Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		1141 00 44 50	B. WING		R	
		HAL034150	B. WINO		04/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
THE IVY A	THE IVY AT CLEMMONS CLEMM			MALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 000	Initial Comments		D 000			
	annual and follow-up	5/21, 04/16/21 and 04/19/21				
D 074	10A NCAC 13F .0306 Furnishings	s(a)(1) Housekeeping And	D 074			
	10A NCAC 13F .0306 Furnishings (a) Adult care homes (1) have walls, ceiling coverings kept clean a	shall: gs, and floors or floor				
		as evidenced by: as and interviews, the facility and floors were kept clean				
	and in good repair in 3 (301, 307, and 311) o	3 of 14 resident bedrooms				
	The findings are:					
	between 9:15 am - 9:4 -The bathroom in roor seeped from under the build-up around the bastrounding tiles.	m 307 had sewage that e toilet and formed a black				
		ong overwhelming smell of				

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

TITLE (X6) DATE

DIVISION	n nealth Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		1101 004450	B. WING		R
		HAL034150			04/20/2021
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		
040.1=	CLIMMADY CT		<u> </u>	DROVIDEDIS DI ANI OF CORRECTIO	M 0.50
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(- /
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
D 074	Continued From page	2.1	D 074		
		vith yellowish browns stains			
	•	the left of the toilet that was			
	wet.				
	•	307 was stained and had			
	-	color that appeared to be			
	growing.				
		oset door that was off the			
		d in front of the residents			
	clothing that was han	ging in the closet.			
	Interview with the res	ident residing in room 307			
	on 04/15/21 9:25 am				
	-The bathroom toilet h	nad previously been			
		onths ago due to leaking			
	around the base.				
	-The sewage smell be	othered him.			
	-He was told the toile	t and the floor in the			
	bathroom would be fix	xed.			
	-He walked bare foote	ed and had a bandage on			
	his left foot due to ulc	ers and sometimes the			
	bandage got wet whe	n he walked in the			
	bathroom.				
		e carpet in his room had			
	ever been cleaned.				
	Intonvious with the two	regidente regidina in regn			
	311 on 04/15/21 9:35	residents residing in room			
		been broken and off the			
	tract for three weeks.	been broken and on the			
		physically move the door to			
		the other resident could not			
		on his side completely open			
	to get to his clothing i				
		heavy and hard to move.			
		,			
	Interview with housek	ceeping staff on 04/15/21 at			
	9:39 am revealed:				
		d at the facility for two weeks			
	and the bathroom floo	or in room 307 had been			

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black and odorous since she was hired.

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יוטופועום	n Health Service Regu	iauon					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED	
						₹	
		HAL034150	B. WING			20/2021	
NAME OF PE	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE. ZIP CODE			
			ADOWBROOK N				
THE IVY A	T CLEMMONS		NS, NC 27012	MALL GOOK!			
	OLIMANA DV OT		<u> </u>	DDOVIDEDIO DI ANI OF CODDEC	TION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR	ROPRIATE	DATE	
				DEFICIENCY)			
D 074	Continued From page	2	D 074				
	-She mopped the batl	hroom floor daily.					
	• •	e powder with bleach and a					
	sanitizing agent to sci	rub the bathroom floor (did					
	not specify date), but	it did not remove the black					
	from the tiles or from						
		o placed the sheet to the					
	left of the toilet.						
		the carpet in room 307 but					
	she had not shampoo	oed, or steam cleaned it.					
	Interview with a media	cation aide (MA) on					
	04/15/21 at 9:30 am r						
		ed all the bathroom floors					
	•	n floor in room 307 did not					
		odor never went away.					
		307 was legally blind and					
	sometimes missed the						
		or was to absorb some of					
	urine when the reside	toilet and to help absorb					
		w long the carpet had been					
	dirty, but it had been '						
		nance had quit and the					
		staff had only been at the					
	facility for 3 weeks.						
	-Maintenance staff cle	eaned the hall carpets, but					
		e had cleaned the carpets in					
	the resident's room.						
	Interview with a Maint	tenance Staff on 04/15/21 at					
	10:50 am revealed:						
	-He had only worked	at the facility for 3 weeks					
	and was doing all he						
		athroom in room 307.					
		hroom floor (did not specify					
	•	the tiles did not come clean					
	and the odor did not g						
	-He would have to rep						
	bathroom floor and w	ould check the wax seal in					

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the toilet, when he replaced the tiles.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R
HAL034150		B. WING		04/20/2021	
NAME OF P	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 074	Continued From page	e 3	D 074		
	clean the carpet in ro	ance to shampoo or steam om 307. ministrator on 04/15/21 at			
	307 or about the dirty	out the leaking toilet in room carpet. out the broken closet door in			
	room 311. -She had not had a c	hance to do a walk through			
	-Her focus had been	eded to be worked on. on providing adequate staff are and getting medications			
	Interview with a representative from the cleaning crew on 04/15/21 at 4:25 pm revealed: -They had been contracted to vacuum the resident rooms on the third floor. -He had seen toilets with black around them previously and they were like that because the wax seal had gone bad and sewage was seeping from underneath the toilet and into the tiles. -The floor tiles would have to be replaced. -The sewage would continue to seep from under the toilet if the wax seal was not replaced. -He would clean it the best he could.				
	am revealed the bath	301 on 04/15/21 at 11:40 room floor tiles in front of ken and raised up creating a			
	301 on 04/15/21 at 1 ^o -He didn't know how l broken.	long the tiles had been			
	-He had not informed	staff the tiles were broken.			

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STATE FORM 6899 YYKO11 If continuation sheet 4 of 132

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			, BOILDING		R
		HAL034150	B. WING		04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
THE IVY A	T CLEMMONS		ADOWBROOK M	ALL COURT	
			ONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 074	Continued From page	e 4	D 074		
	04/15/21 at 11:45 am -She had not noticed tile in room 301The resident who resindependent and did care or ambulating to -She would let the Mafound anything broker. Interview with the first on 04/15/21 at 11:50 -She had not noticed bathroom floor of room-She had not informed bathroom floor tilesStaff would inform the	the broken bathroom floor sided in the room was not need help with personal the restroom. aintenance staff know if she n. t shift medication aide (MA) am revealed: the tile broken in the			
	12:00 pm revealed: -The Maintenance stawere reportedShe did not know the broken in room 301Staff reported neede Administrator or the Mat 12:05 pm revealed -He made needed reported in the did not know the 301 was brokenHe did not receive ar room 301's bathroom	Maintenance staff. intenance staff on 04/15/21 : pairs as they were reported. bathroom floor tile in room ny report from staff that tile needed repaired.			
		nsure floors were kept clean evidenced by a sewage			

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leak from underneath a toilet in a resident room

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT 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		04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		6010 MEAL	OWBROOK N	IALL COURT	
THE IVY A	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 COMPLETE
D 074	Continued From page	e 5	D 074		
	causing sewage stain ongoing exposure to which could cause the broken floor tile in a nuneven surface for refailure was detrimentathe residents which coviolation. The facility provided a accordance with G.S. this violation.	as on the flooring, and raw sewage in the bathroom erisk of infection, and esident room causing an sidents to walk on. This all to the health and safety of constitutes a Type B			
D 164 10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and		D 164			

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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		R 04/20/2021
NAME OF P	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 164	Continued From page (f) blood glucose more precautions; (g) universal precaut (h) appropriate admir (i) sliding scale insuli	nitoring; universal ions; nistration times; and	D 164		
	facility failed to ensuraides (Staff B), who a residents completed t	and record reviews, the e 1 of 3 sampled medication			
	The findings are:				
	raining on the care of Review of residents' I Medication Administrative revealed there was de	ealed: was 02/07/21. nentation Staff B completed f diabetic residents. March and April 2021 ation Records (MARs) ocumentation Staff B o residents on 24 occasions			
	revealed: -She worked as a MA administered medicat -When she worked, s medications including	tions to residents. he administered prinsulin injections. er completing any formal			

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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		04/20/2021
					1 0-1/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE	
THE IVY A	T CLEMMONS		ADOWBROOK M	IALL COURT	
		CLEMMO	ONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 164	Continued From page	7	D 164		
	-She was hired as a prebruary 2021The former Administr training as a MA inclumedication cart in late. She trained one wee with an MA that was reacility. Interview with the Adr. 4:10 pm revealed: -All MAs were to recediabetic residentsThe facility's Registe responsible for trainindiabetic residentsThere had not been at the facility during the received diabetic trair. The new Resident Chired to begin 04/19/2The RCD is a RegistThe new RCD would MAs on diabetic careStaff B was hired by -Staff B was working at the Administrator in Masside to care training. Interview with the facility care was a temporari 2021 to help train MA within the facilityThe Administrator gare.	personal care aide (PCA) in rator asked her to begin ading working on the experience February 2021. Ek on the medication cart no longer employed at the ministrator on 04/19/21 at eive training for care of exed Nurse (RN) was an gmas on the care of a qualified RN employed at time Staff B should have ning. are Director (RCD) was 21. Exerced Nurse (RN). I be responsible for training the previous Administrator as a MA when she became march 2021. aff B had not completed illity's Contracted RN on revealed: Exerced Staff B and the March as as well as other tasks			
		aff B needed diabetic care			

training. Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
		HAL034150	B. WING		04	R / 20/2021
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	•		
INCIVIA	AT CLEIWINIONS	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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 164	Continued From page	÷ 8	D 164			
	revealed: -She was a registered 04/19/21MAs should have dia -She was responsible trainingThe contracted RN v care training when ne	for MA diabetic care				
D 188	10A NCAC 13F .0604 Other Staffing	e(e) Personal Care And	D 188			
	Staffing (e) Homes with capa shall comply with the home is staffing to ce below 21 residents, the ahome with a census (1) The home shall high the needs of the residuty hours on each 8 be at least: (A) First shift (morning for facilities with a census delitional hours of aid 10 or fewer residents; and 16 hou additional hours of aid 10 or fewer residents or capacity of 40 or more chart, see Rule .0606 (B) Second shift (after duty for facilities with to 40 residents; and 16 four additional hours.	ave staff on duty to meet lents. The daily total of aide hour shift shall at all times arg) - 16 hours of aide duty insus or capacity of 21 to 40 ars of aide duty plus four de duty for every additional for facilities with a census are residents. (For staffing of this Subchapter.) ernoon) - 16 hours of aide a census or capacity of 21 6 hours of aide duty plus				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R	l l
HAL034150		HAL034150	B. WING		04/2	0/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		ADOWBROOK N	IALL COURT		
		CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 188	Continued From page	9	D 188			
	census or capacity of staffing chart, see Ru (C) Third shift (evening per 30 or fewer resideresident census). (Fo. 0606 of this Subchap (D) The facility shall I meet the needs of the residents equal to the by Medicaid. As used "heavy care resident" residing in an adult ca "heavy care" by Medicis receiving enhanced (E) The Department if it determines the nemet by the staffing receiving enhanced facility failed to ensure were met on second a census of 31-40 for 3 to 04/03/21. The findings are: Review of the facility 03/21/21 to 03/31/21 revealed: -On 03/23/21 there we coverage on third shift hoursOn 03/28/21 there we coverage on third shift hours.	40 or more residents. (For le .0606 of this Subchapter.) ng) - 8.0 hours of aide duty ents (licensed capacity or or staffing chart, see Rule ofter.) have additional aide duty to efacility's heavy care amount of time reimbursed in this Rule, the term, means an individual are home who is defined as caid and for which the facility Medicaid payments. It was a feel of residents cannot be equirements of this Rule. The see evidenced by: The see evidenced by: The see evidenced by: The see of this Rule. The see of this Rule of this Rule. The see of this seed on a condition of the seed of the s				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED	
						R	
		HAL034150	B. WING			20/2021	
		HAL034130			04/	20/2021	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
THE BOX 4	T 01 FMM0N0	6010 ME	ADOWBROOK M	IALL COURT			
THE IVY AT CLEMMONS CLEMMO		ONS, NC 27012					
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	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 APPR DEFICIENCY)	ROPRIATE	DATE	
				DEFICIENCY)			
D 188	Continued From page	e 10	D 188				
	Review of the facility						
	04/01/21 to 04/03/21						
	census of 40 resident	is.					
	Davidana af fina a canda	fra 0.4/0.4/0.4 to 0.4/0.0/0.4					
		from 04/01/21 to 04/03/21					
		1/21 there was a total of					
		overage on third shift, with a					
	shortage of 7.25 hour	S.					
	Interview with a PCA	on 04/15/21 at 11:20 am					
	revealed:	1011 04/13/21 at 11:20 am					
	-She worked first shif	t					
		2 PCAs on each floor and					
	an MA on first shift.	2 i o i o o i o o o o o o o o o o o o o					
		nal staff call-outs causing					
	there to be 1 PCA on	•					
	-The Administrator wo	ould attempt to have other					
		er the shift when staff					
	called-out.						
	Interview with a MA o	n 04/15/21 at 4:20 pm					
	revealed:						
	-There was an MA an	nd 2 PCAs on each shift on					
	each floor.						
		ll-outs or the shift was					
		dication Manager (MM),					
	Business Office Mana	• ,					
	Administrator would p						
		he Administrator have had to					
	pass medications free	quently in the last month.					
	Interview with a seco	nd MA on 04/16/21 at 7:55					
	am revealed:	114 WITCOIL 07/10/21 at 1.00					
		ft and stayed over 04/16/21					
		: MA did not come to work.					
	-When staff called-ou						
		attempt to have other staff					
	work to cover each sl	The state of the s					
		ot cover a shift, the MM,					

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BOM or the Administrator would pass

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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
					R
		HAL034150	B. WING		04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
			DOWBROOK M		
THE IVY A	T CLEMMONS		NS, NC 27012		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 188	Continued From page	e 11	D 188		
	medications for that s	hift/floor			
		2 MAs and 1 PCA who			
	_	and fourth-floors on third			
	shift.	and fourth-moors on thind			
	Interview with the BO revealed:	M on 04/16/21 at 9:30 am			
	-The Administrator wa	as responsible for the staff			
	schedule.	·			
	-The schedule was us	sually covered, but there had			
	been daily staff call-o				
		that morning (04/16/21)			
	because there was a				
		ifts often due to call-outs.			
		id MM also helped fill in as			
	the MA when needed	•			
	Interview with the Adr	ministrator on 04/19/21 at			
	2:40 pm revealed:				
		for the staff schedule.			
	 Staff would not show daily. 	up to work and called-out			
	•	ble to find staff to cover			
		s medications on any of the			
	3 shifts.	•			
	-The BOM and MM w	ould also fill-in for short			
	shifts.				
		fts were short staffed, either			
		MM would have worked any			
	shift on the short staff	fed floor.			
D 238	10A NCAC 13F .0703	3 (c-4) Tuberculosis Test,	D 238		
	Medical Examination				
	10A NCAC 13F .0703	3 Tuberculosis Test, Medical			
	Examination And Imn				
	The results of the cor	nplete examination required			
		is Rule are to be entered on			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	BENTI IOATION NOMBER.	A. BUILDING: _	A. BUILDING:		
			D MINO	P. WING		
		HAL034150	B. WING		04/20	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	AT CLEMMONS	6010 MEAI	OWBROOK N	IALL COURT		
INCIVIA	AT CLEIMINIONS	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 238	Continued From page	e 12	D 238			
J 200	the FL-2, North Carol Term Care Services, Medicaid Program Me which shall comply w	ina Medicaid Program Long or MR-2, North Carolina ental Retardation Services, ith the following:	5 200			
	(4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.					
	This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure FL2s included complete information and was clarified by the primary care provider (PCP) for 3 of 6 sampled residents (Residents #2, #3 and #7) who had no medication orders listed on the current FL2s.					
	The findings are:					
	1. Review of Resident #2's current FL2 dated 01/19/21 revealed: -Diagnoses included depression, anxiety, bipolar disorder, rheumatoid arthritis, kidney failure, tachycardia, sinusitis, constipation, anemia, vitamin D deficiency, hypernatremia, chronic obstructive pulmonary disease (COPD), pain, hypertension, and gastroesophageal reflux disease (GERD). -There was a medication order for Advair disk aero (used to treat COPD) with no dosage or frequency. -There was a medication order for clonazepam 1mg (used to treat anxiety) with no frequency. -There was a medication order for doxepin 25mg (used to treat depression) with no frequency. -There was a medication order for Humira					
	obstructive pulmonary hypertension, and gardisease (GERD)There was a medical aero (used to treat ConfrequencyThere was a medical 1mg (used to treat and 1mg cused to treat depress)There was a medical (used to treat depress).	y disease (COPD), pain, stroesophageal reflux tion order for Advair disk OPD) with no dosage or tion order for clonazepam (xiety) with no frequency. tion order for doxepin 25mg sion) with no frequency.				

Division of Health Service Regulation

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Division of	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL034150	B. WING		04/20/2021
NAME OF D		CTDEET A	DDEEC CITY CTA	TE 7/D CODE	·
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
THE IVY A	T CLEMMONS		ADOWBROOK N	IALL COURT	
			ONS, NC 27012		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
D 238	Continued From page	. 12	D 238		
D 230	Continued From page	: 13	D 230		
	no frequency.				
	-There was a medical				
	hydroxychloroquine 2	O (
	rheumatoid arthritis) v				
		tion order for Latuda 120mg			
		hrenia) with no frequency.			
		tion order for omeprazole			
	40mg (used to treat a	cid reflux) with no			
	frequency.	tion and a forestancia D 40			
		tion order for vitamin B-12			
	,	eficiency) with no frequency.			
		tion order for vitamin D3			
	2000IU (50mcg) (use				
	deficiency) with no free	equency. tion order for senexon-x			
	8.6mg (used to treat of				
	frequency.	consupation) with no			
		tion order for tizanidine 4mg			
		spasms) with no frequency.			
		tion order for tramadol 50mg			
	(used to treat pain) w				
		tion order for melatonin			
	10mg (50mcg) (used	to treat insomnia) with no			
	frequency.				
		tion order for omeprazole			
	40mg (used to treat a				
	frequency.	,			
		tion order for prazosin 1mg			
	(used to treat high blo	ood pressure) with no			
	frequency.				
	-There was a medical	tion order for promethazine			
	25mg (used to treat to	o treat nausea) with no			
	frequency.				
		tion order for albuterol			
	sulfate 90mcg (used t				
	shortness of breath) v				
		for duloxetine 60mg twice			
		epression and anxiety).			
	-There was no order f	for flexeril 5mg three times			

daily as needed for muscle spasms (used to treat

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			_		_	
			B. WING		F	
		HAL034150	B. WING		04/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	ΓΕ, ZIP CODE		
		6010 ME	ADOWBROOK M	ALL COURT		
THE IVY A	T CLEMMONS		ONS, NC 27012			
	OLUMANA DV OT			PROMINERIO DI ANI OF CORRECTIO		
(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 220	0	- 44	D 238			
D 238	Continued From page	3 14	D 236			
	muscle spasms).					
		for miralax 17mg twice daily				
	(used to treat constip	•				
	Review of Resident #	[‡] 2's physician's orders				
	revealed:	. ,				
	-There were no physi	ician's orders updated after				
	the current FL2 dated					
	-There were no order	s that verified the frequency				
		dered on the current FL2				
	dated 01/19/21.					
	-There were no admir	nistration frequencies				
		MARs for Advair disk aero,				
	clonazepam 1mg, do					
		oroquine 200mg, Latuda				
		40mg, vitamin B-12, vitamin				
		-x 8.6mg, tizanidine 4mg,				
	· ·	tonin 10mg, omeprazole				
		promethazine 25mg and				
	albuterol sulfate 90m	· ·				
		S .				
	Review of Resident #	[‡] 2's January, February,				
		1 medication administration				
	records (MARs) revea					
	` ,	for advair diskus 250-50mcg				
	1 puff twice daily sche	eduled for administration at				
	8:00 am and 8:00 pm					
		for clonazepam 1mg three				
	1	for administration at 8:00				
	am 2:00 pm and 8:00					
		for doxepin 25mg at bedtime				
	scheduled for adminis	stration at 8:00 pm.				
		for Humira 40/0.4ml injection				
	scheduled every 14 d					
		for hydroxychloroquine				
		neduled for administration at				
	8:00 am.					
	-There was an entry f	for Latuda 120mg once daily				
	scheduled for adminis					

