Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDIEAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING: _		
		HAL034150	B. WING		R 10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 000}	O) Initial Comments		{D 000}		
	follow-up and COVID Control survey with o 09/25/20, desk review	nsite visits on 09/17/20 and v on 09/17/20 to 09/18/20, , 09/28/20 to 09/30/20 and			
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276		
	following in the reside (3) written procedures a physician or other li and (4) implementation of	ssure documentation of the			
	facility failed to ensuring implemented for 1 of	and record reviews, the e physician's orders were			
	The findings are:				
	02/14/20 revealed dia	4's current FL2 dated agnoses included diabetes chizophrenic disorder.			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
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TO WILL OF TH	to vibert of tool i eleft		ADOWBROOK N	,	
THE IVY A	T CLEMMONS		ONS, NC 27012	IALL GOOK!	
	OLIMANA DV OT			DROVIDEDIO DI ANI OF CODDECTIO	
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				DEFICIENCY)	
D 276	Continued From page	2 1	D 276		
	-An order to check the	e resident's BP weekly.			
	-All older to check the	e resident's bi-weekly.			
	Review of Resident #	4's record revealed there			
	was no documentatio	n of weekly BP checks.			
	Interview with Reside	•			
	` ,	/29/20 at 12:05pm revealed:			
	,	BP checks for Resident #4 to monitor the resident's BP.			
		e facility no longer checked			
	Resident #4's BP wee	-			
	-She did not give an o	-			
	Resident #4's weekly				
		to continue to check the			
	resident's BP weekly.				
		h Resident #4, she checked			
	her BP, but she wante	ed the BP checked between			
	THEI VISIUS WILLI THE TEST	ident.			
	Interview with a perso	onal care aide (PCA) on			
	09/29/20 at 1:33pm re	` ,			
	-She checked resider	nts' BP.			
	-The medication aide				
	resident had BP chec				
		ld to check Resident #4's			
	BP.				
	Interview with a medi	cation aide (MA) on			
	09/25/20 at 4:43pm re	, ,			
		d not be checked because it			
	was not documented	on the MARs.			
		ne facility since June 2020,			
		aware Resident #4 had an			
	order to check his BP	weekly.			
	Interview with the Adr	ministrator on 10/01/20 at			
	10:43am revealed:	111113114101 011 10/01/20 at			
		eekly BP was received, the			
	order would be put or				

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-Resident #4's PCP looked at the MARs and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING: (X3) DATE SURV				
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		HAL034150	B. WING	····	10	/01/2020
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THE IVY A	T CLEMMONS		ADOWBROOK MA	LL COURT		
		CLEMM	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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	2	D 276			
	she should have mad -She had worked at the and did not know whe Resident #4's BP wee Based on observation interviews it was dete	BP to be checked weekly e staff aware. ne facility since June 2020 en or if staff obtained				
{D 338}	interviewable. 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 a FOLLOW-UP TO A T	•				
	The Type A2 Violation Non-compliance conti					
	THIS IS A TYPE B VI	OLATION				
	interviews, the facility recommendations and the Centers for Disea North Carolina Depar Services (NC DHHS) maintained to provide during the global coropandemic and practic prevention and controrisk of transmission and	d guidance established by se Control (CDC) and the tment of Health and Human were implemented and protection of the residents				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
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		HAL034150	B. WING		10	R 0/ 01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
THE NAVA	T CI EMMONE	6010 ME	ADOWBROOK M	ALL COURT		
THE IVY	AT 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{D 338}	Continued From page	3	{D 338}			
	kiosk utilized by visito usage, no signage po appropriately wear fa maintaining a social of	nitizing the self-screening ors and staff before and after osted reminding staff how to ce coverings, and staff not listance of 6 feet from opropriately wearing PPE.				
	The findings are:					
	guideline for the previous (COVID-	for Disease Control (CDC) ention and spread of the 19) disease in long-term d personnel should always ile in the facility.	ong-term			
	Care (LTC) Facilities, must wear face cover those face coverings	e of North Carolina 7 all workers in Long-Term including adult care homes ings while in the facility, and must be surgical masks as a supplies are available.				
	through droplet, there	COVID-19 is transmitted fore the mouth and nose covered when wearing a contamination and				
	09/17/20 at 11:28am -The facility had a CC kioskThe COVID-19 self-s at least 20 feet inside -The kiosk contained tablet, hand sanitizer, disposable gloves, distissues.	ovide the front door of the facility. a wall mounted electronic sanitation wipes,				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
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	TO CELIMINO NO	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	(X5) COMPLETE DATE
{D 338}	Continued From page	÷ 4	{D 338}			
{D 338}	the facility and checke kiosk located in the hat the facility. -A resident who was repast the unmasked viself-screening at the socially distance, due. The visitor was provisithe facility staff. -The kiosk was not savisitor using the kiosk the kiosk. Interview with the Bus (BOM) on 09/27/20 at The COVID-19 kiosk visitors to self screen. The kiosk was cleaned the kiosk. Observation of the havarious times on 09/1 2:20pm revealed: -At 11:57am, a house elevator preparing to The housekeeper was covering that only covering that only coversidents' rooms to characteristics. The housekeeper has the cloth face covering was affixed to the houseloth face covering was affixed to the houselosh that the face t	ed in at the self-screening allway, at least 20 feet inside not wearing a mask walked sitor as he was kiosk and was unable to to the width of the hallway. ded a disposable mask by anitized by staff prior to the nor after the visitor used siness Office Manager to 11:25am revealed: was set up for staff and and sign in to the facility. The ded by staff after each use of allway on third floor at 7/20 between 11:50am and keeper was standing at the mop. The selection is wearing a cloth face wered her mouth. The selection is wearing a cloth face wered her mouth.	{D 338}			
	chin leaving her mout					

Division of Health Service Regulation

-She knew her face covering needed to cover her

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Division of	<u>of Health Service Regu</u>	lation				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
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{D 338}	Continued From page	÷ 5	{D 338}			
	mask or cloth face co-She preferred to wear coveringShe usually wore her her nose and mouth word cleaningShe sometimes pulled down when she was in Observation of the nure on 09/17/20 at 12:04prefer was a MA sea was standing at the swere less than 6 feet -Both the MA and the face coveringThe PCA who was standing below in the standing standing.	they could wear a surgical overing. ar her own cloth face or cloth face covering to cover when she was in a resident's led her cloth face covering in the hallways. ourses' desk on the third floor pm revealed: atted at the desk and a PCA side of the desk and they				
	revealed: -Staff "usually" wore a covering when interactive residentsShe did not have her	cting with each other and r face covering above her ause she had just gotten off				
	revealed: -She did not realize the mask on when she was talking to herThe facility gave her	he PCA did not have her ras standing at the desk cloth face coverings to wear one of them with the facility				

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-She was not told she needed to wear a surgical

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
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		HAL034150	B. WING		10/01/2	020
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{D 338}	Continued From page	e 6	{D 338}			
, ,			` '			
		did provide surgical masks if				
	staff wanted them.					
		illway on the 3rd floor on				
	09/25/20 at 1:38pm re	evealed:				
	-The housekeeper wa	as in the hallway was				
	wearing a cloth face of	covering below her nose.				
	-She was coming out	of a resident's room, but it				
	was not observed wh	ether the resident was				
	present in the room.					
	'					
	Interview with housek	seeper on 09/25/20 at				
	1:39pm revealed:	•				
		ng kept falling down below				
		ed to wear the cloth face				
	· ·	he surgical mask because				
	_	oke her face out a little.				
	_	d staff that surgical masks				
		n face covering, but staff				
		of wearing either surgical				
	masks or cloth face o					
	_	were available for staff upon				
		y at the screening station on				
	the first floorShe also had a stack	of 20 to 25 ourgical				
	facemasks on her cle	aning caπ.				
	0, , ,	411 51 1 00/47/00 1				
		e 4th floor at 09/17/20 at				
	11:55am revealed:	and the state of t				
	, , ,	ge in the hallway to remind				
		sks, cover coughs, practice				
	frequent handwashing	_				
		was exiting the elevator,				
		ering which was down below				
	her nose.					
		7/20 at 12:32pm revealed:				
		lway wearing a cloth face				
	covering pulled down	below her nose.				

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-A resident was also in the hallway.

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL034150	B. WING		R 10/01/2020	
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THE IVY AT CLEMMONS		NS, NC 27012	ALL COURT		
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{D 338} Continued From page	7	{D 338}			
1:50pm revealed: -There were 2 staff obs -Both staff wore cloth for the cloud noseThere were 2 resident Interview with a resident revealed: -Facility staff provided went outside earlier took the had not been proving until todayHe did not usually weak the had not been told for facility until today. Interview with the Admid 4:30pm revealed: -About a month ago, the cloth face coveringsThe facility staff provided coverings to the reside at 1:30pm revealed: -There were 2 staff weak the control of the staff wore for	face coverings. oth face covering below her ts in the hallway. ent on 09/17/20 at 2:05pm him with a mask when he day to smoke. vided a mask by the facility ar a mask inside the facility. to wear a mask inside the hinistrator on 09/17/20 at he facility was sent 5,000 ded the cloth face ents at that time. on the 4th floor on 09/25/20 earing cloth face coverings. the cloth face covering ekeeper on 09/25/20 at he cloth face covering she				

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-She washed the cloth face covering at least twice a week, either by hand in the sink or in the

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PRINTED: 10/09/2020

Division of	of Health Service Regu	lation			FORINI APPROVED	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		R 10/01/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	AT CLEMMONS	6010 ME	ADOWBROOK N	MALL COURT		
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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 APPROPE DEFICIENCY)	BE COMPLETE	
{D 338}	Continued From page	8	{D 338}			
	washing machine.					
	09/25/20 at 1:45pm re- The cloth face coveri the facilityHe washed the cloth the washing machine laundryNo one at the facility the disposable face m face covering. Interview with a secon 1:48pm revealed: -The facility did not pr covering she woreShe bought the face -The facility gave her masks, but she forgot -Today she wore the o in her work locker. Interview with a secon 4:40pm revealed: -The facility did not pr covering she woreShe bought her face -The facility gave her	face covering every night in along with his other had advised him to wear hask instead of the cloth and staff on 09/25/20 at rovide the cloth face covering herself. some disposable face them today. cloth face covering she had and PCA on 09/25/20 at rovide the cloth face				
	face coverings. Observation of the PC 4:40pm on 09/25/20 r	CA during the interview at evealed:				

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as she spoke.

-The PCA wore a cloth face covering.

-The face covering kept dropping below her nose

-The staff pulled her mask back in to place at least 15 times during the interview, repeatedly touching the outside of the face covering.

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Division of	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
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				,		
{D 338}	Continued From page	e 9	{D 338}			
	Observation of the PF	PE supply on the third floor				
	on 09/17/20 at 12:07					
		nt box of facemasks on the				
	counter at the nurses					
		nt box of facemasks in the				
		vith 16 boxes of gloves, 5				
	•	nt disinfecting wipes, and 5				
	gowns.	it dominoung wipos, and o				
	gowno.					
	Observation of the fac	cility's PPE storage area on				
		evealed there were more				
	-	e mask were available.				
	than ooo oargioar lao	o maon word available.				
	Interview with the Adr	ministrator on 09/25/20 at				
	5:25pm revealed:					
		n staff last week regarding				
	the appropriate use a					
		staff regarding surgical				
	mask.	3 3 3				
	-She had asthma and	still wore her surgical mask				
		Ity wearing a facemask they				
	should let her know.	, ,				
	Observation of a pers	sonal care aide (PCA) on the				
	third floor on 09/25/20	0 at 2:20pm revealed:				
	-The PCA was observ	ved going into residents				
	rooms with residents	present in the room.				
	-The PCA had menu	sheets in her hand and was				
	talking with residents	obtaining their meal				
	selection.					
	-The PCA was wearing	ng a cloth face covering.				
	-The cloth face cover	ing only covered the top of				
	the PCA's lips, and he	er nose was uncovered.				
		A on 09/25/20 at 2:30pm				
	revealed:					
		with residents wearing her				
	cloth face covering.					
	 -When interacting wit 	h the residents she did not				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		R 10/01/2020	
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NAME OF F	ROVIDER OR SUPPLIER		ADOWBROOK MA			
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{D 338}	Continued From page	e 10	{D 338}			
	have her nose covere	ed.				
	-She had asthma and	did not pull the cloth face				
	covering over her nos					
	-No one at the facility	had told her that she				
	needed to cover her r					
		had said anything to her				
	• •	lents' rooms with her nose				
	uncovered.					
	· ·	had offered her a surgical				
	face mask.	A dustinistants with at all a lead				
	asthma and did not co	Administrator that she had				
	astrima and did not co	over her nose.				
	Interview with the Adr 4:38pm revealed:	ministrator on 09/17/20 at				
	-Staff at the facility pro-	ovided direct care to the				
	residents through per	sonal care services and				
	medication administra					
		wear face coverings.				
		and NC DHHS had made				
	recommendations for mask.	staff to wear surgical face				
	-She considered the r	ecommendation not be a				
	requirement and she	elected to allow facility staff				
	to wear their own clot	h face coverings.				
		to recall exact date), she				
	•	ID-19 training with facility				
		oper way to wear PPE,				
	covering the mouth a					
		staff to ensure they covered				
	their mouth and nose	wnen wearing face				
	coverings.					
	Interview with a nurse	e from the local health				
		25 at 12:40pm revealed:				
	•	and assistance to long-term				

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during the pandemic.

care facilities related to keeping residents safe

-If an assisted living facility staff called for suggestions related to the type of PPE that staff

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			E SURVEY PLETED	
		HAL034150	B. WING		10	R 0/ 01/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	<u> </u>	
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THE IVY A	AT CLEMMONS	CLEMMO	ONS, NC 27012			
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{D 338}	Continued From page	======================================	{D 338}			
	should wear, then should wear, then should wear, then should have set by -No one at the named	e would tell them to follow the regulatory agency. I facility had contacted their ut the type of PPE that staff				
	Disease Control (CDC Division of Health and DHHS) guidelines for recommendations for equipment (PPE) for ensure staff wear fac global pandemic of C the self-screening kic staff before and after posted reminding use maintaining a social or residents when not a was detrimental to the of residents and conservations.	distance of 6 feet from oppropriately wearing PPE e health, safety and welfare titutes a Type B violation. //as provided by the facility in 131D-37 on September 17,				
	CORRECTION DATE VIOLATION SHALL N 15, 2020.	FOR THE TYPE B NOT EXCEED NOVEMBER				
D 344	10A NCAC 13F .1002	2(a) Medication Orders	D 344			
	the resident's physici for verification or clar medications and trea (1) if orders for admis	ne shall ensure contact with an or prescribing practitioner ification of orders for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		HAL034150	B. WING		10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		DOWBROOK N	IALL COURT	
			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 SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 344	Continued From page	: 12	D 344		
	admission or readmis forms are not the sam The facility shall ensu clarification is docume record. This Rule is not met a Based on observation reviews, the facility fa orders were clarified to	ear or complete; or on forms are received upon sion and orders on the ne. re that this verification or ented in the resident's as evidenced by: as, interviews, and record illed to ensure medication with the prescribing sampled residents (#6)			
	The findings are:				
	Review of Resident #6's current FL2 dated 02/14/20 revealed there were no diagnoses documented on the FL2: -There was an order for Entresto 24-26mg twice daily (used to treat elevated blood pressure).				
	correction by the Prim that Entresto 24-26mg administered once da -An electronically sign 07/29/20 for Entresto -An electronically sign 08/14/20 for Entresto -A physician's order d 24-26mg twice daily.	ated 07/04/20 with a noted hary Care Provider (PCP) g should be one tablet ily. ned order by the PCP dated 24-26mg once daily. ned order by the PCP dated 24-26mg once daily. ated 08/18/20 for Entresto			

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING: _			
		HAL034150	B. WING			R /01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	·	
THE BOX 6	- aaa	6010 MEA	DOWBROOK N	IALL COURT		
THE IVY A	AT 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 C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 344	Continued From page	e 13	D 344			
	Review of Resident # revealed: -There was an entry f daily scheduled for at 8:00pmThere was documen administered 56 time: 08/31/20. Review of Resident # revealed: -There was an entry f daily scheduled for at 8:00pmThere was documen was administered 57 09/29/20.	6's August 2020 MAR for Entresto 24-26mg twice dministration at 8:00am and tation Entresto 24-26mg s from 08/01/20 through 6's September 2020 MAR for Entresto 24-26mg twice dministration at 8:00am and tation Entresto 24-26mg times from 09/01/20 through				
	#6's medications on h	5/20 at 2:50pm of Resident nand at the facility revealed ce daily was available for				
	09/29/20 at 12:58pm -Resident #6 had a dipressureShe ordered Entrestrin reducing the reside -On the 07/04/20 phy the order for Entresto -She changed the order should be administered -She expected facility and ensure Entrestory once daily as ordered -After each visit at the	agnosis of high blood 24-26mg once daily to aid ent's high blood pressure. sician's order, she noticed 24-26mg was twice daily. Her noting the medication ed once daily. The staff to notify the pharmacy 24-26mg was administered I. The facility she followed-up with orders that listed current				

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DIVISION	or riealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
			_			_
			D WING			R
		HAL034150	B. WING		10/	01/2020
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE ZIR CODE		
NAME OF T	NOVIDEN ON 3011 LIEN		, ,	,		
THE IVY A	T CLEMMONS		DOWBROOK N	MALL COURT		
		CLEMMOI	NS, NC 27012			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP	ROPRIATE	DATE
				DEFICIENCY)		
D 344	Continued From page	e 14	D 344			
	the orders with her.	they had questions to clarify				
		uld have contacted her				
		o prior to administering the				
	medication.					
		August 2020 physician's				
	_	sto 24-26mg back to twice.				
		d visit day, she had asked				
		nat facility staff faxed to her				
	the MARs of residents	s that she was scheduled to				
	see.					
	-She wanted the MAF	Rs prior to her visit, so that				
	her assistant could re	view the medications on the				
	MAR with orders in he	er records to ensure current				
	medications were adr	ninistered.				
	-The facility had neve	r complied with her request				
	and faxed the MARs					
	'					
	Interview with Reside	nt #6 on 09/25/20 at 2:40pm				
	revealed:	, o o oo, _o, _o a op				
		e but was unsure about high				
	blood pressure.	but was unsure about mgm				
	· ·	was ordered a medication				
	for high blood pressul -He did not know wha					
	administered by facilit	ty staπ.				
	Intorvious with a ropro	sentative from the facility's				
		on 09/30/20 at 3:38pm				
	revealed:	on 09/30/20 at 3.30pm				
	-In July 2020, the pha					
		dent #6's PCP that Entresto				
	_	dministered once daily.				
		ted, so the pharmacy did not				
	change the medicatio					
		ility faxed a physician's				
	order for Entresto 24-	26mg twice daily.				
	-The pharmacy had n	o way of knowing the PCP				
		r for Entresto to be twice				

daily.

