy care or \$\frac{4}{2}\$). [Refer to Tag 0338, 10A sident Rights (Type A2				
3. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 4 residents						

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(Residents #1, #10, #13 and #14) observed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _				
	HAL034150		B. WING		02/	02/11/2020	
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
THE IVY AT	CLEMMONS		DOWBROOK N NS, NC 27012	MALL COURT			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
din batti (II reference of the control of the contr	PROVIDER OR SUPPLIER  STREET ADDR  6010 MEADO CLEMMONS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		D980				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL034150		B. WING		02/11/2020		
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
THE IVY A	T CLEMMONS		OOWBROOK N S, NC 27012	IALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D980	unit and the same resadequate colostomy of were not obtained for about the facility with skin and clothes; personal to a resident who requires doses of an ato weekly labs not obtainistered an immorant medications not a residents; two residents; two residents at risand serious neglect with Violation.  The facility provided a accordance with G.S.	sion to an acute psychiatric sident not receiving care and colostomy bags the resident and walking intestinal contents on his sonal care was not provided uired extensive assistance; ntipsychotic medication due tained, a resident was not unosuppressive injection administered as ordered to 7 nts who were physically lited by Staff D. This failure sk of serious physical harm which constitutes a Type A1	D980			

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