Division of Health Service Regulation

-There was an entry for omeprazole 40mg once

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Division of	of Health Service Regu	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
			_		_	_
			B. WING		R	
		HAL034150	B. WING		04/2	20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			ADOWBROOK M			
THE IVY A	T CLEMMONS		ONS, NC 27012			
(X4) ID		TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
	I			DEFICIENCY)		
7.000	, <u>-</u>		-			
D 238	Continued From page	e 15	D 238			
	daily scheduled for a	dministration at 6:30 am.				
	_	for vitamin B-12 once daily				
	scheduled for adminis					
		for vitamin D3 2000IU once				
	_	dministration at 8:00 am.				
	_	for senexon-x 8.6mg twice				
		dministration at 8:00 am and				
	8:00 pm.	311111100000011 at 0.00 a a				
	•	for tizanidine 4mg every six				
		:00 am, 12:00 pm, 6:00 pm				
ļ	and 12:00 am.	.00 am, 12.00 pm, 0.00 pm				
		for tramadol 50mg four times				
	_	dministration at 8:00 am				
	12:00 pm, 4:00 pm, a					
	I	for melatonin 10mg at				
	_	or administration at 8:00 pm.				
ļ		for omeprazole 40mg at				
	_	· · · · · · · · · · · · · · · · · · ·				
		or administration at 8:00 pm.				
	scheduled for adminis	for prazosin 1mg at bedtime				
		•				
	_	for promethazine 25mg				
ļ	every six hours as ne					
		for albuterol sulfate 90mcg x hours as needed for				
	shortness of breath.					
		for duloxetine 60mg twice				
	8:00 pm.	dministration at 8:00 am and				
	•	for Flexeril 5mg three times				
	daily as needed for m					
		for miralax 17gm twice-daily				
		stration at 8:00 am and 8:00				
		stration at 6.00 am and 6.00				
	pm.	or 17 of 20 medications not				
	ordered on the currer	nt FL2 dated 01/19/21.				
		-t:				
	Interview with medica	- , ,				
	04/15/21 at 9:32 am r					
	_I -She was not aware F	Resident #2's FL2 was			ľ	

incomplete.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND LEAVE GOINGEN	IDENTIFICATION NOMBER.	A. BUILDING:			
	HAL034150 B. WING		R 04/20 /2	2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMMONS		OWBROOK M S, NC 27012	IALL COURT		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ET BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE ((X5) COMPLETE DATE
D 238 Continued From page 16 -She did not have time to i each resident's record. Telephone interview with the 04/20/21 at 2:17 pm reveal. The MM was responsible orders and ensure the order. If the order was not composupposed to contact the resthe orderThe facility's system was responsible for auditing the daily to ensure orders accused. 2. Review of Resident #3's 02/07/21 revealed: -Diagnoses included esser schizo-affective disorder, the mucosa, anxiety disorder depressive disorderThere were no medication. There was documentation MAR" typed in the space for be listed on Resident #3's rewas no documentation dated 03/01/21-03/31/21 w FL2. Review of Resident #3's rewas no documentation the (PCP) was contacted for comedication orders. Interview with the facility's 04/16/21 at 2:25 pm revealshe was contracted in Mato assist in resident record had not been able to do so updating resident's License.	he Administrator on alled: to review medication ers were complete. blete the MM was exident's PCP to clarify the MM was eresident's records urately. Is current FL2 dated Initial hypertension, unspecified lesions of der and major Ins listed on the FL2. In as "See attached for medication orders to FL2. I administration record was attached to the I ecord revealed there exprimary care provider clarification of Contracted Nurse on alled: I arch 2021 by the facility of audits for FL2s, but by yet due to her	D 238			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL034150	B. WING		R 04/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		NDOWBROOK N NS, NC 27012	MALL 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)	JLD BE COMPLETE	
D 238	Continued From page	e 17	D 238			
	-Residents' FL2s sho medications and sho -She did not know Re	uld have a current list of uld be reviewed by the PCP. esident #3's FL2 did not eations listed on the FL2.				
	2:30 pm revealed: -The residents' PCP medication orders on -The PCP had not incorders on FL2s, but we	cluded current medication would request staff to attach physicians' order sheets				
	pm revealed a consu March 2021 to help a	nistrator on 04/19/21 at 1:13 Itant nurse had been hired in udit records and determine d updated FL2s.				
	residents who needed updated FL2s. Telephone interview with the Resident #3's PCP on 04/19/21 at 10:40 am revealed: -She visited the facility every Tuesday to assess residents and reviewed the current medications listed on their FL2s; then sign the FL2sResident #3's FL2 was signed on a Sunday 02/07/21, a day in which she would not have been at the facilityShe would not have signed an FL2 without current medication orders listed on the FL2 for any residentShe did not remember and could not find documentation when she last assessed Resident #3 for her to sign the current FL2The previous Resident Care Director (RCD) completed the residents' FL2 forms before she arrived at the facility for the PCP to sign.					
	3. Review of Resider 02/14/21 revealed: -There were diagnose	it #7's current FL2 dated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(V2) MULTIDLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			A. BUILDING		
			D MINO		R
		HAL034150	B. WING		04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
THE DOLA	- aaa	6010 MEA	DOWBROOK N	IALL COURT	
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 238	Continued From page	: 18	D 238		
D 236	schizophrenia and ref -There were no medic FL2There was document as "See attached MAI for the medication list -Resident #7's MAR of medications document FL2. Review of Resident # Administration Record	clux esophagitis. cation orders listed on the tation on Resident #7's FL2 R" was typed in the space dated 03/01/21-03/31/21 with nited on was attached to the T's March 2021 Medication d (MAR) revealed:	D 236		
	-There was an entry finsulin) insulin before using scale of 18 unit (FSBS) over 250 and FSBS over 400 for a factor of the control of the cont	or Humalog (a rapid acting breakfast, lunch, and dinner is for fingerstick blood sugar give additional 6 units for total of 24 units of Humalog. To check FSBS 3 times a day or Lantus (a long acting is at bedtime. To Vitamin D 1.25mg (a every Friday. To or fluoxetine 20mg (used to ry day. To or omeprazole 20mg (used rice a day. To or vitamin B12 500mcg (a conce daily. To or metformin ER 750 ER is) twice a day, with the or olanzapine 5mg (used to e a day. To or olanzapine 15mg at to or clonazepam 0.5mg (used			
		or divalproex 500mg (used ers) 2 tablets at bedtime.			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	
ANDIEAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL034150	B. WING		04/2	R 20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		OWBROOK N	IALL COURT		
			S, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 238	Continued From page	e 19	D 238			
	treat elevated triglyce-There was an entry f drops) each eye at be Review of Resident # was no documentatio (PCP) was contacted medication orders.	for Systane (lubricating eye editime. 7's record revealed there in the Primary Care Provider for clarification of for clarification of the contracted Nurse (CN) in revealed:				
	medications listed on the PCPResident #7's FL2 da have a March 2021 M and documented as a to 03/03/21 attached medications.	the FL2 and reviewed by ated 02/14/21 should not MAR with medications listed administered from 03/01/21 to the FL2 as current				
	-She was contracted in March 2021 to assist in resident record audits for FL2s but has not been able to do so yet due to her updating resident's Licensed Health Professional Services (LHPS) assessments.					
	2:30 pm revealed: -She was not working 2021She started working -The residents' provid current medications of -The PCP had not list FL2sAt the present time,	at the facility in February at the facility on 03/03/21. Her should routinely write in on the FL2s. Her ded current medications on the PCP had staff to attach ans' order sheets (POS) or				

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Interview of the Administrator on 04/19/21 at 1:13