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					l R	,
		HAL034150	B. WING		1	1/2020
		TIAL COTTO			1 10/0	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	T CLEMMONS	6010 MEA	DOWBROOK N	MALL COURT		
INCIVIA	CLEMMO					
(X4) ID	SUMMARY STA	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 L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				BEI ICIEROT)		
D 344	Continued From page	e 15	D 344			
		sto 24-26mg had been				
	-	y the facility could have				
		lication using what they had				
		anged the MAR to read				
	once daily.					
	•	ave clarified the order with				
	•	ior to faxing the order to the				
	pharmacy.					
		s of Entresto 24-26mg				
	dispensed on 09/12/2					
	administer the medica	•				
	-There were 42 tablet	s dispensed on 08/28/20				
	with instructions to ad	Iminister the medication				
	twice daily.					
		on 09/29/20 at 2:41pm				
	revealed:					
		en administered Entresto				
	24-26mg twice daily f					
		ime when Entresto 24-26mg				
		sistered to Resident #6.				
		eceived, the previous RCD				
	was responsible for fa	axing orders to the				
	pharmacy.					
	•	as also responsible for				
	letting the MA know to	•				
	medication on the MA					
		e clarified with the PCP the				
		sponsible for contacting the				
	PCP to clarify orders.					
	Internal Control					
		ministrator on 09/25/20 at				
	2:17pm revealed:	and according to the Albert Co. 1991. C				
		ad worked at the facility for				
	barely 90 days.					
	-	ad been responsible for				
	auditing the medication					
		as supposed to check				
	medications listed on	the MARs with current	1			

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orders to identify discrepancies.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL034150	B. WING		10	R 9/ 01/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 MEA	DOWBROOK M	ALL 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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 344	Continued From page	e 16	D 344			
	was to contact the resordersUltimately, the previous ensuring the medication correctly on the MAR Interview with a Medi 09/25/20 at 3:47pm re-The previous RCD hensuring medication of medication orders we available for medication the Administrator was the residents' orders and Medication Administrator was Medication Administrator.	cation Aide (MA) on evealed: ad been responsible for orders and changes in ere on the MAR and on administration, but now a responsible. as responsible for reviewing and compared them to the ation Record (MAR).				
	09/29/20 at 3:56pm re-When she worked at responsibilities include the medication cart. -Most times after a viscouple of days, and the Administrator's couple Administrator woorders. -Because she was ne facility's process, after	the facility, her ed auditing the MARs and sit the facility's PCP waited a nen would email orders to emputer. ould print off and review the ew and still learning the er reviewing the orders the the orders and told her what				
{D 358}	10A NCAC 13F .1004 Administration	l(a) Medication	{D 358}			
	(a) An adult care hor	I Medication Administration ne shall assure that the nistration of medications,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
74101 2741	or dorate of the transfer of t	IDEITH IO/HIGH HOMBER	A. BUILDING: _			
		HAL034150	B. WING		R 10/01/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
{D 358}	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 FOLLOW-UP TO A To	prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by:	{D 358}			
	Violation was not abaccontinues. Based on observation reviews, the facility farmedications as orders residents (Residents including a sleep aide used for mood/sleep supplement (#5); an in anti-inflammatory, and and a laxative (#3); a insulin, and a short acting insulin armedication (#4). The findings are: Review of the facility's 07/17/20 revealed: -Request refills when blue area of the card.	ted. Non-compliance as, interviews and record iled to administer ed for 5 of 6 sampled #1, #3, #4, #5 and #6) e medication, a medication disorder, a potassium mmunomodular agent, an nuscle relaxant, and a pain nti-hypertensive medication laxative, a long acting cting insulin (#6), a topical t				
	doses are missedMedication aides are	to fill out the refill sheet and the pharmacy and document				

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Division of	Division of Health Service Regulation					
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R	
		HAL034150	B. WING		1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE. ZIP CODE		
			ADOWBROOK M			
THE IVY A	AT CLEMMONS		ONS, NC 27012	7111 GCG		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIA1E	DAIL
(5,050)						
{D 358}	Continued From page	∍ 18	{D 358}			
	the date and time it w					
	-	verify they received the fax				
		ou spoke to and when they				
		n place in the RCD in box in				
	the med room.	the medication room for				
		assume that there are none.				
		ng must be done as ordered				
	and documented on t	•				
	-All blood sugar readi	-				
	documented on the M					
	_	e documented with the				
	amount and the site y	you administered. e documented with the				
	reading and units of in					
	_	tered put a 0 on the MAR				
	with initials.					
		nsible for ensuring a weekly				
		or accuracy and reporting				
	results to the Executiv	ve Director.				
	1 Poview of Residen	nt #1's current FL2 dated				
	09/15/20 revealed dia					
		, elevated white blood cells,				
	Vitamin D deficiency,					
	hypertension, pain, ch	hronic obstructive pulmonary				
		nageal reflux disease, kidney				
	failure, tachycardia, a	and anxiolytic dependence.				
	Paview of Resident #	t1's rheumatologist office				
	visit summary dated (•				
		ry diagnosis was rheumatoid				
	arthritis involving mult	tiple sites.				
	_	uded multilevel degenerative				
	1	mary osteoarthritis involving				
	multiple joints.					
	a Review of Residen	nt #1's current FL2 dated				
	09/15/20 revealed an					

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hydroxychloroquine 200mg 1 tablet daily (used to

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _		_	
		HAL034150	B. WING		R	R 01/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	AT CLEMMONS	6010 ME <i>P</i>	ADOWBROOK M	IALL COURT		
	· · · · · · · · · · · · · · · · · · ·	СІЕММО	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 19	{D 358}			
	treat rheumatoid arthi	ritis).				
	Review of Resident #1's physician's orders dated 07/04/20 revealed there was no order for hydroxychloroquine.					
	September 2020 reve	1's Medication d (MAR) for August and ealed there was no entry for 200mg take 1 tablet daily.				
	Observation of Resident #1's medications on hand on 09/17/20 at 5:57pm revealed: -There was a bubble pack of hydroxychloroquine 200mg 1 tablet dailyThere were 15 tablets of hydroxychloroquine dispensed on 09/03/20 and there were 14 tablets remaining.					
		ss notes were requested on 20, but not provided prior to				
	revealed: -She saw her rheumaher rheumatoid arthrit-The rheumatologist toontinue to take hydrorheumatoid arthritisShe thought hydroxyadministered to her d	told her she needed to oxychloroquine for vchloroquine was				
	the pharmacy on 09/1 -There was an active hydroxychloroquine 2					

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facility in a quantity of 30 tablets on 05/23/20 and

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Division of Health Service Regulation

DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					F	,
		HAL034150	B. WING		1	1/2020
		11AE034130			1 10/0	71/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
	6010 ME			MALL COURT		
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
{D 358}	Continued From page	e 20	{D 358}			
	a quantity of 15 tablet	ts on 09/03/20 and was set				
		edication on 09/03/20.				
	-The facility had not re					
		rom the pharmacy between				
	05/23/20 and 09/03/2	. ,				
	03/23/20 and 09/03/2	0.				
	Interview with a medi	cation aide (MA) on				
	09/25/20 at 3:27pm re	` ,				
	•	cychloroquine was in the				
		was not on the MAR.				
	•	er hydroxychloroquine to				
		it was not on the MAR and				
		ether she should administer				
	or not.	etrier sile silouid administer				
		nyone about whether the				
		ve been administered or				
	not.	ve been administered of				
	-She had not contacte	ed Resident #1's				
		mary Care Provider (PCP)				
		cychloroquine should have				
	been administered or	•				
	boon duminiotorou or	not.				
	A second interview wi	ith the Medication Aide (MA)				
	on 09/25/20 at 3:47pr					
	-	ad been responsible for				
	•	orders were on the MAR for				
	medication administra					
	Administrator was res	•				
		as responsible for reviewing				
		and comparing them to the				
	MAR.	and companing alon to the				
		blet administered, but she				
		IA administered the tablet or				
	when.	, tadiiiiiistoroa tile tablet ol				
	WITCH.					
	Telephone interview v	vith a nurse from Resident				
	#1's rheumatologist's					
	3:59pm revealed:	530 5 55/25/25 at				
		en by the rheumatologist on				
	TOSIGOTIL # 1 Was Sec	m by the incumation	1			ı

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05/07/20 and 08/27/20.

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _		_	
		HAL034150	B. WING		R 10/0	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	T CLEMMONS	6010 MEA	DOWBROOK N	MALL COURT		
	TOLLININIO 143	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 358}	Continued From page	21	{D 358}			
{D 330}	-Resident #1 was prefor rheumatoid arthriti-On 05/07/20 and 08/documented Residen hydroxychloroquine 2-The rheumatologist whad been administered once in September 20-The rheumatologist of hydroxychloroquine to ordered. A second telephone in Resident #1's rheumatologist whydroxychloroquine was ordered. -Resident #1's rheumatologist whydroxychloroquine was orderedIf hydroxychloroquine in causing joint damage. Telephone interview wollow on the was orderedShe did not know Rehydroxychloroquine in quantity of 15 tablets on the was orderedShe did not know hydroxychloroquine in causing in the was only 1 to administeredShe did not know hydroxychloroquine in causing in the was only 1 to administeredShe did not know hydroxychloroquine in causing in the was only 1 to administeredShe did not know hydroxychloroquine in causing in the was only 1 to administeredShe did not know hydroxychloroquine in causing in the was only 1 to administered.	scribed hydroxychloroquine s. 27/20, the rheumatologist t #1 was to continue taking 00mg 1 tablet daily. was not aware Resident #1 ed hydroxychloroquine only 020. expected Resident #1's to be administered as the atologist's office on 09/29/20 order for hydroxychloroquine atologist did not know was not being administered for sordered, her rheumatoid and could be harmful as well as organ damage. With the Administrator on evealed: esident #1 had in the medication cart with a dispensed to the facility on ablet had been droxychloroquine was not on tradministration. ent #1's medications to be red by the physician.	{D 330}			
	the MAR to documen -She expected Reside administered as order	t administration. ent #1's medications to be				

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DIVISION	n rieaith Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
						,
		1141 024450	B. WING		F 40/0	
		HAL034150	5		10/0	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		6010 MEA	DOWBROOK N	IALL COURT		
THE IVY A	THE IVY AT CLEMMONS CLEMMO					
	OLIMANA DV OT		'	DDOV/DEDIO DI ANI OF CODDECTION		
(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	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
(D 250)	Cantinuad Francisco	. 22	(D 350)			
{D 358}	Continued From page	22	{D 358}			
	Refer to interview with	n a medication aide (MA) on				
	09/25/20 at 3:47pm.	,				
	'					
	Refer to interview with	n the previous Resident				
		on 09/29/20 at 3:50pm.				
	· · · · · · · · · · · · · · · · · · ·	oo:				
	b. Review of Residen	t #1's current FL2 dated				
		order for Miralax 17 grams				
		ally as needed (used to treat				
	constipation).	any as needed (asea to treat				
	consupation).					
	Review of Resident #	1's physician's orders dated				
		order for Miralax mix 17				
	_	fluid daily as needed (used				
	to treat constipation).					
	Review of Resident #	1'a Madigation				
		d for August 2020 revealed:				
		or Miralax mix 17 grams in 6				
	ounces of fluid daily a					
		nted as administered once a				
	day 5 times from 08/2					
		nted as administered twice				
	a day 4 times from 08					
		nted as administered three				
	times a day on 08/26/					
		16 doses documented as				
	administered to Resid					
	•	re should have only been up				
	to 11 doses administe	ered.				
		4				
	Review of Resident #					
	Administration Record	d for September 2020				
	revealed:					
		or Miralax mix 17 grams in 6				
	ounces of fluid daily a					
		nted as administered once a				
	day 10 times from 09/	/01/20 to 09/17/20.				
	-Miralay was docume	nted as administered twice	1			

Division of Health Service Regulation

a day on 09/11/20.

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Division of Health Service Regulation

DIVISION	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		HAL034150	B. WING		1	2020
		HALU34150			10/01/2	2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		6010 MEA	DOWBROOK N	IALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012			
	CLIMMADY CT		<u>, </u>	DDOVIDEDIC DI AN OF CODDECTION	.,	
(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 APPROPF		DATE
				DEFICIENCY)		
(D 250)	0	- 00	(D 350)			
{D 358}	Continued From page	e 23	{D 358}			
	-There was a total of	12 doses documented as				
	administered to Resid	dent #1 in September 2020.				
		·				
	Resident #1's progres	ss notes were requested on				
		0, but not provided prior to				
	exit on 10/01/20.					
	5/ 51. 16/6 1/ 2 0.					
	Observation of Resid	ent #1's medications on				
		5:57pm revealed Miralax				
	was not available for					
	ras not available for	aurimieu aueri.				
	Interview with Reside	ent #1 on 09/25/20 at 1:58pm				
	revealed:	me // 1 311 33/23/23 at 1.33pm				
	-She needed Miralax	almost daily due to				
	constipation.	amost daily due to				
	•	liralax on the evening of				
	09/24/20 and on the r					
		alax for a few weeks prior to				
	the morning of 09/25/					
		liralax daily up until 09/24/20				
		cation Aides (MA) there was				
		d they could not borrow				
	Miralax from other res	•				
	will alax II OIII Olliel Tex	olderite.				
	Telephone interview v	with a representative from				
	•	acy on 09/18/20 at 10:57am				
	revealed:	ady on 03/10/20 at 10.07 am				
		order for Miralax mix 17				
		fluid daily as needed.				
	•	ed by the pharmacy for a 30				
		20, 08/26/20, and 09/19/20.				
	-Staff had to request					
	-Glaii Hau to request	TOTHIS TOT WITH ALAX.				
	Telenhone interviews	with a MA on 09/30/20 at				
	2:08pm revealed:	with a MA OH 03/30/20 at				
	•	of Miralax for a few days in				
	September 2020.	. Or ivilialax IOI a IEW Uays III				
	•	nacy but she did not				
	-She called the pharn	nacy, but sne did fibl				

Division of Health Service Regulation

remember what she was told by the pharmacy. -Resident #1 had asked for Miralax during the

STATE FORM 6899 69Q014 If continuation sheet 24 of 98

Division of Health Service Regulation

Division of	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		CON	IPLETED
						R
		HAL034150	B. WING		1 1	0/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
			ADOWBROOK N			
THE IVY A	T CLEMMONS		NS, NC 27012	IALL GOOK!		
240.15	CUMMADV CT		<u> </u>	DROVIDERIS DI ANI OF (CORRECTION	0.00
(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 ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page 24		{D 358}			
	time that it was not in	the facility.				
	-Resident #1's order t	for Miralax was as needed.				
		ed a second dose of Miralax				
		gust because she thought				
	_	ant that Resident #1 could				
		y times as she needed it				
	when she was constit					
	1	sident #1 was administered				
		n the morning and in the at's when she asked for it.				
	everings because the	at 5 When she asked for it.				
	Telephone interview v	with Resident #1's Primary				
	I	on 09/29/20 at 12:51pm				
	revealed:	•				
	-Resident #1 had an	order for Miralax 1 scoop				
	daily as needed.					
	-She did not know the	ere were times when				
		ng administered Miralax				
	more than once daily					
	•	cility to let her know if				
		Miralax more than once				
	daily.	eant up to 1 time a day.				
	•	eant up to 1 time a day. mes for administration of				
	Miralax more than on					
	-She knew the facility	•				
		Resident #1 let her know				
	and she contacted the					
	-She expected staff to	o administer Miralax to				
	Resident #1 as order	ed.				
	Talambana intamiaww	with the Adversaria to the transfer of the				
		with the Administrator on				
	09/30/20 at 1:11pm re	evealed: ralax was not available on				
	the medication cart of					
		As had administered more				
		ax daily to Resident #1 in				
	August and Septemb					
		ent #1's medications to be				

Division of Health Service Regulation

administered as ordered.

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING		 R		
		HAL034150	B. WING		1	1/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
THE IVY A	T CLEMMONS		DOWBROOK N	IALL COURT			
			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 358}	Continued From page	25	{D 358}				
	Refer to interview with the Administrator on 09/25/20 at 2:17pm.						
	Refer to interview with 09/25/20 at 3:47pm.	n a medication aide (MA) on					
		n the previous Resident on 09/29/20 at 3:50pm.					
	c. Review of Resident #1's current FL2 dated 09/15/20 revealed an order for Humira 40mg/0.4ML inject 1 pen every 14 days (used to treat rheumatoid arthritis).						
		1's physician's orders dated ere was no order for Humira.					
	visit summary dated (-Resident #1's primar arthritis involving mult -Diagnoses also inclu	y diagnosis was rheumatoid					
	02/18/20 revealed an	inject 1 pen (40 mg dose)					
		1's Medication d (MAR) for August and aled there was no entry for					
	#1 revealed Resident	lth (HH) notes for Resident #1 was administered a 7/23/20, 08/07/20, and					

Division of Health Service Regulation

09/01/20.

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Division of Health Service Regulation

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
					l ,	_
			B. WING			₹
		HAL034150	B. WING		10/0	01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		6010 MFA	DOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012			
	OLIMANA DV OT			DDOV/DEDIO DI ANI OF CODE		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AI		DATE
				DEFICIENCY)		
(D 250)	Cantinuad Francisco	. 00	{D 358}			
{D 358}	Continued From page	20	{D 330}			
	Resident #1's progres	ss notes were requested on				
	09/17/20 and 09/21/2	0, but not provided prior to				
	exit on 10/01/20.					
	Observation of Reside	ent #1's medications on				
	hand on 09/17/20 at 5	5:57pm revealed Humira				
	was not available for					
	Telephone interview v	vith a representative from				
	the contracted pharm	acy on 09/18/20 at 10:57am				
	revealed:	,				
	-There was an order f	for Humira 40mg/0.4ML				
	inject 1 pen every 14					
	-The pharmacy dispe	nsed Humira 2 pens at a				
	time on 07/17/20, 08/					
	Interview with Reside	nt #1 on 09/25/20 at 1:58pm				
	revealed:					
	-She was administere	ed Humira every two weeks				
	by a HH nurse for her	rheumatoid arthritis.				
	-She thought her last	injection was given on				
	09/18/20.					
	-The HH nurse was a	t the facility last Wednesday				
	on 09/16/20, to admir	nistered Humira, but Humira				
	was not available in the	ne facility.				
	-The HH nurse had to	come back on 09/18/20				
	(she thought) to admi	nister the medication.				
	Interview with a MA o	n 09/25/20 at 3:47pm				
	revealed:					
	-She did not know Hu	•				
	administered by a HH					
	-Humira was not on the	ne MAR ans she had never				
	requested a refill from	n the pharmacy.				
	Telephone interview v					
	09/28/20 at 10:38am					
	-Resident #1 had an	order for Humira				

Division of Health Service Regulation

40mg/0.4ML inject subcutaneously every 2

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION		SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		I COMI	PLETED
						R
		HAL034150	B. WING		10	/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
		6010 ME	EADOWBROOK MA	ALL COURT		
THE IVY A	AT CLEMMONS	CLEMM	ONS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A		COMPLETE DATE
IAG	TREGOLATORY ON		IAG	DEFICIENCY)	a ritoritari	
(D 359)	Continued From page	27	(D 358)			
{D 358}	8} Continued From page 27		{D 358}			
	weeks.					
		for Humira was written for 2				
	injections at a time.	went to administer the				
		went to administer the would take the empty				
	•	prescription label to the MA				
		ent Care Director (RCD)				
		rder the Humira for the next				
	injection in two weeks					
		e HH nurse came out to				
		ne medication was not there.				
	· ·	there were 2 or 3 times				
		was not available in the eeded to administer on the				
	14th day.	seded to administer on the				
	-	the previous RCD or the				
		mira was not available in the				
	facility.					
	Telephone interview v	with a nurse from Resident				
	#1's rheumatologist's					
	2:04pm revealed:					
	-Resident #1 had an	order for Humira				
	40mg/0.4ML inject 40					
		did not know Humira had				
		eyond 14 days, but there was				
		nt #1 with the medication				
	being administered a	expected for Humira to be				
	administered as orde	•				
	-	with Resident #1's Primary				
		on 09/29/202 at 12:51pm				
	revealed:	bains and				
		a was being managed by				
	wrote the order for HI	ut she was the one who				
	medication.	i to administer the				

Division of Health Service Regulation

-She did not know Humira was not always available in the facility to administer to Resident

STATE FORM 6899 69Q014 If continuation sheet 28 of 98

Division of Health Service Regulation

DIVISION	Division of Health Service Regulation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					_
			B. WING		R
		HAL034150	B. WING		10/01/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		6010 ME	ADOWBROOK N	IALL COURT	
THE IVY A	T CLEMMONS			IALL GOOK!	
		CLEMMC	NS, NC 27012		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
TAG	TREGOEM ON L	iso is live in the in standing	TAG	DEFICIENCY)	
			+		
{D 358}	Continued From page	e 28	{D 358}		
	#4 44				
	#1 every 14 days.	21.1			
		o was responsible for			
	•	was available in the facility.			
		sident #1's medications to			
	be administered as or	rdered by the physician.			
	Telephone interview v				
	09/30/20 at 1:11pm re				
		#1 was to be administered			
	Humira every 2 week	s by the HH nurse.			
	-Resident #1's HH nu	rse came to her the last			
	time she was in the fa	acility to let her know Humira			
	was not available and	I needed to be ordered and			
	she made sure Humir	a was ordered.			
	-She thought the HH	nurse for Resident #1 called			
	the facility to inform w	hen she would be making a			
	visit and the Humira v	vas ordered at that time.			
		as responsible for making			
		ilable in the facility for HH to			
	administer.	,			
	-She expected Humir	a to be available in the			
	facility and administer				
	physician.				
	py = . =				
	Refer to interview with	n the Administrator on			
	09/25/20 at 2:17pm.				
	00/20/20 at 2:17 pm.				
	Refer to interview with	n a medication aide (MA) on			
	09/25/20 at 3:47pm.	Ta medication aide (MA) on			
	03/23/20 at 3.47 pm.				
	Refer to interview with	n the previous Resident			
		on 09/29/20 at 3:50pm.			
	Cale Director (RCD)	οπ σ <i>εί</i> είναι στο συριπ.			
	d Daviou of Dasidar	t #1's current FL2 date			
		t#15 Current FLZ date			
	09/15/20 revealed:	for the man and all 4 to be left for the			
		for tramadol 1 tablet four			
	times daily (used for r				
	-There was no dosage	e aocumented.			

Division of Health Service Regulation

Review of resident #1's physician's orders dated

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
					F	5
		HAL034150	B. WING		I	\ 01/2020
		11AE034130			1 10/0	71/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ATE, ZIP CODE		
- 11- 00/4	- a:a:	6010 ME	ADOWBROOK N	MALL COURT		
THE IVY	T CLEMMONS	CLEMMO	NS, NC 27012			
(X4) ID	SUMMARY ST	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 I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEFICIENCY)		
{D 358}	Continued From page	2 9	{D 358}			
•	. •		' '			
		order for tramadol 50mg 1				
	tablet 4 times daily.					
	D i f D i t t t	41				
		1's physician's orders dated				
		order for tramadol 50mg 1				
	tablet 4 times daily.					
	Review of Resident #	1's Medication				
		d (MAR) for August 2020				
	revealed:	d (MAIX) for August 2020				
		or tramadol 50mg 1 tablet 4				
		Juled for administration at				
	8:00am, 12:00pm, 4:0					
		nentation tramadol was				
	administered for 8 of					
) initials were documented				
		om 08/24/20 to 08/30/20				
	with documentation o	n the back of the MAR of				
	"waiting on pharmacy	," "waiting on pharmacy,				
		ed pharmacy, medication				
	should be here tonigh	nt."				
	Review of Resident #	1's Medication				
	Administration Record	d (MAR) for September				
	2020 revealed:					
	_	or tramadol 50mg 1 tablet 4				
	_	luled for administration at				
	8:00am, 12:00pm, 4:0					
		nentation tramadol was				
	administered for 13 o	• •				
		pace on 09/17/20 at 8:00am				
		n on the back of the MAR				
		dol was not administered.				
		umented and circled 12				
	times from 09/05/20 t					
	documentation on the					
	•	ing on PCP to sign new				
	order"There were 9 times v	when there was no				
		e back of the MAR indicating				
	accumentation on the	, back of the MAIX indicating	1	ĺ		1

Division of Health Service Regulation

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Division of Health Service Regulation

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
		1141 004450	B. WING		R
		HAL034150	B. WIIVO		10/01/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		6010 ME	ADOWBROOK M	MALL COURT	
THE IVY AT CLEMMONS				IALL COOK I	
		CLEMINIC	ONS, NC 27012		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAG	REGOEMONT ON	iso is live in order,	TAG	DEFICIENCY)	W. (1) E
			+		
{D 358}	Continued From page	2 30	{D 358}		
		t - dusinistans d			
	why tramadol was no	i administered.			
	D:-				
		ss notes were requested on			
		0, but not provided prior to			
	exit on 10/01/20.				
	_	ent #1's medications on			
	hand on 09/17/20 at 5				
	•	olet 6 hours as needed was			
	available on the medi				
		madol were dispensed to the			
	facility on 09/07/20 ar	nd there was 1 tablet			
	remaining.				
	Interview with Reside	nt #1 on 09/25/20 at 1:58pm			
	revealed:				
	-She was administered	ed tramadol 4 times a day			
	and she did not have	any tramadol as needed.			
	-She was not adminis	tered tramadol for about a			
	week in August 2020.				
	-"They told me they w	vere waiting on the			
	pharmacy."				
	-She was administere	ed tramadol for her pain and			
	she had pain daily, m	ainly in her back.			
	Telephone interview v	vith a representative with the			
	contracted pharmacy	on 09/18/20 at 10:57am			
	revealed:				
	-Resident #1 had an	order for tramadol 50mg 1			
	tablet 4 times a day.	Ğ			
	-There were 120 table	ets of tramadol 50mg			
		ity on 07/14/20 and 20			
	•	ed to the facility on 08/12/20,			
		8/30/20, and 09/07/20.			
		additional 20 tablets of			
		nsed on the facility on			
	09/07/20 and 09/17/2				
	-She was not sure wh				
		ay supply and thought it may			

Division of Health Service Regulation

have been due to insurance.

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		UAL 024450	B. WING		R	
		HAL034150			10/01/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	FE, ZIP CODE		
THE IVY A	T CLEMMONS		ADOWBROOK M ONS, NC 27012	ALL COURT		
	CLIMMADY CT	ATEMENT OF DEFICIENCIES	, 	DDOVIDEDIC DI AN OF CODDECTION		
(X4) ID PREFIX TAG	(PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page 31		{D 358}			
	-The facility had to contact the pharmacy to request a refill for tramadol.					
	Interview with a MA o revealed:	n 09/25/20 at 2:25pm				
	-Resident #1 had an otablet 4 times a daily.	order for tramadol 50mg 1				
	-Resident #1 did not have any as needed orders					
	for tramadol that she	was aware or. ntion to the label on the				
	• •	ck for tramadol, but she				
		lication according to the				
	MAR, 1 tablet 4 times					
		on the MAR for tramadol				
	50mg 1 tablet 4 times 50mg every 6 hours a	s a day, but not for tramadol as needed.				
	Interview with a second 3:27pm revealed:	nd MA on 09/25/20 at				
	•	ministered tramadol 50mg 4				
	-Resident #1 had bee	en out of medication for a				
	few days in Septembershe did not know wh	er 2020. ny it took 3 days to get the				
		lity from the pharmacy.				
		ually reordered from the				
	•	ications were administered				
		on the medication bubble				
	pack.	eek of medication left when				
	the medication got do					
	•	nen controlled substances				
	were reordered, beca	use the previous Resident				
	Care Director (RCD)					
	controlled substances	= -				
	-She had not contacte tramadol 50mg.	ed the pharmacy regarding				

Division of Health Service Regulation

Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/29/20 at 12:51pm

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Division of Health Service Regulation

ווטופועום	n nealth Service Negu	ialion				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAIN (J. GORREGION	DENTIFICATION NOINDER.	A. BUILDING: _		COMILLIED	
		HAL034150	B. WING		R 10/01/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE. ZIP CODE		
			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 APPROPE DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	e 32	{D 358}			
(111,	. •	d Resident #1's medications				
	09/30/20 at 1:11pm re-She knew Resident of for tramadolShe was made award times a day had been administered in Septeral of the september administered in Septeral of the pharmacyThe pharmacy and Procontacted on the third administered, but the medication out to the September 2020The previous RCD wup with the pharmacy she expected Reside administered as order	et 1 had a physician's order e Tramadol 50mg 1 tablet 4 documented as not ember 2020 on 09/25/20. Inented as not administered een sent out by the PCP should have been I day the medication was not pharmacy sent the facility on the third day in eas responsible for following and the physician. ent #1's medication to be red by the physician.				
	Refer to interview with 09/25/20 at 2:17pm.	n the Administrator on				
	Refer to interview with 09/25/20 at 3:47pm.	n a medication aide (MA) on				
		n the previous Resident on 09/29/20 at 3:50pm.				
		t #1's current FL2 dated order for prednisone 5mg 1 reat arthritis).				
		1's physician's orders dated order for prednisone 5mg 1				

Division of Health Service Regulation

tablet daily.

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	or riealth Service Regu		T		T	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND LEAN	SI CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _			
					F	₹
		HAL034150	B. WING		1	1/2020
					1	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
	T CLEMMONS	6010 ME	ADOWBROOK N	IALL COURT		
INEIVIA	AT CLEIVINIONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) BE	(X5) COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				,		
{D 358}	Continued From page	e 33	{D 358}			
	Review of a Refill Aut	horization Request dated				
		ere was a verbal order taken				
		rimary Care Provider (PCP)				
		nisone 5 mg 1 tablet daily				
	with a quantity of 30 t	•				
	with a quantity of 50 t	ablets and Tritellis.				
	Review of Resident #	1's Medication				
		d (MAR) for August 2020				
	revealed:	a (1717 117) 101 7 tagast 2020				
		or prednisone 5mg 1 tablet				
	daily to be administer	· ·				
		nentation prednisone 5mg				
		4 of 11 opportunities on				
		• •				
	from 08/20/20 through					
		tation prednisone 5mg was				
		/24/20 through 08/31/20.				
		tation on the back of the				
		was not administered from				
	08/20/20 through 08/2	23/20.				
	Review of Resident # 2020 revealed:	1's MAR for September				
		itten entry for prednisone				
		be administered at 8:00am.				
	_	tation prednisone 5mg was				
		om 09/01/20 through 09/16/2.				
	auministered daily no	iii 09/01/20 tillough 09/10/2.				
	Resident #1's progres	ss notes were requested on				
		0, but not provided prior to				
	exit on 10/01/20.	o, but not provided prior to				
	CAIL OIT 10/01/20.					
	Observation of Resid	ent #1's medications on				
	hand on 09/17/20 at 5					
		packs of Prednisone 5mg 1				
		on the medication cart.				
	_					
		pack of prednisone 5mg				
	dispensed to the facil					
		and there were 14 tablets				
	remaining.	hubble pools of mandaire and				
	- i nere was a second	bubble pack of prednisone				

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Division of Health Service Regulation

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:		COMPL	ETED
			-		_	
			D MANO		F	
		HAL034150	B. WING		10/0	1/2020
NAME OF D	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	TOVIDER OR SOLT LIER					
THE IVY A	T CLEMMONS		DOWBROOK N	MALL COURT		
		CLEMMO	NS, NC 27012			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
				DEFICIENCY)		
{D 358}	Continued From page	3/	{D 358}			
(2 000)	Continued i form page	, o-ı	(2 333)			
	5mg dispensed to the	facility on 09/04/20 with a				
	quantity of 15 with 8 t	ablets remaining.				
	-There was a third bu	bble pack of prednisone				
		facility on 09/15/20 with a				
	quantity of 30 and the					
	remaining.					
	romaning.					
	Interview with Reside	nt #1 on 09/25/20 at 1:58pm				
	revealed:	111 #1 011 09/25/20 at 1.50pm				
		out of prodpicens in August				
		out of prednisone in August				
		MAs what was going on with				
	the medication.					
		ednisone was not available in				
	the facility, but they d					
	-She did not think the	_				
	administering prednis	one to her.				
	Telephone interview v	vith a representative from				
	the contracted pharm	acy on 09/18/20 at 10:57am				
	revealed:					
	-There was a current	order for prednisone 5mg 1				
	tablet daily dated 07/2	23/20.				
	-Prednisone 5mg was	s dispensed to the facility on				
	07/23/20 with a quant					
	•	s dispensed to the facility on				
	08/14/20 with a quant					
	•	s dispensed to the facility on				
	09/04/20 with a quant					
		s dispensed to the facility on				
	•					
	09/15/20 with a quant					
	-The facility should ha	•				
		020 because the prednisone				
) with 30 tablets and on				
	08/14/20 with 30 table	ets.				
	Interview with a medi					
	09/25/20 at 3:47pm re					
	-Resident #1 had an	order for prednisone 5mg 1				
	tablet daily.					
	-She had circled her i	nitials on the MAR in August				

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DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						R
		HAL034150	B. WING			
		HAL034150			10/	01/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		6010 ME	ADOWBROOK N	MALL COURT		
THE IVY AT CLEMMONS CLEMMOI			ONS, NC 27012			
(VA) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORF	PECTION	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION S		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF	PPROPRIATE	DATE
				DEFICIENCY)		
{D 358}	Continued From page	e 35	{D 358}			
, ,	. •					
	administered.	isone 5mg had not been				
		one 5mg had not been				
	• .	y days because they were				
	waiting on the pharma					
	•	not in the medication cart,				
		he overstock and if the				
		overstock, MAs were to				
	contact the pharmacy	•				
	-She had not contacte	ed the pharmacist, Resident				
	#1's rheumatologist, o					
	prednisone 5mg.					
	-The previous RCD h	ad been responsible for				
		s regarding medications and				
	MAs were responsible	e for contacting the				
	pharmacy.					
	Telephone interview v	vith a nurse from Resident				
	#1's rheumatologist's					
	3:59pm revealed:					
	•	en by the rheumatologist on				
	05/07/20 and on 08/2					
		sone was decreased from				
	10mg to 5mg on 05/0					
		onal orders for prednisone				
	after 05/07/20.					
	•	nterview with a nurse from				
		atologist's office on 09/29/20				
	at 3:59pm revealed: -There was no docum	contation in the				
		nentation in the s Resident #1 was on				
	prednisone during the					
		rheumatologist, he stated				
		on prednisone and did not				
	need to be on prednis					
	need to be on preding	JOHO.				
	A third telephone inte	rview with a nurse from				
		atologist's office on 10/01/20				

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at 11:24am revealed:

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DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	O CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMI ELTED
					R
		HAL034150	B. WING		10/01/2020
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		NS, NC 27012		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI	O BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	'RIATE DATE
			 		
{D 358}	Continued From page		{D 358}		
		taking prednisone at the			
	time of visit on 08/27/	 :			
	-Prednisone was not	necessary pecause atoid arthritis was controlled			
	with her other medica				
		dnisone could cause issues			
	with bone loss.				
	-If there had not been	any other orders for			
	prednisone after 05/0	7/20.			
	Telephone interview v	vith Resident #1's Primary			
	-	on 09/29/20 at 12:03pm.			
	-Resident #1 was on	prednisone 5mg 1 tablet			
	daily.				
		atologist managed her			
	•	nad refilled the medication.			
	_	sident #1's rheumatologist sone, but she was not sure.			
	-Sometimes Resident				
		rders were changed, but not			
	communicated with th	ne facility.			
		he facility contacted the			
	rheumatologist about				
		sident #1 did not get her			
		0/20 through 08/23/20 and			
	she did not know med	nistered from 08/24/20			
	through 09/16/20.	11316164 110111 00/24/20			
	•	ent #1's medication to be			
	administered as orde				
	Refer to interview with	n the Administrator on			
	09/25/20 at 2:17pm.	. a.o / tarriirii suator off			
	Refer to interview with	n a medication aide (MA) on			
	09/25/20 at 3:47pm.	(1711 /) 011			
	Refer to interview with	n the previous Resident			
		on 09/29/20 at 3:50pm.			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		1141 004455			R
		HAL034150	B. WING		10/01/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		ADOWBROOK N ONS, 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 APPROPE DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	37	{D 358}		
	02/14/20 revealed dia cardiomyopathy, anxi systolic and diastolic (chronic obstructive post a. Review of Resider dated 08/18/20 revea Trazodone 150mg on mood/sleep. Review of Resident # note dated 08/13/20 reduction (GDR) of post-Trazodone 150mg we-There was an order to bedtime. Review of Resident # note dated 08/24/20 reduction (GDR) of post-Trazodone 150mg we-There was an order to be dated 08/24/20 reduction (GDR) of post-Trazodone 150mg we-There was an order to be dated 08/24/20 reduction (GDR) of the dated 08/24/20	ety disorder, combined heart failure and COPD bulmonary disease). Int #5's physician orders led there was an order for e tablet at bedtime for 5's mental health progress revealed: dication for a gradual dose sychiatric medication. as discontinued. to start Trazodone 100mg at 5's mental health progress revealed:			
	note dated 09/10/20 r -The Trazodone GDR been implemented ar -There was an order to	d ordered last visit had not and would be reordered. to discontinue Trazodone			
	administration record -There was a printed one tablet at bedtime -The printed entry for	5's August 2020 medication (MAR) revealed: entry for Trazodone 150mg,			

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08/13/20 with an undated "DC" hand-written on

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Division of	of Health Service Regu	lation			FORM APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034150	B. WING		R 10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
THE NAV A	T OLEMMONE	6010 ME	ADOWBROOK N	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 .SC 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	38	{D 358}		
	the remainder of the	entry.			
	MAR revealed:	sident #5's August 2020			
		ed handwritten entry for			
	Trazodone 100mg at documented as admir				
	08/22/20.	11010104 0/2 1/20, and			
	-The Trazodone 100n	ng had a box drawn around			
		20 to 08/14/20 and two			
	large "X"s filled the bo				
	-The Trazodone 100n indicating not adminis 08/23/20 to 08/25/20.	stered, on 08/20/20 and from			
		ng entry was marked as			
	-On 08/20/20 there wa	as documentation the			
	arrive that night.	, and the medication was to			
	-On 08/24/20 there wa				
	"waiting on pharmacy				
	-There was no docum 100mg was not admir	nentation why Trazodone			
		nentation why Trazodone			
	was not administered	-			
	Continued review of F MAR revealed:	Resident #5's August 2020			
	-There was a handwr	itten entry for Trazodone			
	50mg take one at bed 08/26/20.				
		g had a box drawn around 20 to 08/26/20 and three			

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08/28/20.

large "X"s filled the box.