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
					R
		HAL034150	B. WING		04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
		6010 MEA	DOWBROOK N	IALL COURT	
THE IVY AT CLEMMONS CLEMMOI			IS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 238	Continued From page	20	D 238		
D 230	pm revealed a consul in March 2021 to help LHPS evaluations, and Telephone interview would with the previous RCD would be resident and review orders listed on their Resident #7's FL2 would would would would would be rebruary 2021 becautime was updating resident yould be records. The facility should had a dated February 2021 -She would not have current medication or	Itant Nurse had been hired of audit records, update and update residents' FL2s. With the facility's PCP on a revealed: Yould fill out the residents agot to the facility. By every Tuesday to assess the current medication FL2s; then sign the FL2s. By as dated on a Sunday which she would not have a see the Administrator at the sidents' FL2 when auditing are included the signed POS	<i>D</i> 230		
D 270	10A NCAC 13F .0901 Supervision	I(b) Personal Care and	D 270		
	10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.				
	This Rule is not met FOLLOW-UP TO TYPE				
	Non-compliance cont severity resulting in re				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		` '	(X3) DATE SURVEY COMPLETED	
	1141 024450	B WING		R	004	
	HAL034150	B. W		04/20/2	021	
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE			
T CLEMMONS	6010 ME	ADOWBROOK MA	ALL COURT			
T OLLIMINOITO	CLEMMO	ONS, NC 27012				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE C	(X5) COMPLETE DATE	
Continued From page	21	D 270				
THIS A TYPE A2 VIO	LATION					
reviews the facility fai supervision for 1 of 2 a history of falls resul- sutures and required evaluation on 3 occas	led to provide adequate sampled residents (#6) with ting in a laceration requiring emergency room (ER)					
The indings are.						
revealed: -Anytime a resident e incident, even if there Incident/Accident RepimmediatelyAll incidents or accid	xperienced an accident or was no visible injury, an port had to be completed ents involving the residents					
02/16/21 revealed: -Diagnoses included of mellitus type II, hyper impairment, chronic of disease (COPD), cord disease, major depressmuscle weaknessResident #6 was interpressed on the cord of the	encephalopathy, diabetes tension, mild cognitive obstructive pulmonary onary artery disease, heart ssive disorder, falls, and ermittently disoriented. ni-ambulatory. #6's care plan dated netimes disoriented. equate memory.					
	Continued From page substantial risk that dharm, abuse, neglect THIS A TYPE A2 VIO Based on observation reviews the facility fai supervision for 1 of 2 a history of falls resul sutures and required evaluation on 3 occas. The findings are: Review of the facility's revealed: -Anytime a resident eincident, even if there Incident/Accident RegimmediatelyAll incidents or accid must be documented record. Review of Resident # 02/16/21 revealed: -Diagnoses included mellitus type II, hyper impairment, chronic of disease, COPD), cord disease, COPD), cord disease (COPD), cord	TCLEMMONS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS A TYPE A2 VIOLATION Based on observations, interviews and record reviews the facility failed to provide adequate supervision for 1 of 2 sampled residents (#6) with a history of falls resulting in a laceration requiring sutures and required emergency room (ER) evaluation on 3 occasions. The findings are: Review of the facility's Accident Policy (no date) revealed: -Anytime a resident experienced an accident or incident, even if there was no visible injury, an Incident/Accident Report had to be completed immediatelyAll incidents or accidents involving the residents must be documented in the resident's medical record. Review of Resident #6's current FL2 dated 02/16/21 revealed: -Diagnoses included encephalopathy, diabetes mellitus type II, hypertension, mild cognitive impairment, chronic obstructive pulmonary disease (COPD), coronary artery disease, heart disease, major depressive disorder, falls, and muscle weaknessResident #6 was intermittently disorientedResident #6 was semi-ambulatory. Review of Resident #6's care plan dated	ROVIDER OR SUPPLIER TICLEMMONS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Based on observations, interviews and record reviews the facility failed to provide adequate supervision for 1 of 2 sampled residents (#6) with a history of falls resulting in a laceration requiring sutures and required emergency room (ER) evaluation on 3 occasions. The findings are: Review of the facility's Accident Policy (no date) revealed: -Anytime a resident experienced an accident or incident, even if there was no visible injury, an Incident/Accident Report had to be completed immediately. -All incidents or accidents involving the residents must be documented in the resident's medical record. Review of Resident #6's current FL2 dated 02/16/21 revealed: Diagnoses included encephalopathy, diabetes mellitus type II, hypertension, mild cognitive impairment, chronic obstructive pulmonary disease, major depressive disorder, falls, and muscle weakness. Resident #6 was semi-ambulatory. Review of Resident #6's care plan dated 02/16/21 revealed: -Resident #6 was sometimes disoriented. -Resident #6 was sometimes disoriented. -Resident #6 was sometimes disoriented. -Resident #6 had adequate memory.	ROWIDER OR SUPPLIER TO CLEMMONS SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING IMPORMATION) COntinued From page 21 Substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS A TYPE A2 VIOLATION Based on observations, interviews and record reviews the facility failed to provide adequate supervision for 1 of 2 sampled residents (#6) with a history of falls resulting in a laceration requiring sutures and required emergency room (ER) evaluation on 3 occasions. The findings are: Review of the facility's Accident Policy (no date) revealed: -Anytime a resident experienced an accident or incident, even if there was no visible injury, an Incident/Accident Report had to be completed immediately. -All incidents or accidents involving the residents must be documented in the resident's medical record. Review of Resident #6's current FL2 dated 02/16/21 revealed: -Diagnoses included encephalopathy, diabetes mellitus type II, hypertension, mild cognitive impairment, chronic obstructive pulmonary disease, (COPD), coronary artery disease, heart disease, major depressive disorder, falls, and muscle weakness. -Resident #6 was sometimes disoriented. -Resident #6 was sometimes disoriented.	A BUILDING: HAL034150 BYING BYING	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION (X2)			
7.11.2.1.2.11.1	o. 001.11.2011011	.52.***********************************	A. BUILDING:			PLETED
		HAL034150	B. WING		04	R J/ 20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
THE NO.	T 01 FMM0N0	6010 ME	ADOWBROOK 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)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 22	D 270			
	extremities.	ted strength in her upper d extensive assistance with ferring.				
	revealed: -Her condition change careShe had several falls	(LHPS) dated 01/29/21 ed, and she required more				
	forgot her oxygen wh	a walker and frequently en she ambulated.				
	revealed: -On 01/15/21 at 9:15 help and was found of lying on her right sideShe stated she had lethe bed and hit her her right armEmergency Medical and assessed the resto the emergency root-There was no docum supervision, monitoring place after the fall on Resident #6 from falling.	been asleep and fell out of ead on the nightstand. tation of two skin tears on Services (EMS) was called sident, but she refused to go em. nentation of increased ng, or interventions put in 01/15/21 to prevent ng.				
	Report for the incider 01/15/21 revealed: -The next morning the her feetThe resident compla-On second shift the	6's 24-Hour Follow-Up nt/accident report dated e resident was unsteady on ined of pain in her right arm. resident fell out of bed and emergency room (ER).				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
741012741	or dorace mon	BENTI IO/MIGN NOMBER.	A. BUILDING: _	A. BUILDING:		
		HAL034150	B. WING		04/2	R 20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
D 270	she slept most of the complaints. -There was no docum supervision, monitoring place after the 01/15/#6 from falling. Review of Resident # -There were no care in 01/15/21. -There was no docum supervision or monitor. -There was no docum in place after the 01/1 #6 from falling. Attempted telephone medication aide (MA) incident/accident report was unsuccessful. Review of Resident # revealed: -On 01/16/21 at 7:40 help and was found on sitting "Indian style". -She stated she fell one the complaint of the comp	e resident returned from ER, night and did not have any nentation of increased ng, or interventions put in 21 fall to prevent Resident 6's care notes revealed: notes documented on nentation of increased oring for Resident #6. nentation of interventions put 15/21 fall to prevent Resident interview with the nentation of interventions put 15/21 fall to prevent Resident interview with the nentation of interventions put 15/21 fall to prevent Resident interview with the nentation of interventions put 15/21 fall to prevent Resident interview with the nentation of interventions put 15/21 fall to prevent Resident interview with the nentation of interventions put 15/21 fall to prevent Resident interview with the nentation of the graph of the gra	D 270			
	Report for the inciden 01/16/21 revealed:	eresident remained at the				

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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 04/20/2	2021
	ROVIDER OR SUPPLIER	6010 MEA	DRESS, CITY, STA DOWBROOK N IS, NC 27012	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	amThe resident had stit prescriptionThere was no docum the reportThere was no docum supervision, monitoring place after the 01/16/#6 from falling. Review of Resident # -There was no docum supervision or monitoring place after the 01/16/21 -There was no docum supervision or monitoring place after the 01/16/16/16 from falling. Review of Resident # summary dated 01/16/16 a fallResident #6's chin lastitches. Attempted telephone medication aide (MA) incident/accident reports was unsuccessful. Review of Resident # summary dated 01/16/16/16/16/16/16/16/16/16/16/16/16/16	d to the facility around 11:00 ches in her chin and a new nentation for third shift on nentation of increased ng, or interventions put in 21 fall to prevent Resident 6's care notes revealed: notes documented on nentation of increased ring for Resident #6. nentation of interventions put 6/21 fall to prevent Resident 6's hospital discharge 6/21 revealed: R visit was documented as neceration was repaired with interview with the , who completed the ort, on 04/19/21 at 9:58 am 6's hospital discharge 0/21 revealed: R visit was documented as	D 270			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 '	CONSTRUCTION	(X3) DATE S		
74101 2741	or contraction	IDENTIFICATION NOMBERS	A. BUILDING: _			
		HAL034150	B. WING		04/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		DOWBROOK N IS, 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	(X5) COMPLETE DATE
D 270	Continued From page	e 25	D 270			
	Review of Resident #	6's incident/accident reports o report available for the fall				
		6's 24-Hour Follow-Up cident report revealed there ort dated 01/19/21.				
	Review of Resident # -There were no care i 01/19/21 -There was no docum					
	supervision or monito -There was no docum					
	summary dated 01/26 -The reason for the E a fall.	R visit was documented as				
	her scalp and back, a	gnosed with a contusion of nd while at the ER, the us injury were removed.				
	Review of Resident # 01/26/21 revealed she ER due to a fall due to	e was transported to a local				
		6's incident/accident reports o report available for the fall				
	Report for Incident/ac	6's 24-Hour Follow-Up cident report revealed there ort dated 01/26/21 revealed:				
	Review of Resident # -There were no care i 01/26/21	6's care notes revealed: notes documented on				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		HAL034150	B. WING		R 04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		OOWBROOK N	IALL COURT	
			IS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 26	D 270		
	-There was no docum supervision or monito -There was no docum	nentation of increased			
		6's record revealed there dent reports or care notes and March 2021.			
	Review of Resident #6's incident/accident reports revealed: -On 04/11/21 at 9:10 am, Resident #6 called for help and was found on her bottom complaining of painShe said she had gone to the bathroom and was trying to assist herself. She stumbled backwards and hit her back againstThere was documentation she complained of left leg and back pain.				
	-There was no docum supervision, monitoring place to prevent Resi	ng, or interventions put in			
	Report for Incident/acrevealed: -There was no documThere was documen resident around everyThe resident compla fallThe next day, the resher fallThere was no docum	6's 24-Hour Follow-Up cident report dated 04/11/21 mentation for second shift. tation staff checked on the 2 hours during the night. ined of being sore from her sident remained sore from mentation of increased ng, or interventions put in			
	place after the 04/11/2 #6 from falling.	21 fall to prevent Resident			
	Review of Resident #	6's care notes revealed:			

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		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:	
			1	_	R
		HAL034150	B. WING		04/20/2021
NAME OF D	ROVIDER OR SUPPLIER		DDEEC CITY CTA	TE ZID CODE	1 020.2021
NAIVIE OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
THE IVY A	AT CLEMMONS		.DOWBROOK N NS, NC 27012	IALL COURT	
			N3, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 27	D 270		
	supervision or monito -There was no docum in place after the 04/1 #6 from falling. Review of Resident # revealed: -On 04/12/21 at 12:15 found on the floor layi -She said she was go -There was document	nentation of increased bring for Resident #6. nentation of interventions put 11/21 fall to prevent Resident 16's incident/accident reports 5 am, Resident #6 was ing on her right side bing to the bathroom. tation she had some			
	cleaned, and antibioti -There was no docum supervision, monitorir	nt knee. Her knee was ic ointment was applied. nentation of increased ng, or interventions put in 21 fall to prevent Resident			
	Report for Incident/acrevealed: -During first shift, the painThere was no docum shiftThere was documen resident every two ho-There was no docum supervision, monitoring place after the 04/12/#6 from falling.	6's 24-Hour Follow-Up ccident report dated 04/12/21 resident complained of mild mentation during second tation staff checked on the burs through the night. mentation of increased ng, or interventions put in 21 fall to prevent Resident 6's care notes revealed:			
	-There were no care i 04/12/21.	notes documented on			

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supervision or monitoring for Resident #6.