-There was no documentation Trazodone 50mg was administered on 08/26/20, 08/27/20 and

-The Trazodone 50mg was documented as administered from 08/29/20 to 08/31/20.

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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	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					<u> </u>	_
			B. WING		1	₹
		HAL034150	B. WING		10/0	01/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		
		6010 ME	ADOWBROOK M	IALL COURT		
THE IVY A	T CLEMMONS	CLEMM	ONS, NC 27012			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	DATE
				DET IGIENCT)		
{D 358}	Continued From page	e 39	{D 358}			
	Davious of Davidant #	Ela Cantambar 2020 MAD				
	revealed:	5's September 2020 MAR				
		entry for Trazodone 100mg,				
	one tablet at bedtime	,				
		Trazodone 100mg was				
	marked as "D/C" on 0					
	-Trazodone 100mg w					
		1/20, 09/04/20 and from				
	09/07/20 to 09/13/29.	-				
	-There was no docum	nentation Trazodone 100mg				
	was administered on	•				
	09/05/20, and 09/06/2	20 with no documentation				
	why Trazodone 100m	ng was not administered.				
		Resident #5's September				
	2020 MAR further rev					
		ed handwritten entry for				
	Trazodone 50mg at b					
		1/20 to 09/14/20 had a box				
		vith two large "X"s filling the				
	box.					
	-Trazodone 50mg wa administered on 09/1					
		nentation Trazodone 50mg				
	was administered on	•				
		razodone 50mg was not				
	administered.	razodone 30mg was not				
	duministered.					
	Observation of medic	ation on hand for Resident				
	#5 on 09/17/20 at 5:5					
		s dispensed on 08/24/20				
	with a quantity of 25 t					
		available for administration.				
		with a medication aide (MA)				
	on 09/29/20 at 2:46pr	m revealed:				
	-A circle around initial	Is on the MAR indicated the				

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medication was not administered.

-The reason the medication was not administered

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE	TE SURVEY MPLETED	
					l R		
		HAL034150	B. WING		1	1/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
	T CLEMMONS	6010 MEAD	OWBROOK N	MALL COURT			
THE IVI A	TI CLEMINIONS	CLEMMON	S, NC 27012				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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	
{D 358}	Continued From page	40	{D 358}				
{D 358}	should be noted on the The Resident Care Designation responsible to update changes. The RCD was responsible to RCD was responsible to update changes. The RCD was responsible to the RCD was responsible to update changes. Telephone interview was the contracted pharms revealed Trazodone 508/24/20 with a quant Telephone interview was health nurse practition revealed: Gradual dose reduction revealed: Gradual dose reduction revealed: Gradual dose reduction revealed: He was not notified Form the dose for been life threatening a felt different. He was not notified Form of the struggled to get in and now reviewed the facility to see what me administered. He did not look at the available in the medical He thought they may dose of Trazodone over instead of the 50mg of Resident #5 not received the Resident Reside	e back of the MAR. birector (RCD) was the MAR with medication usible to verify the MARs beginning of each month. with a representative from acy on 09/29/20 at 12:17pm flomg was first dispensed on ity of 25 tablets. with Resident #5's mental her on 09/30/20 at 3:01pm ons were recommended for just stopping the a single day would not have and the resident may have Resident #5 had missed to 08/28/20. Information from the facility MAR when he visited the edications had been a dosage of Trazodone ation cart. have copied the 100mg her to the September MAR ose. iving the Trazodone from constituted an abrupt stop of he had been aware of it, he	{D 358}				
		pt stop of Trazodone may wal symptoms including nges.					

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 BOILBING.		
		HAL034150	B. WING		R 10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE 00/ A	T 01 511110110	6010 MEAI	OWBROOK N	IALL COURT	
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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	: 41	{D 358}		
	Refer to interview with 09/25/20 at 2:17pm.				
	Refer to interview with 09/25/20 at 3:47pm.	n a medication aide (MA) on			
		e interview with the previous or (RCD) on 09/29/20 at			
	an order to start Ambi	08/13/20 revealed there was			
	note dated 08/24/20 r	5's mental health progress revealed Ambien 2.5mg was pien 5mg at bedtime was			
	revealed: -There was an undate Ambien 2.5mg at bed -The dates from 08/0 drawn around them w -The entry for Ambien "D/C 8/26"Ambien 2.5mg was of from 08/14/20 to 08/2 -The Ambien entry ini not administered on 0 -On 08/24/20 there w 2.5mg was not admin pharmacy".	1/20 to 08/13/20 had a box with a large "X" filling the box. In 2.5mg was marked as documented as administered 3/20 and on 08/25/20. Itials were circled indicating 18/24/20. Itials documentation Ambien istered due to "waiting on			
	MAR revealed:	Resident #5's August 2020			

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for Ambien 5mg at bedtime.

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					-	,
		1141 004450	B. WING		F	
		HAL034150			10/0	1/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		6010 ME	ADOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012			
	CUMMADVCT			DROVIDEDIC DI ANI OF CORDECTIO		
(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 358}	Continued From page	2.42	{D 358}			
(D 330)	Continued From page	5 42	(D 330)			
	-The dates from 08/0	1/20 to 08/26/20 had a box				
	drawn around them w	vith two large "X"s filling the				
	box.					
		cumented as administered				
	from 08/27/20 to 08/3	31/20				
		nentation Ambien was				
	administered on 08/2	6/20.				
	D : (" D :1					
		ent #5's September 2020				
	MAR revealed:	-				
		olpidem 5mg (For: Ambien),				
	give one-half tablet da					
		ne printed order was "give 2				
	(2.5mg) to =5mg".	and two conflicting doors				
		nad two conflicting doses				
		entry was added, was nistered between 09/01/20				
	and 09/16/20.	nistered between 09/01/20				
	and 09/10/20.					
	Review of the Control	lled Substance Count Sheet				
		mg, partial tablet, dispensed				
	on 08/13/20 revealed					
	-Thirty doses were re					
	•	ed out on 08/24/20 and				
	08/26/20.					
	-Two tablets (5mg) w	ere signed out on 08/28/20,				
	` •,	9/05/20, 09/06/20, and from				
	09/08/20 to 09/11/20.					
	-A single dose of 2.5r	ng was signed out on				
	08/25/20 and 08/29/2	20.				
		for Ambien 5mg, dispensed				
	on 08/24/20, revealed					
	-Thirty tablets were re					
		gned out on 09/09/20, along				
	with two 2.5mg (5mg)) tablets.				
	O " " " "					
		cation on hand for Resident				
	#5 on 09/17/20 at 5:5					
	- I here was one bubb	le pack of Ambien 5mg				

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Division of Health Service Regulation

	i rieaitii Service Regu		1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	' '	CONSTRUCTION	(X3) DATE S COMPLI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	בובט
					R	·
		HAL034150	B. WING		1	1/2020
			1		1 10/0	172020
NAME OF PR	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 ME	ADOWBROOK N	IALL COURT		
111L IV 1 A	T CLLIMINIONS	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		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE
{D 358}	Continued From page	e 43	{D 358}			
	diamana ad an 00/04/0	00 with a swaptity of 20				
	•	20 with a quantity of 30				
	tablets.					
	-There were 18 tablet	s available for				
	administration.					
	Tolonhana intonvious	with Decident #5's mental				
		with Resident #5's mental				
	revealed:	ner on 09/30/20 at 3:01pm				
	-Facility staff did not o	contact him regarding				
	-					
		ien or a double dose being				
	given.	the Centember 2020 MAD				
		the September 2020 MAR				
		ntries and was confusing.				
	-He expected staff to information with him.	cially any conflicting				
		ident #E getting a lower than				
		ident #5 getting a lower than of Ambien could be she did				
	not sleep well at night					
		ident #5 getting a double				
		ot exceed the unsafe limit				
		en drowsier the next day.				
		administer medications as				
	ordered.	administer medications as				
	ordered.					
	Telephone interview v	with a representative from				
	· ·	ed pharmacy on 09/28/20 at				
	2:30pm revealed:	ra priarriady dri do/20/20 at				
	•	started on 08/13/20 and 30				
	half-tablets were disp					
		ased to 5mg on 08/24/20				
		s were last dispensed on				
	08/24/20.					
		ve had 2.5mg tablets left on				
		was increased to 5mg.				
	Refer to interview with	h the Administrator on				
	09/25/20 at 2:17pm.					
	•		1			

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09/25/20 at 3:47pm.

Refer to interview with a medication aide (MA) on

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL034150	B. WING		R 10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		OWBROOK N	IALL COURT	
		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 APPROPF DEFICIENCY)	BE COMPLETE
{D 358}	Continued From page	e 44	{D 358}		
		terview with the previous or (RCD) on 09/29/20 at			
	dated 08/18/20 revea chloride micro tab, 20	t #5's physician's order led an order for potassium lmeq ER (extended release) a medication used to treat			
	administration record -The potassium chlori administered from 08Documentation of ad chloride was handwrit	ide was documented as			
	Review of Resident # revealed no entry for	5's September 2020 MAR potassium chloride.			
	the facility's contracted 3:55pm revealed: -The original order for order given by Resided provider (PCP) to the	vith a representative from ad pharmacy on 09/30/20 at repotassium was a verbal ent #5's primary care pharmacist on 07/16/20. In refills and they were sent			
	automatically to the fa -The last dispensed d tablets were dispense	acility. late was 09/10/20 and thirty ed.			
	each monthThe facility could ma and she would not be	onsible to print the MAR ke changes to the MARs able to see them. by potassium was not on the			

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Division of Health Service Regulation

DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					F	,
		HAI 024450	B. WING		1	
		HAL034150			10/0	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
		6010 MF	ADOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012			
			110, 110 27012	T		1
(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)		
(5.050)			(5.050)			
{D 358}	Continued From page	e 45	{D 358}			
	Telephone interview v	with a medication aide (MA)				
	on 09/29/20 at 2:46pr	, ,				
	·	on Resident #5's September				
	2020 MAR.	in resident #33 deptember				
	-Potassium was not in	n the medication cart				
		pack of potassium for				
	Resident #5 in the ov					
	** *	on the bubble pack was				
	09/10/20.	on the bubble pack was				
	-The Resident Care D	Director (PCD) was				
	responsible for updati					
	-	nsible for printing the MARs				
	for the upcoming mor					
		nsible to make sure the new				
	month's MAR was ac					
		urrently have an RCD.				
	-	as performing the duties of				
	the RCD.	as perioriting the duties of				
	IIIE NOD.					
	Tolonhono intonviow v	with Resident #5's primary				
		on 10/01/20 at 8:30am				
	revealed:	511 10/0 1/20 at 0.30am				
	-She did not disconting	oue the notassium				
		nsible to make sure the				
	MARs were accurate.					
		of Resident #5 not receiving				
		low potassium level that				
	could cause neart arr	hythmias and weakness.				
	Telephone intonvious	with the Administrator on				
	09/29/20 at 4:59pm re					
	-					
		ent Care Director (RCD) was				
	responsible to make saccurate.	Suit the MANS Wele				
		and to sign the batters of				
		osed to sign the bottom of				
		Rafter she reviewed it for				
	accuracy.					
	-The MAR was not sig	gned by the RCD.				

Division of Health Service Regulation

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL034150	B. WING		10/01/2020
		18.2001.00			10/01/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	řE, ZIP CODE	
THE IVY A	T CLEMMONS		ADOWBROOK M	ALL COURT	
		CLEMMC	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	BE COMPLETE
				DEFICIENCY)	
{D 358}	Continued From page	∍ 46	{D 358}		
	Refer to interview with 09/25/20 at 2:17pm.	h the Administrator on			
	Refer to interview witl 09/25/20 at 3:47pm.	h a medication aide (MA) on			
	•	terview with the previous or (RCD) on 09/29/20 at			
	02/14/20 revealed dia	osteoporosis, vascular			
	02/14/20 revealed a r	nt #3's current FL2 dated medication order for ce daily (used to treat high			
	Review of Resident # orders revealed:	t3's subsequent physician			
	07/04/20.	ol 12.5mg twice daily dated			
	-An order for carvedile 08/18/20.	ol 12.5mg twice daily dated			
	Administration Recordance - There was an entry find daily, scheduled for 8 - Carvedilol 12.5 mg wadministered twice da 08/25/20 There was documen hospitalized from 08/2	for carvedilol 12.5mg twice 8:00am and 8:00pm. Pas documented as aily from 08/20/20 through station Resident #3 was 25/20 through 08/31/20.			
	revealed:	3's September 2020 MAR			

Division of Health Service Regulation

-There was no entry for carvedilol 12.5mg.

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Division of Health Service Regulation

HAL034150 B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
	NAME OF PROVIDER OR SUP
THE IVY AT CLEMMONS 6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012	THE IVY AT CLEMMONS
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (X COMMENTAL PROPRIES OF TAGE	PREFIX (EACH I
(D 358) Continued From page 47 -There was no documentation carvedilol 12.5mg was administered as ordered for the month of September 2020There was documentation Resident #3 was hospitalized from 09/01/20 through 09/03/20. Observation of medication on hand for Resident #3 on 09/17/20 at 4:00pm revealed: -The bubble pack of carvedilol 12.5mg was dispensed on 07/22/20 with a quantity of 60 tabletsThere were 26 tablets available for administration. Telephone interview with a representative from the contracted pharmacy on 09/29/20 at 1:00pm revealed: -The pharmacy had a current order for the carvedilol 12.5mg twice daily dated 08/18/20The carvedilol 12.5mg was dispensed with a quantity of 60 tablets on 07/22/20The carvedilol 12.5mg was dispensed with a quantity of 60 tablets on 06/17/20The pharmacy did not have a discontinue order for the carvedilol 12.5mgThe facility had not requested a refill for the carvedilol 12.5mg for Resident #3 since the 60 tablets were dispensed on 07/22/20. Telephone interview with Resident #3's primary care provider (PCP) on 09/29/20 at 12:10pm revealed: -Resident #3 had a current order for carvedilol 12.5mg twice dailyThe carvedilol 12.5mg had not been discontinued for Resident #3Resident #3 should be receiving carvedilol 12.5mg twice dailyThe carvedilol 12.5mg had not been discontinued for Resident #3Resident #3 should be receiving carvedilol 12.5mg twice dailyShe had the expectation facility staff administer	-There was rivas administ September 2 -There was controlled in the contracter revealed: -The pharmat carvedilol 12 -The carvedil quantity of 60 -The pharmat for the carvedilol 12 -The facility is carvedilol 12 -The carvedil quantity of 60 -The pharmat for the carvedilol 12 -The carvedil quantity of 60 -The pharmat for the carvedilol 12 -The carvedilol 12 -The carvedilol 12 -The facility is carvedilol 12 -The facility is carvedilol 12 -The facility is carvedilol 12 -The seident was 12.5mg twice -The carvedil discontinued -Resident #3 12.5mg twice

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medication as it was ordered by the provider.

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DIVISION	of Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					F	₹
		HAL034150	B. WING		10/0	1/2020
NAME OF D	DOVIDED OD CUDDUED	CTDEET A	DDECC CITY CTA	TE 710 CODE		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
THE IVY A	T CLEMMONS	6010 ME	ADOWBROOK N	MALL COURT		
		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		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
{D 358}	Continued From page	- 18	{D 358}			
(D 000)	Continued From page	5 40	[D 330]			
	Interview with a medi	cation aide (MA) on				
	09/17/20 at 3:40pm re	` ,				
	· ·	the carvedilol 12.5mg was				
	not on the September					
	-	e carvedilol 12.5mg had				
	been discontinued.	e carvedilor 12.5mg flad				
		ent Care Director (RCD) was				
		ng changes to medication				
	orders to the MARs.					
		as responsible for the				
		from the old MARs to the				
	new MARs.					
	-He did not know who	was responsible now for				
	making changes to th	ne medication orders on the				
	MARs or for completi	ng the monthly comparison				
	from the old MARs to	• •				
	Interview with Reside	ent #3 on 09/17/20 at 4:00pm				
	revealed:	, с с				
		nat medications she was				
	prescribed.	iat medications one was				
	-She depended on the	a facility to provide				
	medications as order					
	Theulcalions as order	ed by the FCF.				
	leteniew view vyith the Adv	ministrator on 09/17/20 at				
		ministrator on 09/17/20 at				
	4:30 pm revealed:					
		ne MARs on a monthly basis.				
	-The previous RCD w					
		ARs to the newly printed				
		ARs were used by the MAs.				
		ed the medication orders				
	into the MARs and m	ade any changes as needed				
	to the MARs.					
	-The MARs often had	l errors and that was one				
	reason the previous F	RCD had to check the MARs				
	monthly.	_				
	•	ny the carvedilol 12.5mg was				
		r MAR for Resident #3.				
		sitioning to a new pharmacy				
	- me racinty was trails	smorning to a new phannacy	1			

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DIVISION	n nealth Service Negu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			B. WING		R	
		HAL034150			10/01	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
		6010 ME	ADOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012			
040.15	STIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ON	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
{D 358}	Continued From page	2.40	{D 358}			
(5 000)		. 	(2 000)			
	on 10/01/20.					
		h the Administrator on				
	09/25/20 at 2:17pm.					
		h a medication aide (MA) on				
	09/25/20 at 3:47pm.					
		terview with the previous				
		or (RCD) on 09/29/20 at				
	3:50pm.					
		t #3's current FL2 dated				
	02/14/20 revealed an					
	8.6mg-50mg one tabl	et dally (used to treat				
	constipation).					
	Davious of Davidant #	21a aubaaguant nhyaisian				
	orders revealed:	3's subsequent physician				
		S 8.6mg-50mg one tablet				
	daily dated 07/04/20.	5 6.omg-5omg one tablet				
		S 8.6mg-50mg one tablet				
	daily dated 08/18/20.	3 6.0mg-30mg one tablet				
	daily dated 00/10/20.					
	Review of Resident #	3's August 2020 Medication				
	Administration Record	•				
		for Senna-S 8.6mg-50mg				
		duled for administration at				
	8:00am.	duction administration at				
		ng was documented as				
	_	/20/20 through 08/24/20.				
		tation Resident #3 was				
		25/20 through 08/31/20.				
	1103pitalizeu IIOIII 00/2	25/20 tillough 00/31/20.				
	Review of Resident #	3's September 2020 MAR				
	revealed:	0 1 1 5 pto 11 20 1 20 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
		or Senna-S 8.6mg-50mg				
		duled for administration at				
	8:00am.					

Division of Health Service Regulation

-There was documentation Resident #3 was

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034150	B. WING		R 10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
			ADOWBROOK N		
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY 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
{D 358}	Continued From page 50		{D 358}		
	· · · · · · · · · · · · · · · · · · ·	01/20 through 09/03/20. g was documented as 4/20.			
	-There was no docum Senna-S 8.6mg-50mg	nentation of administration of g on 09/05/20.			
	_	g had circled initials, stered from 09/06/20 through			
	09/11/20.	nentation of administration of			
	Senna-S 8.6 mg-50m				
	-Senna-S 8.6mg-50m	g had circled initials,			
	indicating not adminis 09/14/20.	stered 09/13/20 and			
		istration documentation for			
		g was blank on 09/15/20.			
	-Senna-S 8.6mg-50m indicating not adminis 09/17/20.	•			
	"waiting on pharmacy	g was documented as " on the back of the MAR on			
	09/06/20, 09/08/20 ar	nd 09/11/20. tes from 09/05/20 through			
		entation to support either the			
	blank space or circled	l initials.			
		ent #3's medication on hand 0pm revealed there was no			
	Senna-S 8.6mg-50mg	available for			
		vith a representative from acy on 09/29/20 at 1:00pm			
	-The pharmacy had a 8.6mg-50mg daily dat				
	-Senna-S 8.6mg-50m 05/20/20 for a quantit				

Division of Health Service Regulation

-Senna-S 8.6mg-50mg was dispensed on 06/17/20 for a quantity of 30 tablets. -The pharmacy had an order for Senna-S

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Division of Health Service Regulation

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL034150	B. WING		10/01/2020
NAME OF D	ROVIDER OR SUPPLIER	CTDEET AF	DDRESS, CITY, STA	ATE ZID CODE	•
NAME OF F	NOVIDER OR SUFFLIER				
THE IVY A	T CLEMMONS		ADOWBROOK N	MALL COURT	
	T	CLEMMO	NS, NC 27012	T.	
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
{D 358}	Continued From page	e 51	{D 358}		
	0 6ma F0ma daily da	tod 0.9/1.9/20			
	8.6mg-50mg daily da -The pharmacy receiv				
		g 2 tablets twice daily as			
	needed (prn) on 09/0				
	-Senna-S 8.6mg-50m				
	09/18/20 for a quantit				
	03/10/20 101 a quantit	y or 120 tablets.			
	Telephone interview v	with Resident #3's Primary			
		on 09/29/20 at 12:10pm			
	revealed:				
	-Senna-S 8.6mg-50m	ng daily was the current			
	order until the order of				
		aily as needed (prn) on			
	-Resident #3 should h	nave received the			
		I the order changed on			
	-She expected facility	staff to administer			
		ordered by the provider.			
	Interview with medica at 3:40pm revealed:	ation aide (MA) on 09/17/20			
	-	ered Senna-S 8.6mg-50mg			
	-There was no Senna	a-S 8.6mg-50mg available			
	for administration for				
	-He had reported that				
		ng several times to the			
	previous Resident Ca	exact dates he had reported			
		the Senna-S 8.6mg - 50mg			
	to the previous RCD.				
	-	the previous RCD that MAs			
		e pharmacy when refills			
		o many requests to the			
		to miscommunication.			
		as responsible for notifying			
	the pharmacy when r				
		was responsible now for			

Division of Health Service Regulation

contacting the pharmacy when refills of

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Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034150	B. WING		R 10/01/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	,
THE IVY A	T CLEMMONS		NDOWBROOK N	IALL COURT	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{D 358}	4:30 pm revealed: -The facility printed the The previous Resider responsible for companewly printed MARs, by the MAsThe pharmacy entersinto the MARs and mount to the MARs and mount to the MARs often had the RCD had to check the RCD had to check the ARS of the MARS of	ministrator on 09/17/20 at me MARs on a monthly basis. Int Care Director (RCD) was aring the old MARs to the before the MARs are used and the medication orders ade any changes as needed a errors, that was one reason at the MARs monthly. Sitioning to a new pharmacy and the process to locate a at 4:00pm with Resident #3 and constipation. That medications she was be a medication aide (MA) on the Administrator on the a medication aide (MA) on the review with the previous or (RCD) on 09/29/20 at at #6's current FL2 dated	{D 358}		
	02/14/20 revealed the on the FL2.	ere were no diagnoses listed			

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a. Review of Resident #6's current FL2 dated

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DIVISION	n nealth Service Regu	iation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		R 10/01/	/2020
		11AE034130			1 10/01/	2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE NO. 4	T 01 F14140110	6010 MEAI	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 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	÷ 53	{D 358}			
	(polyethylene glycol 3	order for gavilax powder 350) 17gm in liquid daily (a llate bowel movements).				
	powder 17gm in liquid	•				
	gavilax powder 17gm	in liquid daily.				
	-An electronically sign	ned order by the PCP dated				
	08/26/20 for gavilax p	owder 17gm in liquid daily.				
	revealed: -There was an entry f liquid daily was sched 8:00amThere was document	6's August 2020 MAR or gavilax powder 17gm in fuled for administration at tation gavilax powder 17gm by 31 times from 08/01/20				
	revealed: -There was an entry f	6's September 2020 MAR or gavilax powder 17gm in luled for administration at				
		tation gavilax powder 17gm ly 28 times from 09/01/20				
	hand at the facility on	ent #6's medications on 09/25/20 at 2:50pm der 17gm was not available				
	Interview with Reside	nt #6 on 09/25/20 at 2:40pm				

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-He was administered medications daily, but he

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034150	B. WING		R 10/01/2020
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 358}	liquid or a medication Telephone interview was the facility's contracted 3:38pm revealed: -The pharmacy had a 08/18/20 for gavilax particles and only dispensed was request a refill. -The last time gavilax be refilled was on 06/ was dispensed. -There were no probled dispensing the gavilan needed to call and result of the facility had called to repowder since 06/11/2 Telephone interview waide (MA) on 09/30/2. -Resident #6 had not powder in months. -She knew the medication recould order the medication of the facility is policy was also unable requested the medication. -She was also unable requested the medication. -The facility's policy was also unable requested the medication.	es of the medications ing a medication that was a that resembled water. with a representative from depharmacy on 09/30/20 at current order dated lowder 17gm once daily. was not automatically refilled when facility staff called to powder was requested to 11/20, and a 30-day supply lems that prevented ex powder, facility staff just quest the medication. 109/30/20), no one at the lequest a refill of gavilax or one at the lequest a refill of gavilax or one at the lequest and ministered gavilax leation was on the MAR, but nistration. 10 at 4:16pm revealed: 11 been administered gavilax leation was on the MAR, but nistration. 12 leation herself or complete a leating the savilax powder. 12 leating the medication of the leating herself or complete a leating herself or complete	{D 358}		

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following a refill request, she had to contact the

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Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034150	B. WING		R 10/01/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE ZIP CODE	10/01/2020
NAME OF T	TOVIDER OR SOLT EIER		ADOWBROOK M		
THE IVY A	T CLEMMONS		NS, NC 27012	ALL GOOK!	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
{D 358}	358) Continued From page 55		{D 358}		
	pharmacy.				
		s unavailable the second day			
	she was to inform the	•			
	-If the medication was	s unavailable the third day			
	the RCD was to let th				
		umentation on the MAR or			
	was not available.	d why the gavilax powder			
		ecall the last time Resident			
	#6 was administered				
	-She had not docume	•			
	followed the facility's	protocol and notified the			
		6's gavilax powder needed to			
	be refilled.				
	Telephone interview v	vith Resident #6's PCP on			
	-She did not know Re				
	administered gavilax				
		ordered because Resident			
	#6 currently had orde				
		etimes caused constipation.			
		uld not stop a medication			
	without consulting her	not available the facility staff			
		hen she could determine if			
		he medication or switch to			
	another medication.				
	Refer to interview with	n the Administrator on			
	09/25/20 at 2:17pm.	Tule Autilinistrator off			
	Refer to interview with 09/25/20 at 3:47pm.	n a medication aide (MA) on			
		erview with the previous or (RCD) on 09/29/20 at			

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3:50pm.

b. Resident of Resident #6's current FL2 dated

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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. BUILDING: _			
		HAL034150	B. WING		10	R / 01/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		DOWBROOK N	IALL COURT		
		СLЕММО	NS, NC 27012	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 56	{D 358}			
,	02/14/20 revealed an subcutaneously at be used to treat elevated	order for Lantus 24 units dtime (a long acting insulin				
	dated and signed by to orders for Lantus 30 to daily at 6:30am and 4	the PCP on 08/18/20 with units subcutaneously twice :30pm.				
	Administration Record -There was an entry f units twice daily sche	6's August 2020 Medication d (MAR) revealed: for Lantus insulin inject 30 duled for administration at from 08/20/20 through				
	on 08/22/20, and 08/3	22 opportunities at 8:00am 31/20; and at 8:00pm on 0 with no explanation for				
	revealed: -There was an entry f	6's September 2020 MAR or Lantus insulin inject 30 duled for administration at				
		rom 09/01/20 through				
	documented as admit opportunities from 09.					
	Lantus 12 times at 6: 09/16/20. -There was an entry f units twice daily sche	tation Resident #6 refused 30am from 09/04/20 to for Lantus insulin inject 36 duled for administration at from 09/16/20 through				

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMF	PLETED
						R
		HAL034150	B. WING			/01/2020
		11112001100			1 10	70 172020
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 ME	ADOWBROOK N	IALL COURT		
		CLEMMO	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 57	{D 358}			
	on 09/26/20; and at 9 09/29/20. -There was documen	26 opportunities at 9:00am 0:00pm on 09/16/20 and station Resident #6 refused es from 09/16/20 through				
	•	ent #6's medication on hand 5/20 at 2:50pm revealed for administration.				
	aide (MA) on 09/29/2 -Resident #6 had mai insulinThe Lantus was orde twice dailyThe previous RCD w MARs to identify hole not administeredIf Lantus was not add documentation on the was not administered	with a first shift medication 0 at 2:41pm revealed: ny changes with his Lantus ered to be administered was supposed to review the es in the MAR or medications ministered there should be e MAR why the medication I. mentation why Lantus was				
	Telephone interview v 09/29/20 at 09/29/20 -When she administe she was to document medication had been -If the MAs worked th MAR from the previous to leave a note and m -The MA was suppos documented why the administered.	with a second shift MA on at 4:59pm revealed: ered Resident #6's Lantus, ton the MAR showing the administered. Help looked for holes on the lus MA, they were supposed make the MA aware.				

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possible the medication was not administered.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		R 10/0	1/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		DOWBROOK N	IALL COURT		
			NS, NC 27012		. 1	
(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	(X5) COMPLETE DATE
{D 358}	Continued From page	e 58	{D 358}			
	-Resident #6 had unc -She ordered Lantus the resident's high blo -She expected facility #6's medications as of	l/29/20 at 12:05pm revealed: controlled diabetes. twice daily to help control cod sugar levels. staff to administer Resident ordered. nformed if a resident was				
	Refer to interview with 09/25/20 at 2:17pm.	n the Administrator on				
	Refer to interview with 09/25/20 at 3:47pm.	n a medication aide (MA) on				
	· ·	terview with the previous or (RCD) on 09/29/20 at				
	02/14/20 revealed an Sugar (FSBS) before					
	revealed a physician's dated 08/18/20 by the (PCP) with an order for	6's physician's orders sorder sheet signed and Primary Care Provider or Novolog 14 units for a additional 10 units for total of 24 units.				

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Review of Resident #6's August 2020 MAR

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		R 10/01/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6010 MEADOWBROOK MALL COURT CLEMMONS, 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 358}	units subcutaneously additional 10 units for of 24 units. -Novolog insulin was administered on 3 of 08/20/20 to 08/31/20. -Novolog insulin was administered 3 times at 11:30am on 08/20, with no explanation for not administered. -Resident #6's FSBS from 08/20/20 throughto of the content of	for Novolog insulin inject 14 for FSBS over 250 and FSBS over 450 for a total not documented as 13 opportunities from not documented as at 7:30am on 08/23/20 and and at 4:30pm on 08/31/20 or why the medication was ranged between 140 to 454 in 08/31/20. 6's September 2020 MAR for Novolog insulin inject 14 for FSBS over 250 and in FSBS over 250 and in FSBS over 450 for a total not documented as if 39 opportunities from 29/20 with no explanation for itas not administered. Inted as administered instead intunities as follows: Inter as follows: Inter as administered instead intunities as follows: Inter as administered, but all have been administered. Inter as administered, but all have been administered. Itation Resident #6 refused in 09/01/20 to 09/29/20. Italian resident #6 to 501	{D 358}			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	R 34150 B. WING R 10/01/2		R 10/01/2020	
	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA Dowbrook N NS, NC 27012		10/01/2020	
(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}	revealed: -Some days facility st dailyDepending on the stars FSBS was not checkedSometimes staff admichecked his FSBS, but of the insulin or how madministered. Telephone interview was 4:59pm revealed: -When she administes she was to document medication had been -She worked on 09/1 she administered Resulf she did not administered she was supple and document why the administeredShe did not know who the documentWithout documentation that she administeredTelephone interview was administeredShe did not know who the documentWithout documentation that she administeredTelephone interview was administeredShe did not know who the documentWithout documentation that she administeredShe did not should a should be sh	aff checked his FSBS twice aff working, some days his ed at all. hinistered insulin after they at he did not know the name much insulin was with a MA on at 09/29/20 at red Resident #6's Novolog, on the MAR showing the administered. 1/20 but could not recall if sident #6's Novolog or not. ster the medication as posed to circle her initials he medication was not at happen and why she did on she could not be certain I the medication. with Resident #6's Primary 29/20 at 12:05pm revealed: controlled diabetes and she is needed (PRN). De administered 14 units of er 250 and additional 10	{D 358}			

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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	
			71. BOILBING.		R	
		HAL034150	B. WING		10/01/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY	AT CLEMMONS		ADOWBROOK M	IALL 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 APPROPE DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	e 61	{D 358}			
	Refer to interview witl 09/25/20 at 2:17pm.	n the Administrator on				
	Refer to interview witl 09/25/20 at 3:47pm.	n a medication aide (MA) on				
	Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. 5. Review of Resident #4's current FL2 dated 02/14/20 revealed diagnoses included type II diabetes mellitus and schizophrenic disorder.					
		t #4's current FL2 dated lazime skin protect cream				
	Review of Resident #	4's physician's orders				
	-A physician's order s order for calazime ski topically to buttocks to protection cream).	heet dated 08/18/20 with an in protect cream - apply wice daily (a topical skin 7/20 for calazime paste se daily.				
	record revealed: -There was an entry foream - apply topicall diaper dermatitis sche and 3:00pm to 11:00ppp -Calazime skin protect 8 of 22 opportunities with no explanation wapplied.	4's August 2020 MAR for calazime skin protect by to buttocks twice daily for eduled for 7:00am to 3:00pm bm. etion cream was not applied from 08/20/20 to 08/31/20 by the medication was not tation Resident #6 refused				

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08/31/20.