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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		R 04/20/2021
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	
(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 270	Continued From page	÷ 28	D 270		
	in place after the 04/1 #6 from falling.	nentation of interventions put 2/21 fall to prevent Resident interview on 04/19/21 at			
		lication aide (MA) who nt/accident report was			
	revealed: -On 04/14/21 at 2:37 she had fell. Staff wer	know what she was trying nentation of injury.			
	supervision, monitorir	ng, or interventions put in 21 fall to prevent Resident			
	Report for the incident 04/14/21 revealed: -There was no documThere was document resident around every -There was no document dayThere was no document day.	6's 24-Hour Follow-Up t/accident report dated nentation for second shift. tation staff checked on the / 2 hours during the night. nentation for first shift the nentation of increased ng, or interventions put in 21 fall to prevent Resident			
	Review of Resident # -There were no care in 04/14/21There was no docume supervision or monito.	nentation of increased			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		HAL034150	B. WING		04/2	0/2021
	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
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	(X5) COMPLETE DATE
D 270	Continued From page	29	D 270			
	in place after the 04/1 #6 from falling.	4/21 fall to prevent Resident				
	Interview with the MA incident/accident reporevealed: -She was administering resident and a housely help the Resident #6 -The resident was sittle. Resident #6 had a look -When a resident fell checking on the resident on the resident on the resident was a revealed to the check, whether 15-m for Resident #6 or any long long to the times. The falls made her heno one at the facility caused her falls, they	ort, on 04/19/21 at 9:59 am Ing medication to another keeper came and got her to who had fallen. Ing straight up in the floor. It of falls. Ithe MA was responsible for ent every 2 hours. I uested she do increased hinute or 30-minute checks by other resident. Int #6 on 04/19/21 at 10:13 ER due to falls "quite a few urt worse. I ever tried to find out what injust brushed her off.				
	as a reminder to call f never had a fall mat c -She could not call for	offered a chair or bed alarm for assistance and she had or physical therapy. r help unless she was right yelled for assistance.				
	Provider (PCP) on 04 revealed: -She knew the resided the residentShe had ordered PT past (no date given).	·				

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would take it off, then became hypoxic and she

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		_	
		HAL034150	B. WING		R 04/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMMONS 6010 MEA			OWBROOK N	IALL COURT		
11121417		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 COMPLE	
D 270	Continued From page	÷ 30	D 270			
	fellMultiple falls could coresident hit their head the brain, a stroke, ar -The resident transition their primary provider Interview with Reside 04/19/21 at 10:56 am -Resident #6 was adr 01/27/21The resident was a firm the resident was on -The resident had free snakes and alligators -Hospice had inquired alarm, bed alarm, and	ause broken bones and if a I it could cause bleeding on and multiple hospital visits. Oned to hospice care and on 01/27/21. Int #6's hospice physician on revealed: Initted to hospice on all risk. I oxygen. I quent hallucinations of after her. I dabout the use of a chair I fall mat but facility staff owed because they were				
	incident/accident repo 911 if bleeding or the notify the physicianThe MA also had to of which the resident's of documented for 3 shift- Nothing had been do Resident #6's falls as changes, no fall mat, increased checksShe had never been or 30-minute checks of -The facility used to he staff would check on the	revealed: Ills last week. the MA had to complete a ort, assess for injuries, call resident hit their head, and complete a 24-hour report in condition and vital signs were fits following the incident. One to intervene with evidenced by no medication no physical therapy, and no instructed to do 15-minute on a resident who had a fall. Ave a fall policy that stated the resident every 2 hours the current Administrator did				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL034150	B. WING		04/20/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
THE IVY AT CLEMMONS			DOWBROOK N	IALL COURT	
1			IS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 31	D 270		
	10:44 am revealed: -When a resident fell, injury and check the reliance of the resident hit their automatically sent to the resident for the MA completed a was supposed to doc following the incident, 24-Hour ReportStaff were supposed every 2 hours and as increase supervision 15-30 minute check to the facility failed to provide the sampled residents (#resulting in Resident resulted in multiple triming with a chin laceration scalp contusion, a knot tears. This failure resiphysical harm and nearly to the facility provided a accordance with G.S. this violation. CORRECTION DATE	head, they were the ER. In incident/accident form and ument on each shift If or 24 hours, on the to monitor the resident needed but they did not and the facility did not use ogs. Tovide supervision for 1 of 2 If one of alls If on			
	VIOLATION SHALL N 2021.	IOT EXCEED MAY 20,			
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276		
	10A NCAC 13F .0902 (c) The facility shall a following in the reside	ssure documentation of the			

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(3) DATE SURVEY COMPLETED		
		HAL034150	B. WING		04	R I/20/2021
					0-	H/20/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
THE IVY	AT CLEMMONS		ADOWBROOK MA	LL COURT		
		CLEMMO	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	e 32	D 276			
	a physician or other I and (4) implementation of	s, treatments or orders from icensed health professional; procedures, treatments or ubparagraph (c)(3) of this				
	reviews, the facility fa	ns, interviews, and record hiled to implement orders for ents (#1) who had a history				
	08/12/20 revealed: -Diagnoses included constipation, chronic disease, gastroesoph hyperthyroidismThere was an order daily on at 10:00 am,	t1's February, March, and n administration record was no entry for				
	Observation of Resid	ent #1's feet and legs on revealed:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL034150	B. WING		R 04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
	T CI EMMONE	6010 ME	ADOWBROOK M	IALL COURT	
I HE IV I A	T CLEMMONS	CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 276	Continued From page	33	D 276		
	-Resident #1 was not stockingsResident #1 had on a ribbed elastic top-edg-The socks left a smallegThe resident had sor indention in both legs. Interview with Reside am revealed: -She was ordered the to her history of edem-She had edema in he-Some days she had daysShe had at least two stockingsShe applied the com-Some days she did recompression stocking onFacility staff had not applying the compression stocking onFacility staff had not applying the compression stocking onTwo to 3 weeks ago, MMIn her role as MM, shensuring orders were -She was supposed to record to ensure curre on the MARsShe had not had time	wearing compression multi-colored socks with a de. Il indention in the resident's me puffiness above the . Int #1 on 04/19/21 at 11:01 e compression stockings due na. er calves, legs, and feet. more edema than other pairs of compression pression stockings herself. not feel like applying the gs, so she did not put them offered to assist her with sion stockings. dication manager (MM) on revealed:			

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ensure they were documented on the MAR.
-She did not know Resident #1 had an order for

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
					R	
		HAL034150	B. WING		04/20/202	21
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COI	(X5) MPLETE DATE
D 276	6 Continued From page 34		D 276			
	compression stockings.					
	Interview with a media 04/20/21 at 2:29 pm r -She did not know Recompression stocking -Resident #1 had nev putting on or taking of -The MM was responsivere documented on Telephone interview v Care Provider (PCP) revealed: -She expected Reside compression hose dated edema present in hereThe facility should have remind the MA to put and take them off at be-When she wrote an offacility to implement the telephone interview v 04/20/21 at 2:16 pm resident records to make the most and the MM was responsible mentedThe MM was responsible recompression stocking implemented on -The MM was responsible recompression order for compression documented on the MM was responsible of the MM was resp	cation aide (MA) on evealed: sident #1 had an order for ps. er asked for assistance with ff compression stockings. sible for making sure orders the MAR. with Resident #1's Primary on 04/19/21 at 12:37 pm ent #1 to wear the ily, especially if there was legs. ave the order on the MAR to the hose on in the morning pedtime. order, she expected the he order. with the Administrator on evealed: Resident #1 had an order for ps that was not sible for checking each ake sure current orders the MAR. sible for making sure the n stockings was IAR. sible for ensuring Resident				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
			A. BUILDING: _			
		HAL034150	B. WING		04/20	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	AT CLEMMONS		DOWBROOK N NS, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 280	Continued From page	÷ 35	D 280			
D 280	10A NCAC 13F .0903 Professional Support		D 280			
	registered nurse, occiphysical therapist in the evaluation of the residual plan and care provided (a) of this Rule, is condays of admission or a resident develops the least quarterly thereat following: (1) performing a physical resident as related to current condition requitasks specified in Part (2) evaluating the resident as needed by assessment and evaluation resident; and	assure that participation by a upational therapist or he on-site review and dents' health status, care ed, as required in Paragraph impleted within the first 30 within 30 days from the date ne need for the task and at fter, and includes the sical assessment of the the resident's diagnosis or uiring one or more of the ragraph (a) of this Rule; sident's progress to care in anges in the care of the assed on the physical uation of the progress of the activities in Subparagraphs				
	reviews, the facility fa Health Professional S was completed on 2 c and #4) for the identif administration and mo	ns, interviews, and record illed to ensure a Licensed Support (LHPS) evaluation of 6 sampled residents (#3 illed tasks of oxygen onitoring and inhalation he (#4), and ambulation with				

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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		04	R / 20/2021	
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE, ZIP CODE		72072021	
THE IVY AT CLEMMONS		ADOWBROOK MONS, NC 27012	IALL COURT			
PREFIX (EACH DEFICIENCY N	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
D 280 Continued From page 3	36	D 280				
COPD) 0.63mg/3 ml via daily for shortness of br Review of Resident #4's 11/26/18 revealed: -Diagnoses included en pain syndrome, muscle depressive disorder, ab disorder, chronic obstru (COPD)Resident #4 was semito bowel and bladderThere was an order for liters per minuteThere was an order for COPD) 0.63mg/3 ml via daily for shortness of br Review of Resident #4's orders dated 10/06/20 r -There was an order for liters per minute docum orders with a date of ch minute to 4 liters per mi	ocumented on the FL2. Intation for cognitive vel or bladder status, or Xopenex (used to treat al via nebulizer 3 times reath. Is previous FL2 dated Incephalopathy, chronic Inveakness, major Informality of gait, anxiety Inctive pulmonary disease Inambulatory, and continent Incontinuous oxygen at 3 In Xopenex (used to treat al via nebulizer 3 times Incephalopathy, chronic Incephalopathy,					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
			7. BOILDING.		,	₹
		HAL034150	B. WING			20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 ME	ADOWBROOK M	IALL COURT		
		CLEMMO	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 280	Continued From page	e 37	D 280			
D 280	-There was an order of liters per minuteThere was an order of COPD) 0.63mg/3 ml of daily for shortness of Review of Resident # 03/20/20 revealed LH oxygen administration inhalation medication Review of Resident # revealed there was not evaluation completed Observation on 04/19 -Resident #4 was sitting room and wearing he positionResident #4's oxygen liters per minuteResident #4 had a not the top of the nightstate. Interview with a medication of the nightstate of the nightstate. Interview with Reside pm revealed: -She used oxygen for she had used oxygen for she had a medicatio routinely through the	for Continuous oxygen at 4 for Xopenex (used to treat vial via nebulizer 3 times breath. 4's LHPS evaluation dated IPS identified tasks of and monitoring and by machine. 4's LHPS evaluation of a LHPS since 03/20/20. 1/20 at 12:43 pm revealed: ing in her recliner in her reasal cannula in correct in concentrator was set to 4 ebulizer machine located on and next to her hospital bed. 1/20 at 12:43 pm revealed: ing in her recliner in her recliner in her resulting in her recliner in	D 280			
	Refer to the interview 04/16/21 at 2:30 pm.	with the Administrator on				
	Refer to interview with	h the Contracted Nurse on				

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04/19/21 at 3:00 pm.