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STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		
		1141 024450	B. WING		R	
		HAL034150	B: Wiito		10/01/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
no	T 01 T1410110	6010 MEA	DOWBROOK N	IALL COURT		
THE IVY AT CLEMMONS CLEMMON			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	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
				DEFICIENCY)		
{D 358}	Continued From page	- 62	{D 358}			
(= 555)	Continuou i rom page	3 02	(= 333)			
		4's September 2020 MAR				
	record revealed:					
		or calazime skin protect				
	cream - apply topicall	y to buttocks twice daily for				
		eduled for 7:00am to 3:00pm				
	and 3:00pm to 11:00p	om.				
	-Calazime skin protec	ction cream was not applied				
	24 of 34 opportunities	s from 09/01/20 to 09/17/20				
	with no explanation w	hy the medication was not				
	applied.					
	-There was documen	tation Resident #6 refused				
	calazime paste 10 tin	nes from 09/01/20 to				
	09/17/20.					
		ent #4's medications on				
		4:50pm revealed there were				
	four containers of cal					
	available for applicati	on.				
	Talambana intanciawy	with Decident #415 DCD on				
		with Resident #4's PCP on				
	09/29/20 at 12:05pm					
	wheelchair to get aro	mi-ambulatory and used a				
	-Resident #4 sat mos					
	wheelchair and was o					
	down on the resident	d redness and skin break				
		rier cream to help protect				
	Resident #4's buttock	s and prevent skin				
	breakdown.	dored twice deily:				
		dered twice daily, some				
		ut if the medication was not				
	• •	in a row she wanted to be				
	notified.					
	-Facility staff should r					
	medication without fir	st talking with her.				
	T. 1	·				
	Telephone interview v	with a MA on 09/29/20 at				

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4:59pm revealed:

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	D 14910		R 10/01/2020			
	ROVIDER OR SUPPLIER	STREET AD	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{D 358}	#4She thought the creations applied to Reside Based on observation reviews it was determent interviewable. Refer to interview with 09/25/20 at 2:17pm. Refer to interview with 09/25/20 at 3:47pm. Refer to telephone into Resident Care Director 3:50pm. b. Review of Resident 02/14/20 revealed and twice daily (a long accelevated blood sugar Review of physician's record revealed: -An order dated 08/18 subcutaneously at 6:5-An order dated 09/03 subcutaneously twice -An order dated 09/03 subcutaneously twice daily. Review of Resident #Administration Record-There was an entry for the subcutaneously for the subcutaneously the subcutaneously twice daily.	as not applied to Resident am was discontinued. ecall the last time calazime ent #4's buttocks. In interviews and records hined that Resident #4 was In the Administrator on In a medication aide (MA) on terview with the previous for (RCD) on 09/29/20 at It #4's current FL2 dated forder for Lantus 44 units ting insulin used to treat values). It orders in Resident #4's It	{D 358}			

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-Lantus insulin was not documented as

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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
					R
		HAL034150	B. WING		10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
	AT CLEMMONS	6010 ME	ADOWBROOK N	IALL COURT	
INE IVI A	TI CLEWINIONS	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 COMPLETE
{D 358}	Continued From page	e 64	{D 358}		
		opportunities from 08/20/20 no explanation for why the dministered.			
	revealed: -There was an entry f	4's September 2020 MAR or Lantus insulin inject 28 duled for administration at			
	-Lantus insulin 28 uni administered for 3 of 09/03/20 with no expl				
	units twice daily sche 6:30am and 6:30pm. -Lantus 30 units were	or Lantus insulin inject 30 duled for administration at not documented as			
	administered for 2 of 2 09/03/20 to 09/17/20 the medication was no	with no explanation for why			
		ent #4's medications on I:50pm revealed Lantus was ration.			
	Refer to interview with 09/25/20 at 2:17pm.	n the Administrator on			
	Refer to interview with 09/25/20 at 3:47pm.	n a medication aide (MA) on			
	Resident Care Director 3:50pm.c. Review of I dated 02/14/20 reveated daily before breakfast 10 units for FSBS green	SBS over 400 (a short			

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sugars).

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STATEMENT	T 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		R
		HAL034150	B. WING		10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE ZIP CODE	
IVAIVIL OI II	NOVIDER OR GOLF EIER				
THE IVY A	AT CLEMMONS		ADOWBROOK N	MALL COURT	
		CLEMMO	ONS, NC 27012	T.	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MATE
				,	
{D 358}	Continued From page	∍ 65	{D 358}		
,	1 3		' '		
	Review of Resident #	4's physician's orders			
ļ	revealed:				
	-A physician's order d	dated 08/18/20 for Novolog			
ļ	16 units twice daily fo	or FSBS over 250, give an			
	additional 4 units for f	FSBS over 400 for a total of			
	20 units.				
	-An order dated 09/07	7/20 for Novolog 16 units			
		over 250, give an additional			
	,	400 for a total of 20 units.			
	T GING TOT . EDG C. I.	100 101 a 101a1 a. 20 a			
	Review of Resident #	4's August 2020 MAR			
	record revealed:	+ 3 August 2020 14.1. 1. 1			
	-There was an entry f	for ESRS twice daily			
	scheduled for 6:30am				
		for Novolog insulin inject 16			
		twice for FSBS over than			
	_	units for FSBS over 400.			
	-Novolog insulin was				
		ctly for 5 of 16 opportunities			
		h 08/31/20 as follows:			
	-	om, FSBS was 200, Novolog			
	4 units was document	ted as administered, but			
	Novolog 0 units should	ld have been administered.			
	-On 08/24/20 at 4:30p	om, FSBS was 493, Novolog			
	16 units was docume	nted as administered, but			
	Novolog 20 units sho	uld have been administered.			
	-On 08/29/20 at 6:30a	am, FSBS was 285, Novolog			
		ted as administered, but			
		uld have been administered.			
	_	am, FSBS was 411, Novolog			
		nted as administered, but			
		uld have been administered.			
		om, FSBS was 268, Novolog			
		nted as administered, but			
		uld have been administered.			
		ranged between 149 to 493			
	from 08/21/20 to 08/3	1/20.			

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Review of Resident #4's September 2020 MAR

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Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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		HAL034150	D. WING		10/0	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
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THE IVY A	T CLEMMONS		NS, NC 27012	IALL GOOK!		
		CLEMINIC	NS, NC 27012			
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IAG		,	1/10	DEFICIENCY)		
{D 358}	Continued From page	e 66	{D 358}			
	record revealed:					
	-There was an entry f	or ESBS twice daily				
	_					
	scheduled at 6:30am	•				
		for Novolog insulin inject 16				
	•	twice for FSBS over than				
		units for FSBS over 400.				
	-Novolog insulin was					
		mented incorrectly for 4 of				
		09/01/20 to 09/17/20 as				
	follows:					
	-On 09/01/20 at 6:30a	am, there was no				
	documentation.	FODO 104				
	-	om, FSBS was 464, Lantus				
		nted as administered, but				
	~	uld have been administered.				
		am, FSBS was 233, Lantus				
		nted as administered, but				
		ld have been administered.				
		om, FSBS was 420, Lantus				
		ted as administered, but				
		uld have been administered.				
		ranged between 120 to 567				
	from 09/01/20 to 09/1	//ZU.				
	Observation of Desid	ont #4's modications on				
		ent #4's medications on				
	was available for adm	1:50pm revealed Novolog				
	was available for adm	imistration.				
	Tolophone interviewe	with a modication side (MA)				
		with a medication aide (MA)				
	on 09/29/20 at 2:37pr	n revealed: Resident #4's FSBS she				
		units of insulin administered.				
		s documented on the MAR,				
	then the resident did	_				
		as if a medication was not				
	•	aff had to document the				
	reason why.					
			1	I .		

Division of Health Service Regulation

Telephone interview with Resident #4's PCP on

09/29/20 at 12:29pm revealed:

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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 SUI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	TED
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		HAL034150	B. WING		10/01	/2020
		TIALOG TOO	I		1 10/01/	72020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
	T CLEMMONS	6010 ME	ADOWBROOK N	MALL COURT		
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NATE	D/ ((E
{D 358}	Continued From page	e 67	{D 358}			
	-Resident #4 had diag	gnoses of diabetes mellitus.				
	-She ordered insulin t					
	resident's elevated bl					
		at Resident #4's insulin was				
	not administered as o	ordered.				
	-She expected facility	staff to administer				
	medications as ordered					
		npliant with receiving her				
	•	should be no reason why				
	the resident did not go	et her insulin.				
	D 1 1 "					
		n interviews and records				
	not interviewable.	nined that Resident #4 was				
	not interviewable.					
	Refer to interview with	h the Administrator on				
	09/25/20 at 2:17pm.	Trans / tariimistrator on				
	00/20/20 at 2111 pill					
	Refer to interview with	h a medication aide (MA) on				
	09/25/20 at 3:47pm.	•				
		terview with the previous				
		or (RCD) on 09/29/20 at				
	3:50pm.					
	d Daview of Deed	+ #4le current ELO deted				
		t #4's current FL2 dated order for Metoprolol 50mg				
		et (75mg) twice daily (used				
	to treat elevated bloo					
	to troat did valua billu	a p. 000a.0).				
	Review of Resident #	4's physician's orders				
	revealed:	, ,				
	-A physician's order d	lated 08/18/20 with an order				
		one and one-half tablet				
	(75mg) twice daily.					
		7/20 for Metoprolol 50mg				
	one and one-half tabl	et (75mg) twice daily.				
			1	1		

Division of Health Service Regulation

Review of Resident #4's September 2020 Medication Administration Record (MAR)

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Division of Health Service Regulation

DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
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		HAL034150	B. WING		10/0	1/2020
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THE IVY A	T CLEMMONS		OOWBROOK N	IALL COURT		
		CLEMMON	S, NC 27012			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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				22.10.2.10.1		
{D 358}	Continued From page	e 68	{D 358}			
, ,	. •		'			
	revealed:					
	•	or Metoprolol 50mg one and				
) twice daily scheduled for				
	administration at 8:00	am and 8:00pm.				
	-There was document	tation Metoprolol 50mg was				
	not administered for 5	of 33 opportunities on				
	09/15/20 at 8:00am a	nd 8:00pm, on 09/16/20 at				
	8:00am and 8:00pm a	and on 09/17/20 at 8:00am.				
	-There were two entri	es on the back of the MAR				
	on 09/15/20 at 8:00pr	n and on 09/16/20 at				
	8:00am "waiting on pl					
	5 1	,				
	Observation on 09/17	7/20 at 4:50pm of Resident				
		nand at the facility revealed				
	Metoprolol 50mg was	-				
	administration.	The available for				
	adminionation.					
	Interview with the MA	on 09/17/20 at 4:58pm				
	revealed:	1011 03/17/20 at 4.30pm				
		en out of Metoprolol 50mg for				
		at he worked (09/16/20 and				
	09/17/20).	at the worked (09/10/20 and				
	,	noible for reardering				
	 The RCD was responsed in the response of the resp	naine in renderling				
		e RCD had re-ordered				
	Resident #4's Metopro					
	•	le packed and automatically				
	refilled.					
	Talambana interni	with Danidant #41c DOD				
	•	vith Resident #4's PCP on				
	09/28/20 at 12:49pm					
		story of hypertension and				
	she ordered Metoprol					
	-She did not know Re	esident #4 was out of				
	Metoprolol.					
		cility to have medications				
		ration, so the resident did				
	not miss doses of the	medication.				
			1			

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Telephone interview with a representative from

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STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. BOILBING.		R	
		HAL034150	B. WING		1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY	AT CLEMMONS	6010 ME	ADOWBROOK N	IALL COURT		
	TO SEEMINIONS	CLEMMO	NS, NC 27012			
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{D 358}	Continued From page	e 69	{D 358}			
(D 000)	the facility's contracted 2:44pm revealed: -Resident #4's Metop-The medication was cycleResident #4 should revenue facility staff were taking before the medication back the medication back the sending the medication the medication back the sending the medication the medication back the sending the medication the medication the medication the medication cardThis issue had been numerous times and used all the medication cardIt was also noticed the administering the medication run outless of the medication run outless of the medication because documentation showing dispensed and should be also documentation showing the medication because documentation showing the medication run outless of the medication run out	rolol was on a cycle fill. filled every 28 days per not run out of the Metoprolol. dications were received, ng all medication cards out n was finished and sending to the pharmacy. cion back to the pharmacy ind it was an expense for the discussed with the facility it was suggested that staff ons before starting a new nat sometimes staff dications failed to check the or medications, and they let at and then request a refill. days a resident was without the they must provide ng the medication was				

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DIVISION	n nealth Service Negu	ialion			_
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
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		1101 004450	B. WING		R
		HAL034150	B. W		10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		6010 MFA	DOWBROOK M	MALL COURT	
THE IVY A	T CLEMMONS		NS, NC 27012		
			10, 110 27012	T	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
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		,		DEFICIENCY)	
{D 358}	Continued From page	e 70	{D 358}		
	Interview with the Adr	ministrator on 09/25/20 at			
	2:17pm revealed:	Tillistrator on 09/25/20 at			
		ad worked at the facility for			
	barely 90 days and sh				
	, ,	•			
	the medication cart at	as responsible for auditing			
		as supposed to check			
		the MARs with current			
	orders to identify disc				
		ever told her that she was			
		acility's protocol for auditing			
	_	ne system was in place and			
	being followed.				
	T	ations to be available for			
		there were extenuating			
	circumstances.				
		e previous RCD and MA			
	were not following the				
	_	up on medications that were			
	not available for admi				
		was to reorder a medication			
	before the medication				
		cations were dispensed in			
	bubble packaged card				
	-The bubble package	d medication card had a			
	designated point that	specified when to reorder			
	the medication.				
		r medications for refill or			
		a medication refill form.			
	· · · · · · · · · · · · · · · · · · ·	the medication refill form,			
	the form was given th				
		as supposed to send the			
	refill request to the ph	narmacy either by fax,			
	telephone call or thro	ugh the pharmacy online			
	system.				
		s unavailable on the next			
	day for administration	ı, then the MA on duty was			
		and document why the			
		vailable on the back of the			

MAR.

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Division of	of Health Service Regu	lation				
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPLI	
					l R	,
		HAL034150	B. WING		1	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
THE IVY	AT CLEMMONS		ADOWBROOK MA	ALL COURT		
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{D 358}	Continued From page	· 71	{D 358}			
	-If the medication was second day the MA w document on the back-The RCD was to condocument the reason availableIf the medication was the RCD was to notify document on the back-There was a back-up main pharmacy, but it antibiotics, because the and they delivered to -A resident should newithout a medicationShe had provided traregarding facility's polfollowing up with the punavailable medicationWhen new, changed were received from hemainly, the RCD's resto the pharmacyThe RCD was suppoon the MARIf the RCD was busy to fax the order to the MARUltimately, the RCD ensuring the medicatic correctly on the MARMedication carts werThe RCD was suppo MA to weekly audit the medication cart and contact in the medication cart in the med	s still not available on the as to notify the RCD and cof the MAR. Itact the pharmacy and why the medication was not why the medication was not available the third day of the Administrator and cof the MAR. Itact the pharmacy used by the awas only used for the pharmacy was open 24/7 the facility twice daily. Itach were be more than three days wining in July 2020 to staff lictly related to refills and coharmacy regarding than on the corresponsibility to fax the orders are providers, it was sponsibility to fax the order than three days are sponsible for on was documented audited weekly. It is sed to assign a third shift				

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matched.

documentation to the RCD.

-If discrepancies were identified the MA was to document the issues found and give the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION		
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		1141 00 44 50	B. WING			R
		HAL034150	B. W. TO		10	/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
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{D 358}	Continued From page	e 72	{D 358}			
	concerns with the MA -She had not seen an discrepancies that res	y documentation related to sulted from the medication therefore she thought there				
	ensuring medication of medication orders we available for medication the Administrator was -The Administrator was the residents' orders and Medication Administrate -If a medication was redication not being contact the pharmacy physician. -Any medication not a contacts with the phashould have been door records. -Medication errors or rights" were not follow route, right time, right documentation, and redication downworth of the person who four notified Administrator. -Third shift MA were redication cart audits medication were delivered.	ad been responsible for orders and changes in the MARs and on administration, but now a responsible as of 09/17/20. The responsible as of 09/17/20 as responsible for reviewing and compared them to the ation Record (MAR). The responsible for reviewing and the facility, the MA should of and the resident's administered and any remacy and physicians cumented in the residents' curred when any of the "6 wed: "right resident, right a dosage, right ight medication." The dosage, right ight medication." The dosage is the responsible for completing is when cycle filled				
	were delivered, but st was documented.	cycle filled medications ne did not know if the audit cart audit, the MA should				

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Division of Health Service Regulation						
STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CO	ORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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			D WING		F	
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		СЕММО	NS, NC 27012			1
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			+			1
{D 358} Co	ntinued From page	e 73	{D 358}			
		-4: 4l				
	make sure the medications on the medication					
cai	rt match what is on	the MAR.				
		ith the secondary DOD on				
	•	vith the previous RCD on				
	/29/20 at 3:56pm re					
	hen she worked at					
	•	ed auditing the MARs and				
	e medication cart.					
		t each week so that at least				
	-	ooked at MARs and the				
	edication cart.					
		edication cart audit, she				
		ons on the cart and				
COI	mpared with the Ma	ARs to make sure				
I		ailable for administration.				
		ere not available, she				
	ecked to see why.					
-If	there was an insura	ance problem and the				
		vailable, she contacted the				
	•	other medication was				
ava	ailable that would b	e covered by the insurance.				
-SI	he also notified the	resident's PCP.				
		medications based on the				
"re	fill order sheet" tha	t she received from the MA.				
-SI	he was having a pr	oblem with the MAs letting				
he	r know when medic	cations needed to be refilled.				
-If	the MA did not give	e her a refill order sheet, she				
ha	d no way of knowin	ng what medications were				
un	available for admin	istration.				
-0	ne problem with me	edications not being				
ad	ministered was the	MAs often did not check				
the	e medication room t	for overstock medications,				
ins	tead they documer	nted on the MAR "waiting on				
the	e pharmacy."					
		addressed and several MAs				
we	ere wrote-up for not	administering medications.				
	·					
Th	e facility failed to e	nsure medications were				
		red by the licensed				
		or 5 of 6 sampled residents				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034150	B. WING		R 10/01/2020
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		OWBROOK 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
{D 358}	receiving two medicat and not receiving a mypertensive resident pressure medication to September 2020 which blood pressures and it a resident with elevate receiving a short actire which could result in mand not receiving 5 do pressure medication welevated blood pressure stroke (#4); a schizopa a medication used to which could result in the disorder, and not receive treat low potassium warrhythmia (#5); and a blood sugars not receive short acting insulin whand organ damage (#administer medication residents at substantian neglect which constituted to the substantian neglect which constituted to the facility provided at the substantian neglect which constituted the substantian neglect which provided at the substantian neglect which constituted the substantian neglect which constituted the substantian neglect which provided at the substantian neglect which provided at the substantian neglect which constituted the substantian neglect which provided at the substantian neglect which provi	6) which resulted in a continued pain due to not tions for rheumatoid arthritis redication for pain (#1); a not receiving a blood twice daily for the month of ch could result in elevated increaed risk for stroke (#3); red blood sugars not and a long acting insulin merve and organ damage coses of a high blood	{D 358}		
{D 367}	10A NCAC 13F .1004 Administration	l(j) Medication	{D 367}		
	(j) The resident's me	Medication Administration dication administration e accurate and include the			