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DIVISION	n Health Service Negu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					_	
			B WING		R	
HAL034150		B. WING		04/20	0/2021	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
	6010 ME			MALL COURT		
THE IVY AT CLEMMONS		NS, NC 27012	MALE COOK!			
		CLEMINO	15, NC 2/012		T	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	NESSENION ON ESS BENTIL TIME IN CHAMMICH,		TAG	DEFICIENCY)	WALL	
D 280	Continued From page	e 38	D 280			
	0 D : (D :)					
		t #3's current FL2 dated				
	02/07/21 revealed:					
		essential hypertension,				
		der, unspecified lesions of				
	the mucosa, anxiety of	disorder and major				
	depressive disorder.					
	-The resident was do	cumented as ambulatory.				
	-The resident was documented as incontinent of bowel and bladder.					
	Review of Resident #	3's Licensed Health				
	Professional Health (I	LHPS) evaluation dated				
	04/08/20 revealed LH	IPS identified tasks of				
	oxygen administration	n, transferring assistance				
	and staff assist with tr	ransferring to a wheel chair.				
		•				
	Review of Resident #	3's record on 04/15/21				
	revealed:					
	-There was a physicia	an's order dated 10/11/20 for				
		as needed for constipation.				
	•	nentation of an order to				
	administer oxygen.					
		nentation of an order for a				
	wheel chair.					
	Review of Resident #	3's LHPS evaluations				
	revealed there was no quarterly documentation of an LHPS evaluation completed from 04/08/20 through 04/16/21.					
	IIIOugii 04/10/21.					
	Observation of Resident #3 on 04/15/20 at 11:10					
	am revealed:	GII πο στι σ τ ι 13/20 αι 11.10				
		ting on her had in her room				
	with her hand on a wa	ting on her bed in her room				
	- rne resident was not	t wearing an oxygen canula.				
	Intonvious with Dooids	nt #3 on 04/19/21 at 11:10				
		111.110 U11 U4/ 19/21 at 11.10				
	am revealed:		1			

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-She had been able to walk with a walker for

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
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		HAL034150	3		04/20/2021	\dashv
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMMONS			OWBROOK N	IALL COURT		
CLEMMON		S, NC 27012				
(X4) ID PREFIX TAG	EIX (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 COMPLE	
D 280	Continued From page	e 39	D 280			
	280 Continued From page 39 several monthsShe has not needed the enema for about 3 month.					
	Refer to the interview 04/16/21 at 2:30 pm.	with the Administrator on				
	Refer to interview with the Contracted Registered Nurse (RN) on 04/19/21 at 3:00 pm. Interview with the Administrator on 04/16/21 at 2:30 pm revealed: -Residents' LHPS evaluations should be completed quarterlyThe previous Resident Care Director (RCD) would have been responsible to track when residents' LHPS evaluations needed to be updatedThe Contract RN had been completing and updating LHPS evaluations as she audited residents' recordsThe new RCD and the Contract RN were now responsible to audit records and update LHPSs for all residents. Interview with the Contract RN on 04/19/21 at 3:00 pm revealed: -She had been contracted by the facility about 2 weeks ago to provide nursing duties including reviewing medication orders, auditing medication orders and medication administration records (MARs) for correctness, and auditing residents' records for completenessThe facility had experienced a lot of staff turnover including the RNs who were contracted to update residents' LHPS evaluationsShe had located some completed LHPS evaluations in various stacks and boxes of facility paperworkShe was in the process of updating residents'					

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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		04	R I/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
THE IVY A	T CLEMMONS		EADOWBROOK MA ONS, NC 27012	LL COURT		
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D 280	Continued From pag	ge 40	D 280			
		ue to the results of her audit and inability to locate HPS evaluations.				
D 310	10A NCAC 13F .090 Service	04(e)(4) Nutrition and Food	D 310			
	10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.					
	interviews, the facilit	ons, record reviews, and y failed to serve a therapeutic ed resident who had an order				
	The findings are:					
		#10's current FL2 dated iagnoses included failure to irment, and stroke.				
	revealed: -There was a physic 10/06/20 with orders meats and nectar liq -There was an order "thickened liquids" w	dated 12/08/20 for				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE COMF	SURVEY	
			A. BUILDING	A. BUILDING:			
	HAL034150		B. WING		l l	R / 20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE			
THE IVY A	T CLEMMONS		DOWBROOK M NS, NC 27012	ALL COURT			
0.0.1-	CLIMMADY CT		1	DDOVIDED'S DI AN O	OF CORRECTION	1 0/5	
(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 A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
D 310	D 310 Continued From page 41		D 310				
	guidance of food servi-ln the food storage at 4-ounce containers of pre-thickened cranbet 4-ounce containers of pre-thickened water, an ectar consistency pre-thickener was a powder thickener in a can available and the direction of the directions for minectar thick consistent tablespoons plus two liquid. The mixing directions measurements to the with a spoon or fork for the pre-thickener in the consistent tablespoons plus two liquid.	t list of residents with sted in the kitchen for the rice staff. rea there were 24 each of nectar consistency rry juice, there were 4 each of nectar consistency and 6 each 4-ounces of e-thickened orange juice. The ed food and beverage aliable for the kitchen staff. The son the canister of the each of the each of the kitchen staff. The son the canister of the each of the each of the kitchen staff. The son the canister of the each of					
	Observation of the lur 12:00 pm to 12:31 pm -At 12:05 pm, the per served Resident #10 ice. -The iced tea was not but was a regular thin -Resident #10 drank to left the table. Interview with the PC revealed:	nch meal on 04/15/21 from a revealed: sonal care aide (PCA) an 8-ounce cup of tea with a nectar thick consistency a consistency. It wo swallows of the tea and A on 04/15/21 at 12:36 pm #10 what she wanted to t asked for tea.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COMPILETED R 04/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE, 2IP CODE 6910 MEADOWBROOK MALL COURT CLEMMONS, NC 27012 PAID PRETIX CRACH DETRICIENCY OR LSC IDENTIFYING INFORMATION) PRETIX TAG PROVIDERS PLAN OF CORRECTION AT TAG PROVIDERS PLAN OF CORRECTION AS THE ADDRESS OF TAG CROSS-AREFERENCED TO THE APPROPRIATE CROSS-AREFERENCED TO T	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY	
NAME OF PROVIDER OR SUPPLIER THE IVY AT CLEMMONS STREET ADDRESS, CITY, STATE, ZIP CODE 610 MEADOWBROOK MALL COURT CLEMMONS, NC 27012 [CALPID (EACH DEPICIENCY MUST BE PRECEDED BY FILL REQULATORY OR LSC (DENTIFYING INFORMATION)) D 310 Continued From page 42 -The cook had made her aware the nectar pre-thickened beverage was for Resident #10. -She was not aware she had to thicken the tea before serving it to Resident #10. -She did not know there was powdered thickener in the kitchen. -No one had trained her or made her aware of how to thicken Resident #10 sheet and if Resident #10 saked for beverages that were not pre-thickened she served the resident the requested beverage and did not add thickener. Interview with the morning cook on 04/15/21 at 9.48 am and 12:51 pm revealed: -The Dietary Manager did not show up for work yesterday. -There was no therapeutic diet list bosted in the kitchen to follow when serving meals. -She did not need a therapeutic diet list because she remembered the diets ordered for each resident. -The nectar consistency pre-thickened liquids in the food storage area were for Resident #10. -She told the PCA to serve the pre-thickened beverages (2 cranberries and 1 water). -She told the PCA to served Resident #10. -She told the PCA to served Resident #10. -She told don the Where PCA served Resident #10.	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
THE IVY AT CLEMMONS G10 MEADOWBROOK MALL COURT CLEMMONS, NC 27012 CALID PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						R	2
CALIFIC SUMMARY STATEMENT OF DEFICIENCIES			HAL034150	B. WING		04/2	0/2021
CLEMMONS, NC 27012 CLEMMONS CLEMMONS, NC 27012 CLEMMONS, NC 27012	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLEMMONS, NC. 27012 CALLED SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (RS) COMMETTE CALLED PRETIX TAG CROSS-REFERENCED TO THE APPROPRIATE DOMESTE DATE DATE DATE		T CI EMMONS	6010 MEA	DOWBROOK N	IALL COURT		
EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY D 310 Continued From page 42 D 310 - The cook had made her aware the nectar pre-thickened beverage was for Resident #10 She was not aware she had to thicken the tea before serving it to Resident #10 She did not know there was powdered thickener in the kitchen No one had trained her or made her aware of how to thicken Resident #10's beverages When she served meals in the dining room and if Resident #10 asked for beverages that were not pre-thickened she served the resident the requested beverage and did not add thickener. Interview with the morning cook on 04/15/21 at 9.48 am and 12.51 pm revealed: - The Dietary Manager did not show up for work yesterday There was no therapeutic diet list because she remembered the diets ordered for each resident The nectar consistency pre-thickened liquids in the food storage area were for Resident #10 She gave the PCA 3 each 4-ounce containers of nectar consistency pre-thickened beverages (2 cramberries and 1 water) She told the PCA to serve the pre-thickened beverages to Resident #10 She did not know the PCA served Resident #10	CLEMMON		NS, NC 27012				
-The cook had made her aware the nectar pre-thickened beverage was for Resident #10She was not aware she had to thicken the tea before serving it to Resident #10She did not know there was powdered thickener in the kitchenNo one had trained her or made her aware of how to thicken Resident #10's beveragesWhen she served meals in the dining room and if Resident #10 asked for beverages that were not pre-thickened she served the resident the requested beverage and did not add thickener. Interview with the morning cook on 04/15/21 at 9:48 am and 12:51 pm revealed: -The Dietary Manager did not show up for work yesterdayThere was no therapeutic diet list posted in the kitchen to follow when serving mealsShe did not need a therapeutic diet list because she remembered the diets ordered for each residentThe nectar consistency pre-thickened liquids in the food storage area were for Resident #10She gave the PCA 3 each 4-ounce containers of nectar consistency pre-thickened beverages (2 cranberries and 1 water)She told the PCA to serve the pre-thickened beverages to Resident #10She did not know the PCA served Resident #10.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
pre-thickened beverage was for Resident #10. -She was not aware she had to thicken the tea before serving it to Resident #10. -She did not know there was powdered thickener in the kitchen. -No one had trained her or made her aware of how to thicken Resident #10's beverages. -When she served meals in the dining room and if Resident #10 asked for beverages that were not pre-thickened she served the resident the requested beverage and did not add thickener. Interview with the morning cook on 04/15/21 at 9:48 am and 12:51 pm revealed: -The Dietary Manager did not show up for work yesterday. -There was no therapeutic diet list posted in the kitchen to follow when serving meals. -She did not need a therapeutic diet list because she remembered the diets ordered for each resident. -The nectar consistency pre-thickened liquids in the food storage area were for Resident #10. -She gave the PCA 3 each 4-ounce containers of nectar consistency pre-thickened beverages (2 cranberries and 1 water). -She told the PCA to serve the pre-thickened beverages to Resident #10. -She did not know the PCA served Resident #10.	D 310	Continued From page	e 42	D 310			
Observation of the dinner meal on 04/15/21 from 5:00 pm to 5:45 pm revealed: -The Business Office Manager (BOM) and PCA delivered the beverages and the meals to the residentsResident #10 was served an 8-ounce cup of cranberry juice without ice.	D 310	-The cook had made pre-thickened beverages to ResidentThe cook had made pre-thickened beverage as before serving it to Re-She did not know the in the kitchenNo one had trained how to thicken Resided. When she served me if Resident #10 asked pre-thickened she ser requested beverage as Interview with the money:48 am and 12:51 pre-The Dietary Manage yesterdayThere was no therap kitchen to follow where she did not need a thicken the food storage area as she gave the PCA 3 nectar consistency precranberries and 1 was she told the PCA to be beverages to Resider she did not know the tea with ice that was as Observation of the diff 5:00 pm to 5:45 pm residentsResident #10 was see the presidentsResident #10 was see the presidents.	her aware the nectar ge was for Resident #10. she had to thicken the tea esident #10. ere was powdered thickener her or made her aware of ent #10's beverages. eals in the dining room and if for beverages that were not rved the resident the and did not add thickener. rning cook on 04/15/21 at m revealed: r did not show up for work reutic diet list posted in the n serving meals. herapeutic diet list because diets ordered for each acy pre-thickened liquids in n were for Resident #10. each 4-ounce containers of re-thickened beverages (2 ter). serve the pre-thickened ant #10. e PCA served Resident #10 not thickened. Anner meal on 04/15/21 from evealed: Manager (BOM) and PCA ges and the meals to the erved an 8-ounce cup of	D 310			

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DIVISION OF FEEDINGS AND		1		T		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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		HAL034150	B. WING			
		11/12/04/100			04/20/2021	
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		6010 MEA	DOWBROOK N	IALL COURT		
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012			
	SUMMARY STATEMENT OF DEFICIENCIES		<u> </u>	DDOV/DEDIC DI ANI OF CODDECTION		
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				DEFICIENCY)		
D 210	0	- 40	D 310			
D 310	Continued From page	e 43	0310			
	consistency but was a	a thin consistency.				
		eyor intervened and asked				
	the PCA working in th					
	Resident #10's bever	•				
		eyor suggested staff remove				
	-	ce and replace it with the				
	consistency ordered.	se and replace it with the				
	consistency ordered.					
	Interview with the BO	M on 04/15/21 at 5:04 pm				
	Interview with the BOM on 04/15/21 at 5:04 pm revealed: -She thought Resident #10 was ordered nectar					
	thickened liquids.	min 4 tableaness of				
	-The cook told her to					
		nces of cranberry juice that				
	was served to Reside					
		ar thick beverages before				
		dent #10 because it needed				
	time to get thicker.					
		ed as a medication aide				
	(MA) and knew how t					
		#10's beverage was not				
	<u> </u>	eded more thickener added.				
		e thickener because the				
	cook insisted to only					
		rage served to Resident				
	#10.					
	-She did not know the	ere were nectar				
	pre-thickened beverages in the food storage areaShe did not see the list with the residents' diets					
	because she was not	allowed to enter the				
	kitchen.					
	-She depended on the	e cook to make her aware of				
	what to serve each re					
	Interview with the eve	ening cook on 04/15/21 at				
	5:27 pm revealed:					
	-He did not know resi	dents' diets ordered				

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in the kitchen.

because there was no therapeutic diet list posted

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DIVISION	n Health Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ΓED
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			D MINO		R	
		HAL034150	B. WING		04/20	/2021
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZID CODE		
NAME OF T						
THE IVY AT CLEMMONS		DOWBROOK N	IALL COURT			
	CLEMI		NS, NC 27012			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IOIENOT)		
D 310	Continued From page	ΔΔΔ	D 310			
	Continuou i rom page	, , ,				
	-He thought there was	s a diet list posted in the				
	kitchen but he just che	ecked and there was no diet				
	list posted.					
	-He did not know the	facility had nectar				
	pre-thickened liquids.					
	•	ng the BOM to only use 1				
	tablespoon of thicken					
	beverage.	or in recondent in re-e				
		d at other facilities and knew				
	how to thicken liquids					
	·	ead the instructions on the				
	container of thickener					
	•	eutic diet list posted in the				
		know the type of liquid				
	consistency ordered F	Resident #10.				
		ector of Quality on 04/15/21				
	at 4:43 pm revealed:					
		r left yesterday and took all				
		ng the therapeutic diet list.				
	-She also thought he	took the diet orders and				
	menus.					
	-She had not checked	d Resident #10's record for a				
	current diet order.					
	-She did not know if a	nyone had been assigned				
	to observe meals to e	nsure diets were served as				
	ordered.					
	Interview with Resident #10 on 04/16/21 at 12:25 pm revealed: -She had difficulty swallowing.					
	-She did not eat much	•				
	difficult to swallow.					
	-She was not always	served thickened liquids.				
	-She was not sure of					
	ordered.					
	ordorod.					
	Interview with Pecido	nt #10's Primary Care				
		/16/21 at 2:49 pm revealed:				
	1 10 VIUCI (FCF) 011 04	i ioiz i al z.45 pill levealeu.	1			

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-Resident #10 had a stroke one and one-half to

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL034150	B. WING		04/20/2021	
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			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 310	Continued From page	e 45	D 310			
	two years ago. -A result of the stroke swallowing difficulties liquids. -The facility staff prep FL2s and prefilled the Resident #10 had no diet order. -Resident #10 should Interview with the me 04/19/21 at 4:50 pm reshe had worked at the February 2021. -Two to 3 weeks ago, MM. -She did not know Renectar thickened liquiell -In her role as MM, shensuring current ordershe had not had time each resident's record Telephone interview wod/20/21 at 2:16 pm reshe was not aware for "thickened liquids. -The MM was respon resident record to madocumented on the Mesident #10's PCP Tuesday, the MM should resident made in the Mesident #10's PCP Tuesday, the MM should resident record to made in the Mesident #10's PCP Tuesday, the MM should resident record to made in the Mesident #10's PCP Tuesday, the MM should resident record to made in the Mesident #10's PCP Tuesday, the MM should resident record to made in the Mesident record to made in the Mesident #10's PCP Tuesday, the MM should resident record to made in the Mesident record rec	was that Resident #10 had and was ordered thickened wared the diet orders and em out. assessment to change her receive nectar thick liquids. dication manager (MM) on revealed: the facility since late she took over the role as resident #10 was ordered ds. the was responsible for resident was responsible for responsible				
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358			
	10A NCAC 13F .1004	Medication Administration				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		04	R // 20/2021
		HAE034130			04	12012021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY	AT CLEMMONS	6010 MEA	DOWBROOK M	IALL COURT		
111111111	AT CELIMINIONS	CLEMMOI	NS, NC 27012			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	358 Continued From page 46		D 358			
	preparation and admi prescription and non- by staff are in accorda (1) orders by a licens which are maintained	ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies				
	This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur.					
	THIS IS A TYPE A2 V	IOLATION				
	reviews, the facility fall medications as ordered (Resident #8 and #9) medication pass on 0 medication to treat and to treat diabetic neuron sampled residents (#for record reviews relation the blood, a medication (#1); a medication for muscle spasms (#2); a medication for anxietinsomnia, a vitamin sumedication to treat deto treat acid reflux, an neuropathy, and a sterile.	ed for 2 of 4 residents sampled during the 8:00 am 4/16/21 related to a exiety (#8), and a medication expathy (#9); and 6 of 9 1, #2, #4, #6, #7, and #11) eated to a medication used to ecation to treat bipolar in for nausea, and a laxative pain, and a medication for a medication for acid reflux, ety, a medication for upplement, and a expression (#4); a medication medication for diabetic eroidal medication for				
	breathing (#6); and a (#7 and #11).	medication to treat diabetes				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_
	HAL034150		B. WING		R 04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE IVY AT CLEMMONS			OOWBROOK N	IALL COURT	
		S, NC 27012			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	58 Continued From page 47		D 358		
	The findings are:				
		or rate was 6% as ervation of 2 errors out of g the 8:00 am medication			
	a. Review of Resident #8's current FL2 dated 08/18/20 revealed diagnoses included chronic pain syndrome, closed fracture, muscle weakness, insomnia, anxiety disorder, paraplegic, and lack of coordination. Review of Resident #8's physician's orders revealed: -There was an order dated 03/30/21 for diazepam 10mg (used to treat anxiety, muscle relaxation and spasms in paraplegic) three times a day. Do not give within 2 hours of administering Oxycodone/Oxycontin (narcotic pain relievers). -There was an order dated 03/31/21 for Oxycontin ER 20mg (a long acting pain reliever) every 12 hours.				
	04/16/21 revealed: -At 8:10 am, the morr on the fourth floor pre including one diazepa ER 20mgShe administered all	on am medication pass on the medication aide (MA) apared 7 oral medications, am 10mg and one Oxycontin the medications at the of water to the resident in			
	his room. Observations of Resident #8's medications on hand on 04/16/21 at 8:30 am revealed a card labeled diazepam 10mg one tablet three times a day, do not give within 2 hours of administering Oxycodone/Oxycontin, dispensed on 03/31/21 for				

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STATE FORM 6899 YYKO11 If continuation sheet 48 of 132

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DIVISION	n nealth Service Regu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
					_	5
			D WING		F	
		HAL034150	B. WING		04/2	20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
			DOWBROOK N			
THE IVY A	T CLEMMONS			MALL COOK!		
		CLEMINO	NS, NC 27012	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
			+			1
D 358	Continued From page	e 48	D 358			
	30 tablet with 11 table	ets remaining				
	oo tablet with 11 table	oto remaining.				
	Review of Resident #	8's April 2021 Medication				
	Administration Record					
		or diazepam 10mg one				
	_	o information for do not give				
		codone/oxycontin) scheduled				
	-	8:00 am, 12:00 pm, and				
	4:00 pm.	0.00 am, 12.00 pm, and				
		or Oxycontin 20mg ER				
		luled for 8:00 am and 8:00				
	pm.	idiod for 0.00 diff diffa 0.00				
	•	l Oxycontin 20mg ER were				
		nistered at 8:00 am daily				
	from 04/02/21 to 04/1	•				
	110111 0 1/02/21 10 0 1/1	0/21.				
	Interview with the mo	rning MA on the fourth floor				
	on 04/16/21 at 11:30	•				
		edications according to the				
	scheduled time on the					
		ve a warning or information				
	for do not take within					
	Oxycodone/Oxycontir	<u> </u>				
		ntil it was pointed out that				
		rom the pharmacy had the				
		ed not taking diazepam				
	10mg within 2 hours of	• •				
	_	direction on the bubble				
	package completely.	direction on the babble				
		e access to medication				
		end on the MARs and				
	·	directions for medication				
	administration.	directions for medication				
	administration.					
	Interview with the Adr	ministrator on 04/16/21 at				
	4:30 pm revealed:					
	-The MAs should adm	ninister medications				
		ication order by reading the				
	MAR and the label on					
		on or the MAR and label did				
	440011		1	1		1