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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 _		B. WING		R 10/01/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
THE IVY A	THE IVY AT CLEMMONS			IALL COURT			
			NS, NC 27012			\dashv	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE		
{D 367}	Continued From page	2 75	{D 367}				
	(3) strength and dosa administered; (4) instructions for admortreatment; (5) reason or justificate medications or treatmedocumenting the result (6) date and time of a (7) documentation of medications or treatmedications or treatmedications, including reference (8) name or initials of the medication or treatmedication or treatmedicatio	any omission of lents and the reason for the lefusals; and, the person administering atment. If initials are used, a those initials is to be intained with the medication (MAR).					
	Based on record reviet facility failed to ensure Administration Record 4 of 6 sampled reside related to correctly endocumenting administration according to physicial documenting the adminedications, medications.	ews and interviews, the ethe Medication ds (MARs) were accurate for ents (#1, #4, #5, and #6) attering, scheduling, and tration of medications n's orders, including					

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The findings are:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE			
AND FLAN OF CORREC	TION	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:		LETED
		HAL034150	B. WING		l l	R 01/2020
NAME OF PROVIDER O	R SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMN	IONS		DOWBROOK N	MALL COURT		
		CLEMMO	NS, NC 27012			
1111111	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{D 367} Continu	ed From page	e 76	{D 367}			
-All block and documed -Insuling amount -Sliding reading -If no in with initing -The Richeck of results -All medincluding -Circled was not MARPRN medincluding -PRN medincluding explanation waiting pharmatic that RCI Administration for a medincluding pharmatic that RCI Administration in the RCI	od sugar testir cumented on to de sugar readication the Market of the Ma	ings results must be MAR with initials. e documented with the you administered. e documented with the insulin administered. ered put a 0 on the MAR insible for ensuring a weekly or accuracy and reporting				

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Division of Health Service Regulation							
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED	
ANDILAN	JI CONNECTION	IDENTIFICATION NONBERG	A. BUILDING: _			OOMI LETED	
		HAL034150	B. WING	B. WING		R 10/01/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
		6010 ME.	ADOWBROOK N	IALL COURT			
THE IVY A	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIAT		
{D 367}	Continued From page 77		{D 367}				
	visit summary dated 0 -Resident #1's primar arthritis involving multi- Diagnoses also inclu disc disease, and prim multiple jointsResident #1 was to 0 40mg injection, inject 14 days for rheumato a. Review of Residen 09/15/20 revealed an 1 pen every 14 days () Review of Resident # 07/04/20 revealed the Review of Resident # 02/18/20 revealed an injection 40mg/0.4ML under the skin every Review of Resident # Administration Record September 2020 reve Humira 40mg/04ML in Review of Resident # revealed Resident # 1 injection on 07/23/20, 09/01/20. Interview with Reside revealed: -She was administere by a HH nurse for her	ry diagnosis was rheumatoid tiple sites. Ided multilevel degenerative mary osteoarthritis involving continue taking Humira Pen 1 pen under the skin every bid arthritis. It #1's current FL2 dated order for Humira 40/0.4 ML (used to treat arthritis). It sphysician's orders dated ere was no order for Humira. It's physician's orders dated order for Humira pen inject 1 pen (40 mg dose) 14 days. It's Medication do (MAR) for August and ealed there was no entry for nject 1 pen every 14 days. It's Home Health (HH) notes was administered a Humira pen 1, 08/07/20, 08/18/20, and					

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09/18/20.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING		_	
		HAL034150	B. WING		10/0	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	THE IVY AT CLEMMONS CLEMMO			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	(X5) COMPLETE DATE
{D 367}	Continued From page 78		{D 367}			
	the contracted pharm revealed: -There was an order inject 1 pen every 14 -The pharmacy dispe 07/17/20, 08/05/20, a Interview with a medi 09/25/20 at 3:47pm re-She did not know Hu administered to Resid because Humira was -Resident #1's Humin been on the MAR and administered by the F-The previous Reside would have been respon the MAR for docur Telephone interview v 09/28/20 at 10:38am -Resident #1 had a pl 40mg/0.4ML administ weeksHumira was administ weeksHumira was administ o9/01/20, and 09/19/2-She documented an but she did not docur or September 2020Humira used to be o document it was adminitials the location of MAR.	nsed Humira 2 pens on nd 09/18/20. cation aide (MA) on evealed: Imira injections were dent #1 by the HH nurse not on the MAR. a injections should have documented as HH nurse. Interest Care Director (RCD) consible for placing Humira mentation. with the HH nurse on revealed: hysician's order for Humira ter subcutaneously every 2 tered on 08/04/20, 08/18/20, 20. entry in the HH notebook, ment on the MAR and she would inistered by writing in her the injection site on the				
	09/25/20 at 3:44pm re	vith the Administrator on evealed: #1 received HH services for				

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	≣TED
					R	,
		HAL034150	B. WING		1	1/2020
					1 10/0	172020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		DOWBROOK N	MALL COURT		
	OLLIMINORO	СLЕММО	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 APPROPF		COMPLETE DATE
IAO		,	IAO	DEFICIENCY)		
(D 267)	O (' 15		(D. 267)			
{D 367}	Continued From page	∍ 79	{D 367}			
		ns should be on the MAR.				
	-She did not know Re					ı !
	_ =	n her August and September				ı
	2020 MARs.					ı .
	•	vas responsible for ensuring				
	Humira was entered o	on the MAR.				
	Pofer to telephone inf	terview with a representative				
		pharmacy on 09/18/20 at				ı
	10:57am.	Tial Tidoy 611 66/16/26 at				ı
						ı
	Refer to interview with	h a medication aide (MA) on				
	09/25/20 at 3:47pm.	, .				
						ı
		h the Administrator on				ı
	09/25/20 at 2:17pm.					ı
	Different talambama ini	· · · · · · · · · · · · · · · · · · ·				
		terview with the previous or (RCD) on 09/29/20 at				ı
	3:50pm.	or (RCD) on 09/29/20 at				ı
	b. Review of Residen	nt #1's FL2 dated 09/15/20				ı
		ot an order for Flexeril (used				ı
	short-term to treat mu					
		1's physician's orders dated				
		order for Flexeril 10mg 1				ı
	tablet 3 times daily as	s needed for up to 10 days.				
	Review of Resident#	t1's Medication				
		d (MAR) for August 2020				ı
		ot an entry for Flexeril 10mg				I
		as need for up to 10 days.				1
		ao noon io ap io io anyo.				
	Review of Resident #	t1's MAR for September				1
	2020 revealed:	•				I
	-There was an entry v	written on the MAR for				I
	_	tablet 3 times a day as				I
	needed for enseme		_ I			ı

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-The entry for Flexeril did not include the limited

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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		(X3) DATE SURVEY COMPLETED
		HAL034150	B. WING		R 10/01/2020
NAME OF P	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	1 10/01/2020
THE IVY A	AT CLEMMONS		ADOWBROOK MA	ALL COURT	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST 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 80	{D 367}		
	administered from 09 days). -One tablet of Flexeria administered on 09/04 09/12/20, 09/13/20, 09/12/20, 09/13/20, 009/12/20, 09/13/20, 009/12/20. -Two tablets of Flexeriadministered on 09/04 09/11/20. -Three tablets of Flexeriadministered on 09/05/09/16/20. - There was no docur MAR indicating the rewas given and the result of the second of the Market of the second of the Market of the second of the Market of the second of the medical of the second	4/20, 09/05/20, 09/08/20, 09/15/20, and 09/17/20. ril were documented as 6/20, 09/09/20, 09/10/20, deril were documented as 7/20, 09/14/20, and deril sults for 9 doses from desay as needed was MAR on 09/22/20. dedication cart on 09/17/20 at det 3 times daily or up to 10 dication cart. deril had been dispensed to 20 and there was 1 tablet dent #1 on 09/25/20 at 1:58pm or Flexeril as needed which devertil again on 08/24/20 at			

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-There was an order for Flexeril 10mg 1 tablet 3 times daily as needed for up to 10 days.

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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		R 10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE NOVA	T OLEMBONO	6010 MEAI	DOWBROOK N	IALL COURT	
THE IVY AT CLEMMONS CLEMMO			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 APPROPE DEFICIENCY)	BE COMPLETE
(D 207)			(D 207)	32.16.2.16.7)	
{D 367}	Continued From page	e 81	{D 367}		
	-Thirty tablets of Flexeril were dispensed to the facility on 08/27/20.				
	Telephone interview von 09/30/20 at 3:27pr	vith a medication aide (MA) n revealed:			
	she did not remembe	exeril to Resident #1, but r seeing the dosage on the			
	MAR.	anneil de Desidend #4 en			
		exeril to Resident #1 on not know Flexeril should			
	have been discontinu				
	-She normally compa				
		ick, but she did not catch			
	that Flexeril was only				
	administered for up to				
	Telephone interview v	vith the Administrator on			
		evealed she did not know			
	·	cumented on the MAR as			
		terview with a representative harmacy on 09/18/20 at			
	Refer to interview with 09/25/20 at 3:47pm.	h a medication aide (MA) on			
	Refer to interview with 09/25/20 at 2:17pm.	h the Administrator on			
	-	terview with the previous or (RCD) on 09/29/20 at			
		nt #1's FL2 dated 09/15/20 ot an order for Ibuprofen ain).			

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Review of Resident #1's physician's orders dated

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			71. BOILBING.		R
		HAL034150	B. WING		10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		DOWBROOK N NS, NC 27012	MALL COURT	
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	'	PROVIDER'S PLAN OF CORRECTION	DN (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETE
{D 367}	Continued From page	e 82	{D 367}		
	08/25/20 revealed an order for Ibuprofen 800mg 1 tablet every 8 hours for 7 days.				
	Review of Resident #	1's Medication			
		d (MAR) for August 2020			
	800mg 1 table every	ot an entry for ibuprofen 9 hours for 7 days.			
	Review of Resident #1's MAR for September 2020 revealed: -There was an entry for ibuprofen 800mg 1 tablet				
	every 8 hours for 7 da	ays and scheduled for lam, 2:00pm, and 8:00pm.			
	-Ibuprofen 800 mg wa				
	_	or 21 of 21 times at 8:00pm			
	i -	2:00pm, and 8:00pm on 09/20; and at 2:00pm and			
	8:00pm on 09/10/20.	•			
	administered on 09/1	mentation ibuprofen was 4/20 at 8:00am and 2:00pm			
	and on 09/16/20 at 8: -There was documen	ບບam and 2:ບບpm. tation ibuprofen was not			
		5/20 due to waiting on the			
		edication cart on 09/17/20 at			
	5:57pm revealed ther medication cart.	e was no Ibuprofen on the			
		nt #1 on 09/25/20 at 1:58pm			
		pered taking ibuprofen for e she popped something in			
	her back.	o one popped something in			
	Interview with a medion 09/25/20 at 3:27pm re	, ,			
		order for Ibuprofen 800mg 1			
	tablet every 8 hours for	or 7 days.			
	 She did not know who documented as admir 	ly ibuprofen was nistered beyond 7 days.			

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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	
					R	
		HAL034150	B. WING		10/01/2020	\dashv
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	THE IVY AT CLEMMONS			IALL COURT		
	CLEMMO					-
(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 COMPLET	ΓE
{D 367}	Continued From page	e 83	{D 367}			
	the contracted pharm revealed: -There was an order of every 8 hours for 7 day -Twenty-one tablets of to the facility on 08/27. Telephone interview wo 09/30/20 at 1:11pm results of the facility on 08/27. Telephone interview wo 09/30/20 at 1:11pm results of the MAR for 9 day. Refer to telephone interview with 09/25/20 at 3:47pm. Refer to interview with 09/25/20 at 2:17pm. Refer to telephone interview with 09/25/20 at 2:17pm. Refer to telephone interview with 09/25/20 at 2:17pm. 2. Review of Resider 02/14/20 revealed diacardiomyopathy, anxious systolic and diastolic (chronic obstructive possession of Resider progress note dated of the contracted of the contraction of the contracted	of Ibuprofen were dispensed 7/20. with the Administrator on evealed she did not know locumented as administered s. terview with a representative harmacy on 09/18/20 at the a medication aide (MA) on the Administrator on terview with the previous for (RCD) on 09/29/20 at of #5's current FL-2 dated agnoses included ety disorder, combined heart failure and COPD culmonary disease). of #5's mental health 08/24/20 revealed:				
	-Trazodone 100mg w -There was an order to bedtime (used to trea	to start Trazodone 50mg at				

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problems).

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			B. WING		R	
		HAL034150	B. WING		10/01	1/2020
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	IIALL GOOKI		
			110, 110 27012			
(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	2		TAG	CROSS-REFERENCED TO THE APPROF		DATE
				DEFICIENCY)		
(D. 007)	0 " 15	0.4	(D. 007)			
{D 367}	Continued From page	2 84	{D 367}			
	Review of Resident #	5's mental health progress				
	note dated 09/10/20 r	· -				
	-The Trazodone grad	ual dose reduction (GDR)				
		not been implemented and				
	would be reordered.	·				
	-There was an order t	o discontinue Trazodone				
	100mg and to start Tr					
	Review of Resident #	5's August 2020 medication				
	administration record	_				
		ed, handwritten entry for				
	Trazodone 100mg.	oa, nanawiiton ontry ioi				
	•	as first documented as				
	administered on 08/1	5/20.				
	-The Trazodone 100n "DC" date of 08/26/20	ng entry was marked with a).				
	-There was a handwr	itten entry for Trazodone				
	50mg take one at bed 08/26/20.	ltime and was dated				
	-Trazodone 50mg wa	s documented as				
	administered from 08					
	Review of Resident #	5's September 2020 MAR				
	revealed:	,				
	-There was a printed	entry for Trazodone 100mg,				
	one tablet at bedtime.					
		Trazodone 100mg was				
	documented as admir	nistered on 09/01/20,				
	09/04/20 and from 09/07/20 to 09/13/29.					
	Continued review of F	Resident #5's September				
	2020 MAR further rev					
	-Trazodone 100mg w					
	09/14/20.					
		ed, handwritten entry for				
	Trazodone 50mg, one					
	-Trazodone 50mg wa					
	administered on 09/1	5/20.				

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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		R 10/01/	/2020
NAME OF PROVIDER OR SUPPLIER THE IVY AT CLEMMONS	STREET ADDR	RESS, CITY, STA OWBROOK M S, NC 27012		, 10.0	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEI	NT OF DEFICIENCIES BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
Observation of medication of #5 on 09/17/20 at 5:57pm relations. The bubble pack of Trazod dispensed on 08/24/20 with tablets. There were 2 tablets availated Telephone interview with a ron 09/29/20 at 2:46pm reversed Resident Care Director (RC verify the MARs were accurreach month. Telephone interview with a ron 09/29/20 at 2:46pm reversed month. Telephone interview with a ron the facility's contracted phare 12:17pm revealed: Trazodone 50mg was first 08/24/20 with a quantity of 20-0n 09/10/20, thirty tablets of facility. Telephone interview with the 09/29/20 at 4:59pm revealed. The previous RCD was resistent the MARs were accurrated to the upcoming new show it had been reviewed that not done that. Refer to telephone interview from the contracted pharmated 10:57am. Refer to interview with the A09/25/20 at 2:17pm. Refer to interview with a med 09/25/20 at 3:47pm.	done 50mg was a quantity of 25 able for administration. medication aide (MA) ealed the previous CD) was responsible to rate at the beginning of a representative from armacy on 09/29/20 at dispensed on 25 tablets. were dispensed to the decimal edicate. pposed to sign the womonth's MAR to and was accurate but a work of the eacy on 09/18/20 at a contract of the eacy of	{D 367}			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		
		HAL034150	B. WING		R 10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
THE IVY A	T CLEMMONS		NDOWBROOK M NS, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
{D 367}	Continued From page	e 86	{D 367}		
	Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. b. Review of Resident #5's physician's orders dated 08/18/20 revealed an order for potassium chloride micro tab 20meq ER (extended release) daily (used to treat low potassium levels). Review of Resident #5's August 2020 medication administration record (MAR) revealed an entry for potassium chloride micro tablet ER, 20mEq one tablet daily.				
	Review of Resident # revealed no entry for	5's September 2020 MAR potassium chloride.			
	Telephone interview with a representative from the facility's contracted pharmacy on 09/30/20 at 3:55pm revealed: -The original order for potassium was a verbal order given by Resident #5's primary care provider (PCP) on 07/16/20. -She did not have a discontinue order for this medication. -The facility printed the MARs for the upcoming month. -The facility could make changes to the MARs and she would not be able to see them. -She did not know why potassium was not on the				
	on 09/29/20 at 2:46pt -Potassium was not of 2020 MAR. -The previous Reside responsible for printing upcoming month.	with a medication aide (MA) m revealed: on Resident #5's September ent Care Director (RCD) was			

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HAL034150 B. WING NAME OF PROVIDER OR SUPPLIER THE IVY AT CLEMMONS SUMMARY STATEMENT OF DESIGNATION SUMMARY STATEMENT OF DESIGNATION SUMMARY STATEMENT OF DESIGNATION B. WING B	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012			HAL034150	B. WING	B. WING			
CHAMADY CTATEMENT OF DEFICIENCIES			6010 MEA	DOWBROOK M				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		((EACH DEFICIENC		PREFIX	CROSS-REFERENCED TO THE APPROPE	BE COM	X5) IPLETE ATE	
(D 367) Continued From page 87 sure the new month's MAR was accurate The facility did not currently have a RCD The Administrator was performing the duties of the RCD He would contact the Administrator for clarification since potassium was not on the MAR. Tetephone interview with the Administrator on 09/25/20 at 4.59pm revealed: - The previous RCD was responsible to make sure the MARs were accurate The previous RCD was supposed to sign the bottom of the new month's MAR after she reviewed it for accuracy The September 2020 MAR was not signed by the RCD. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with the Administrator on 09/25/20 at 2:17pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm. Refer to telephone interview with the previous Resident Care Director (RCD) on 09/29/20 at 3:50pm.		sure the new month's -The facility did not co -The Administrator we the RCDHe would contact the clarification since pot Telephone interview of 09/29/20 at 4:59pm r -The previous RCD we sure the MARs were -The previous RCD we bottom of the new me reviewed it for accura -The September 2020 the RCD. Refer to telephone in from the contracted p 10:57am. Refer to interview wit 09/25/20 at 2:17pm. Refer to interview wit 09/25/20 at 3:47pm. Refer to telephone in Resident Care Direct 3:50pm. 3. Review of Resider 02/14/20 revealed an (polyethylene glycological)	ew month's MAR was accurate. y did not currently have a RCD. nistrator was performing the duties of contact the Administrator for n since potassium was not on the MAR. interview with the Administrator on tt 4:59pm revealed: ous RCD was responsible to make lARs were accurate. ous RCD was supposed to sign the the new month's MAR after she to for accuracy. ember 2020 MAR was not signed by lephone interview with a representative contracted pharmacy on 09/18/20 at terview with the Administrator on tt 2:17pm. terview with a Medication Aide (MA) on tt 3:47pm. lephone interview with the previous Care Director (RCD) on 09/29/20 at of Resident #6's current FL2 dated evealed there were no diagnoses listed. of Resident #6's current FL2- dated evealed an order for gavilax powder ene glycol 3350) (a laxative used to	{D 367}				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPI IDENTIFICATION		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	t
		HAL034150	B. WING		10/0	1/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		OOWBROOK N S, NC 27012	IALL COURT		
			1	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
{D 367}	Continued From page	e 88	{D 367}			
	Review of Resident #6's physician's orders revealed: -An electronically signed order by the Primary Care Provider (PCP) dated 08/14/20 for gavilax powder 17gm in liquid daily. -An order dated 08/18/20 for gavilax powder 17gm in liquid daily. -An electronically signed order by the PCP dated 08/26/20 for gavilax powder 17gm in liquid daily. Review of Resident #6's August 2020 MAR revealed: -There was an entry for gavilax powder 17gm in liquid daily was scheduled for administration at 8:00am. -There was documentation gavilax powder 17gm was administered daily 31 times from 08/01/20 through 08/31/20.					
	revealed: -There was an entry f liquid daily was sched 8:00amThere was documen was administered dai through 09/29/20.	6's September 2020 MAR for gavilax powder 17gm in duled for administration at tation gavilax powder 17gm ly 28 times from 09/01/20 ent #6's medications on 09/25/20 at 2:50pm				
	revealed gavilax powder 17gm was not available for administration. Interview with Resident #6 on 09/25/20 at 2:40pm revealed: -He was administered medications daily, but he					
	did not know the nam administered. -He did not recall gett	es of the medications ing a medication that was a				

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liquid or that resembled water.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7.1. 231251113.		R
		HAL034150	B. WING		10/01/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		ADOWBROOK N NS, NC 27012	IALL COURT	
OUMANDY OTATEMENT OF DEFINITION				PROVIDER'S PLAN OF CORRECTION	d (VE)
(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 APPROPF DEFICIENCY)	BE COMPLETE
{D 367}	Continued From page	e 89	{D 367}		
	the facility's contracted 3:38pm revealed: -The last time gavilax be refilled was on 06/ was dispensedAs of today's, date (0 facility had called to repowder since 06/11/2 Telephone interview vaide (MA) on 09/30/20-Resident #6 had not powder in monthsShe was aware the rebut not available for a -She should have circuithe back of the MAR that she admitted was not available for a refer to telephone interview with 09/25/20 at 2:17pm. Refer to interview with 09/25/20 at 3:47pm. Refer to telephone interview with 09/25/20 at 3:47pm. Refer to telephone interview with 09/25/20 at 3:47pm. Refer to telephone interview with 09/25/20 at 3:47pm.	with a first shift medication 0 at 4:16pm revealed: been administered gavilax medication was on the MAR, idministration. bled her initials and wrote on the medication was not cion why she documented on ministered gavilax when it administration. terview with a representative tharmacy on 09/18/20 at the Administrator on the a medication aide (MA) on terview with the previous or (RCD) on 09/29/20 at			
	b. Review of Residen	t #6's current FL2 dated			

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02/14/20 revealed an order for Finger Stick Blood

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BUILDING.			Б
		HAL034150	B. WING		10	R 0/ 01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
THE IVY	AT CLEMMONS	6010 ME	ADOWBROOK MA	LL COURT		
1112 171 7	CLEMINIONS	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 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{D 367}	Continued From page	90	{D 367}			
	Review of Resident #6's physician's orders dated 08/18/20 revealed an order for Novolog 14 units for FSBS over 250 and an additional 10 units for FSBS over 450 for a total of 24 units. Review of Resident #6's August 2020 MAR revealed: -There was an entry for Novolog insulin inject 14					
	1	for FSBS over 250 and FSBS over 450 for a total				
	Novolog insulin admir	nentation for the units of nistered for FSBS over 250 ties from 08/21/20 through ver 450.				
	Review of Resident #	6's September 2020 MAR				
	units subcutaneously	or Novolog insulin inject 14 for FSBS over 250 and FSBS over 450 for a total				
	Novolog insulin admir for 36 of 53 opportuni	nentation for the units of nistered for FSBS over 250 ities and for 1 of 4 0 from 09/01/20 through				
	on at 09/29/20 at 4:59 -Resident #6's FSBS daily, if the resident d -The resident's FSBS	were checked three times id not refuse. result and the units of were to be documented on				

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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	
			7 50.25 10		R	
		HAL034150	B. WING		1	1/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		OWBROOK N S, NC 27012	IALL COURT		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(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 APPROPE DEFICIENCY)	BE	COMPLETE DATE
{D 367}	Continued From page	91	{D 367}			
		ded training of MAR he noticed that not all staff of insulin administered to				
	Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with the Administrator on 09/25/20 at 2:17pm.					
	Refer to interview with 09/25/20 at 3:47pm.	n a medication aide (MA) on				
	•	terview with the previous or (RCD) on 09/29/20 at				
	02/14/20 revealed:	nt #4's current FL2 dated				
	_	diabetes mellitus Type 2 and				
	schizophrenic disorderThere was an order for FSBS twice daily before breakfast and supper and Novolog 10 units for FSBS greater than 250, give additional 8 units for FSBS over 400.					
	Review of Resident # revealed:	4's physician's orders				
	16 units twice daily fo additional 4 units for F 20 units.	dated 08/18/20 for Novolog r FSBS over 250, give an FSBS over 400 for a total of				
	16 units twice daily fo	dated 09/07/20 for Novolog r FSBS over 250, give an FSBS over 400 for a total of				
	Review of Resident #	4's August 2020 MAR				

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INAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE SHERTY AT CLEMMONS SUMMARY STATEMENT OF DEFICIENCIES SEACH DEFICIENCY MUST BE PRECEDED BY PULL PRETEX TAG PRETIX TAG COntinued From page 92 revealed: -There was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 400 for a total of 20 units. -There was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 250 and additional 4 units for FSBS over 250 and additional 4 units of FSBS over 250 and additional 4 units for FSBS over 250 and 2		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
NAME OF PROVIDER OR SUPPLIER THE IVY AT CLEMMONS SITERET ADDRESS, CITY, STATE, JOP CODE THE IVY AT CLEMMONS SUMMANY STITEMENT OF SEPCRICIONS SOFTO MEADOW/BROOK MALL COURT CLEMMONS, NC 27012 PREFIX PAG CONTINUED From page 92 revealed: -There was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 400 for a total of 20 unitsThere was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 250 and additional 4 units for FSBS over 400 for a total of 20 unitsThere was no documentation for the units of Novolog insulin administered for FSBS over 250 for 3 of 9 opportunities and 6 of 8 opportunities for FSBS over 400 from 08/21/20 through 08/31/20. Review of Resident #3's September 2020 MAR revealed: -There was no documentation for the units of Novolog insulin administered for FSBS over 250 for 6 of 13 opportunities and 6 of 8 opportunities of FSBS over 400 for a total of 20 unitsThere was no documentation for the units of Novolog insulin administered for FSBS over 250 for 6 of 13 opportunities and 6 of 9 opportunities of FSBS over 400 for a total of 20 unitsThere was no documentation for the units of Novolog insulin administered for FSBS over 250 for 6 of 13 opportunities and for 2 of 6 opportunities over 450 from 09/01/20 through 09/17/20. Telephone interview with a medication aide (MA) on 09/29/20 at 2:37pm revealed: -When Resident #4. FSBS were checked, the FSBS and the units of insulin administered were to be documented on the MARShe had no explanation why she did not document the units of insulin administered Resident. #4. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10.57am. Refer to interview with the Administrator on				A. BOILDING.			
CLEMMONS SUMMARY STATEMENT OF DEFICIENCIES DEPOSITION PROPRIET SUMMARY STATEMENT OF DEFICIENCIES DEPOSITION PROPRIET PROVIDERS PLAN OF CORRECTION PROPRIET			HAL034150	B. WING		1	
THE INV AT CLEMMONS CLEMMONS, NC 27012 [X4) ID SUMMANY STATEMENT OF DEPICIENCIES REPERLY TAG CLEAN OF CORRECTION ONLY THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING IN-CRAMATION) PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING IN-CRAMATION) PROVIDE THE PROVIDE SEARCH ACTION SHOULD BE CROSS-REPERENCED BY FULL REGULATORY OR LSC IDENTIFYING IN-CRAMATION) There was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 250 and additional 4 units for FSBS over 250 for 3 of 9 opportunities and 6 of 8 opportunities for FSBS over 400 from 08/21/20 through 08/31/20. Review of Resident #4's September 2020 MAR revealed: There was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 250 and additional 4 units for FSBS over 250 and additional 4 units for FSBS over 250 for 6 of 13 opportunities and for 2 of 6 opportunities and for 2 of 6 opportunities and for 2 of 6 opportunities over 450 from 09/01/20 through 09/17/20. Telephone interview with a medication aide (MA) on 09/29/20 at 2:37pm revealed: -When Resident #4's FSBS were checked, the FSBS and the units of insulin administered were to be documented on the MAR. -She had no explanation why she did not document the units of insulin administered Resident. #4. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with the Administrator on	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(BACH DERICIBLY MUST BE PRECEDED BY FILL TAG) (D 367) Continued From page 92 revealed: -There was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 250 for 3 of 9 opportunities and 6 of 8 opportunities for FSBS over 250 for 3 of 9 opportunities and 6 of 8 opportunities for FSBS over 250 and additional 4 units for FSBS over 250 for 3 of 9 opportunities and 6 of 8 opportunities for FSBS over 250 for 3 of 9 opportunities and 6 of 8 opportunities for FSBS over 250 for 3 of 9 opportunities and 6 of 8 opportunities for FSBS over 250 for 6 of 13 opportunities and 6 of 8 opportunities of Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 250 and additional 4 units for FSBS over 250 and additional 4 units for FSBS over 250 for 6 of 13 opportunities and for 5 FSBS over 250 for 6 of 13 opportunities over 450 from 09/01/20 through 09/17/20. There was no documentation for the units of Novolog insulin administered for FSBS over 250 for 6 of 13 opportunities and for 2 of 6 opportunities over 450 from 09/01/20 through 09/17/20. Telephone interview with a medication aide (MA) on 09/29/20 at 2:37pm revealed: -When Resident #4's FSBS were checked, the FSBS and the units of insulin administered were to be documented on the MARShe had no explanation why she did not document the units of insulin administered Resident. #4. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am.	THE IVY A	T CLEMMONS			IALL COURT		
revealed: -There was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 400 for a total of 20 units. -There was no documentation for the units of Novolog insulin administered for FSBS over 250 for 3 of 9 opportunities and 6 of 8 opportunities for FSBS over 400 from 08/21/20 through 08/31/20. Review of Resident #4's September 2020 MAR revealed: -There was an entry for Novolog insulin inject 16 units subcutaneously for FSBS over 250 and additional 4 units for FSBS over 250 and additional 4 units for FSBS over 250 and additional 4 units for FSBS over 250 for 6 of 13 opportunities and for 2 of 6 opportunities over 450 from 09/01/20 through 09/17/20. Telephone interview with a medication aide (MA) on 09/29/20 at 2:37pm revealed: -When Resident #4's FSBS were checked, the FSBS and the units of insulin administered were to be documented on the MAR. -She had no explanation why she did not document the units of insulin administered Resident. #4. Refer to telephone interview with a representative from the contracted pharmacy on 09/18/20 at 10:57am. Refer to interview with the Administrator on	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETE
Refer to interview with a medication aide (MA) on	{D 367}	revealed: -There was an entry funits subcutaneously additional 4 units for It 20 unitsThere was no docum Novolog insulin admir for 3 of 9 opportunitie for FSBS over 400 fro 08/31/20. Review of Resident # revealed: -There was an entry funits subcutaneously additional 4 units for It 20 unitsThere was no docum Novolog insulin admir for 6 of 13 opportunitio opportunities over 4509/17/20. Telephone interview won 09/29/20 at 2:37 promotion with the units of the bedocumented on the shad no explanate document the units of Resident. #4. Refer to telephone interview with 09/25/20 at 2:17 pm.	for Novolog insulin inject 16 for FSBS over 250 and FSBS over 400 for a total of mentation for the units of nistered for FSBS over 250 s and 6 of 8 opportunities om 08/21/20 through 4's September 2020 MAR for Novolog insulin inject 16 for FSBS over 250 and FSBS over 400 for a total of mentation for the units of nistered for FSBS over 250 es and for 2 of 6 0 from 09/01/20 through with a medication aide (MA) m revealed: FSBS were checked, the f insulin administered were the MAR. tion why she did not f insulin administered terview with a representative harmacy on 09/18/20 at the the Administrator on	{D 367}			

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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		
				B. WING		R	
		HAL034150	B. WING		10	0/01/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
THE 00/4	T 01 FMM0N0	6010 ME	EADOWBROOK MA	LL COURT			
THE IVY	AT CLEMMONS	CLEMM	ONS, NC 27012				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)				(X5) COMPLETE DATE	
{D 367}	Continued From page	93	{D 367}				
	09/25/20 at 3:47pm.						
		terview with the previous or (RCD) on 09/29/20 at					
	the contracted pharm revealed: -Medication orders we the physician's office -Once received at the to the pharmacist who Medication Administration -The pharmacist cheever complete and the pharmacy medical remarks were sent to the 23rd of each month for lift there were new mean medication orders, for writing in those or	e pharmacy, the orders went o entered the order in the ation Record (MAR) system. cked to make sure orders hen sent the orders to cords. he facility on the 22nd or					
	2:17pm revealed: -The previous Reside responsible for auditin administration record -When the previous F she was supposed lo orders, check to see documented why, che (PRN) were properly -She met weekly with identify problems with protocol.	s (MARs) every two weeks. RCD reviewed the MARs, ok for holes, incorrect if staff circled initials and ecked to ensure as needed document with results.					
	-	acility's protocol for auditing					

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STATEMENT	of Health Service Regu FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034150	B. WING		R 10/01/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	FE, ZIP CODE	
	T CI EMMONE	6010 MEA	DOWBROOK M	ALL COURT	
THE IVY AT 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 367}	Continued From page	e 94	{D 367}		
	being followed. -Ultimately, the previous ensuring the medication correctly on the MAR. -The previous RCD a weekly to ensure medication cart at with the MARs to ensure the medication cart at with the MARs to ensure the medication cart at with the MARs to ensure the medication to the succession. -If discrepancies were document the issues documentation to the succession. -The previous RCD widentified problems should be made to her for review. -She had not seen and discrepancies that rescart and MARs audit, were no issues with munavailable. Interview with a medication to the previous that rescart and makes audit, were no issues with munavailable.	udited the medication cart dications were available. vas supposed to assign a dy audit the medications on and compare the medications are medications and MARs e identified the MA was to found and give the previous RCD. vas supposed to bring the noticed being done by the any documentation related to sulted from the medication therefore she thought there medications being			
		w medication orders and			
	gave them to the Adn				
	-The Administrator ch accuracy, but she did -The Administrator re and compared them t	not know how often. viewed the residents' orders			
	-A complete order on medication name, do	the MAR included the sage, strength, and how			
	-If MA initials were cir	cation should be given. cled on the MAR, it meant ot given or the resident			

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refused the medication and the reason the medication was not given should have been

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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		10	R / 01/2020
					10	10 1/2020
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT ADOWBROOK M			
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE
{D 367}	Continued From page	e 95	{D 367}			
	documented on the b -If there was a blank s knew whether the me or notIf as needed medica	ack of the MAR. space on the MAR, no one dication was administered tion were administered, MAs reason and effectiveness				
	Care Director (RCD) revealed: -When she worked at responsibilities includ the medication cartShe rotated the auditwice per month she I medication cartWhen she did the Mathrough the MARs on see if staff circled initidocumented why medication administeredWhen she completed she checked the medicompared them to the	t each week so that at least ooked at MARs and the AR audit, she "flipped" the four medication carts to als, and to make sure staff				
{D914}	G.S. 131D-21 Declar Every resident shall h	laration of Residents' Rights ration of Residents' Rights have the following rights: all and physical abuse, ion.	{D914}			
		as evidenced by: ns, interviews, and record led to ensure residents were				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
					R	₹	
		HAL034150	B. WING		10/0	1/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
THE NAVA	T CI EMMONE	6010 ME.	ADOWBROOK N	IALL COURT			
INE IVI A	T CLEMMONS	CLEMMO	ONS, NC 27012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
{D914}	Continued From page 96		{D914}				
	free of neglect as related to resident rights and medication administration. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the						
	North Carolina Department of Health and Human						
	Services (NC DHHS) were implemented and maintained to provide protection of the residents						
	during the global cord						
	pandemic and practicing recommended infection prevention and control practices to reduce the risk of transmission and infection as related to staff appropriately wearing personal protective equipment (PPE), sanitizing the self-screening kiosk utilized by visitors and staff before and after						
usage, no signage posted reminding staff ho appropriately wear face coverings, and staff maintaining a social distance of 6 feet from							
	[Refer to Tag D338 10						
	Residents' Right (Typ	e B Violation)].					
		tions, interviews and record					
	reviews, the facility failed to administer						
	medications as ordered for 5 of 6 sampled residents (Residents #1, #3, #4, #5 and #6)						
	•	e medication, a medication					
	used for mood/sleep	disorder, a potassium					
		mmunomodular agent, an					
	-	nuscle relaxant, and a pain nti-hypertensive medication					
	` '	laxative, a long acting					
		cting insulin (#6), a topical					
	skin protection cream, a long acting insulin, a short acting insulin and an anti-hypertensive						

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medication (#4). [Refer to tag 0358 10A NCAC

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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		R 10/01/2020						
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 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						
{D914}	Continued From page 97		{D914}								
	13F .1004(a) Medication Administration (Unabated Type A2 Violation)].										
{D9999}	Final Observation		{D9999}								

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