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL034150	B. WING		04	R / 20/2021
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	,	·	
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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	not match, the MA sh from the Medication M Care Director, or the to ensure medications ordered. b. Review of Residen 10/20/20 revealed dianeuropathy, diabetes insomnia, depression deficiency. Review of Resident # revealed there was an gabapentin 100mg (u capsule two times a c (300mg) at bedtime. Observation of the 8:04/16/21 revealed: -She had difficulty fine medications on the ca-At 8:20 am, the morron the third floor prepof oral medications the gabapentin 100mg care. Review of Resident # Administration Record-There was an entry f capsule two times a care-The 04/16/21 block to administration of gabawas blank. Observations of Resident Madministration of Resident Madministration of gabawas blank.	ould request assistance Manager (MM), the Resident Contract Registered Nurse is were administered as It #9's current FL2 dated agnoses included mellitus, hypertension, anemia and vitamin B 9's physician's orders in order dated 10/26/20 for sed to treat nerve pain) one day and three capsules 00 am medication pass on ding Resident #9's art but did find them. hing medication aide (MA) hared 5 and one-half tablets hat did not include the hapsule. 9's April 2021 Medication d (MAR) revealed: for gabapentin 100mg one day at 8:00 am and 2:00 pm. o document 8:00 am apentin 100mg on the MAR dent #9's medications on 0:30 am revealed a card 00mg capsule take 1 cap 2:00 pm with seven out of	D 358			

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DIVISION	of Health Service Regu	lation				
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:			COMPLI	ETED
			, boilbing.			
					R	
		HAL034150	B. WING		1	0/2021
		11AE034130			1 04/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, STA	TE. ZIP CODE		
				,		
THE IVY	T CLEMMONS	6010 ME	ADOWBROOK N	MALL COURT		
		CLEMMO	NS, NC 27012			
()(1) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	<u></u>	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
1710		,	1,70	DEFICIENCY)	ľ	
D 358	Continued From page	e 50	D 358		ľ	
	Communication page				ľ	
					ľ	
	Interview with the mo	rning MA on the third floor			ľ	
	on 04/16/21 at 8:25 a				ľ	
					ľ	
		edications according to the			ľ	
	residents' MARs.				ľ	
	-She worked third shi	ft and stayed over on first			ľ	
	shift to help out.	,			ľ	
	•	Lof Docident #0's			ľ	
	-She could not find al				ľ	
		ut she eventually found			ľ	
	them in the medicatio	n cart.			ľ	
	-She was nervous an	d just missed the			ľ	
	gabapentin.	•			ľ	
		had missed administering a			ľ	
		had missed administering a			ľ	
		d go back and give it if it was			ľ	
	within the hour that th	ne medication was			ľ	
	scheduled.				ľ	
					ľ	
	2. Daview of Decider	ot #71a accompant ELO datad			ľ	
		nt #7's current FL2 dated			ľ	
	02/14/21 revealed:				ľ	
	-There were diagnose	es including paranoid			ľ	
	schizophrenia and ref	flux esophagitis.			ľ	
		cation orders listed on the			ľ	
	FL2.	sation states helda on the			ľ	
		4-4: D:- #7 - FI O			ľ	
		tation on Resident #7's FL2			ľ	
	as "See attached MA	R"(Medication			ľ	
	Administration Record	d) typed in the space for the			ľ	
	medication list.	,			ľ	
		dated 03/01/21-03/31/21 with			ľ	
					ľ	
		nted as administered on			ľ	
		nd 03/03/21, was attached			ľ	
	to the FL2.					
					ľ	
	Review of Resident #	7's Primary Care Provider			ľ	
		es dated 02/09/21 revealed				
	laboratory test results					
	documented a 15.8 a	s the value for Hemoglobin				
	A1C (a laboratory val	ue that measure blood				
	sugar levels over a pe					
	instead of at a given t					
	According to the Ame	erican Diabetic Association, a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
						₹
		HAL034150	B. WING		04/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
THE IVV	AT CLEMMONS	6010 MEA	DOWBROOK N	MALL COURT		
INCIVIA	AT 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From page	e 51	D 358			
2 000		than 8.5 was desirable in	2 333			
	insulin given to lower before breakfast, lund 18 units subcutaneou sugar (FSBS) over 25 for FSBS over 400 for HumalogThere was an entry the before meals. Review of Resident # 04/06/21 revealed an 14 units SQ 3 times designed.	or Humalog (a rapid acting blood sugar levels) insulin th, and dinner using scale of sly (SQ) for fingerstick blood and give additional 6 units or a total of 24 units of the check FSBS 3 times a day order for Humalog insulin laily before meals, hold if and give 4 extra units if				
	insulin before breakfa scheduled for 7:30 an using scale of 18 unit give additional 6 units total of 24 units of Hu for Humalog insulin fr The order was discon of 04/06/21. -There was a handwr insulin before meals (dinner) using scale of before meals, hold if I give 4 extra units if FS total of 18 units.	itten entry for Humalog ast, lunch, and dinner, and n, 12:00 pm, and 5:00 pm as SQ for FSBS over 250 and as for FSBS over 400 for a malog with documentation om 04/01/21 to 04/08/21. tinued on 04/08/21 instead				

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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
					R
		HAL034150	B. WING		04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
			ADOWBROOK M		
THE IVY A	T CLEMMONS		ONS, NC 27012		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	: 52	D 358		
	7:30am on 3 of 8 opp 04/14/21 as follows: -On 04/07/21, FSBS of should have received insulin was document -On 04/08/21, FSBS of should have received insulin was document -Humalog insulin was 12:00 pm on 1 of 8 op when FSBS was 451 have received 18 unit 6 units from previous administeredHumalog insulin was 5:00 pm on 5 of 8 opp 04/14/21 as follows: -On 04/07/21, FSBS of should have received	was 223, Resident #7 14 units of insulin, no ed as administered. was 145, Resident #7 14 units of insulin, no ed as administered. administered incorrectly at oportunities on 04/07/21 and Resident #7 should s and 24 units (18 units plus order) was documented as administered incorrectly at order) was documented as administered incorrectly at order) was 122, Resident #7 14 units of insulin, no			
	insulin was document -On 04/09/21, FSBS v	ed as administered. vas 182, Resident #7			
	should have received insulin was document				
	-On 04/10/21, FSBS v				
		14 units of insulin, no			
	insulin was document	ed as administered.			
	-On 04/13/21, FSBS v	•			
	should have received	•			
	insulin was document -On 04/14/21, FSBS v				
		14 units of insulin, no			
	insulin was document				
	Interview with a media 04/16/21 at 5:29 pm r				

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PCP.

11:00 pm) shift.

-MAs did not see original orders written by the

-The Medication Manager (MM) was responsible

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DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					-	,
			B. WING		F	
		HAL034150	B. WING		04/2	20/2021
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	MALL GOOK!		
		CLEIMING	N3, NC 27012			T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		DATE
17.0		,	17.0	DEFICIENCY)		
			+			
D 358	Continued From page	e 53	D 358			
	to enter new orders o	n the MARs and the MAs				
	were supposed to adi					
	according to the MAR					
	-Resident #7 had rece					
	injections.	chity started insum				
	•	some changes to his insulin				
	doses.	dernie drianges te me meann				
		er Resident #7's Humalog				
		nities for 5:00 pm doses in				
		he did not realize Resident				
		order changed to administer				
	•	and only hold if FSBS was				
	less than 100.	and only note in 1 ede was				
		ng Humalog from memory				
		parameters to administer if				
	the FSBS was greate					
	-She did not read the					
	completely.					
	completely.					
	Interview with the MM	1 on 04/16/21 at 4:00 pm				
	revealed:					
		on the residents' MARs for				
		orders until the pharmacy				
		e the order on the MAR to				
	be sent out at the first					
		ystem in place to routinely				
		dministration because she				
		current position for less than				
		en a MA prior to being asked				
	to to be the MM.	and a management				
	-There had been a lot	t of MA turnover.				
		g as a MA to fill call-outs for				
	the last 2 weeks.	J				
		esident #7's insulin was not				
		ccording to the most recent				
	physician's orders.					
	p, 0.0.0.1.1.0 0.10010.					
	Interview with the Co.	ntract Registered Nurse on				
	04/19/21 at 3:00 pm r					
		ng at the facility for 3 weeks.				
		,	1	1		1

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		04	R J/ 20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE	, ,	·	
			ADOWBROOK MA				
THE IVY A	AT CLEMMONS		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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 358	residents' medication -She had not been al because she was tryi out of date Licensed evaluationsShe was told the MN orders on the resider -There was not a sys orders entered by the routine basisThere had been a lo the last 3 months, inc Resident Care Direct Telephone interview of 04/19/21 at 12:43 pm -Resident #7 had bee for diabetes for a long -She started Resident 2021 in response to a revealed a Hemoglob reflected blood sugar -She had changed Re as the resident's FSE -She expected the fa orders to help control decrease the long-tel (kidney and eyes). 3. Review of Residen 06/27/20 revealed: -Diagnoses included and diabetesThere was an order inject 16 to 20 units in needed for blood sugar Review of Resident	to assist with reviewing is, and auditing records. Delete to complete chart audits ing to catch up on residents' Health Professional Support of the Was responsible to enternated Marks. The term to audit the medication of Marks. The Marks with the medication of the Marks of staffing changes within cluding the MM, and for. With Resident #7's PCP on a revealed: The medication of time. The with the medication of time. The marks of the medication of the medicati	D 358				
		‡11's laboratory test results aled a Hemoglobin A1C (a					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034150	B. WING		R 04/20/2021
NAME OF PROVIDER OR SUPPLIER THE IVY AT CLEMMONS	STREET AD	DRESS, CITY, STA DOWBROOK IV NS, NC 27012		1 0 112012021
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
over a period of 2 to 3 r given time like FSBS te the American Diabetic A A1C less than 8.5 was population with other illing Review of Resident #11 dated 01/09/21 reveale -There was an order for insulin) Flexpen 100uni subcutaneously (SQ) be supper as needed for fit (FSBS) over 250. -There was an order for 100units/ml inject additional breakfast and before surver 400. Review of Resident #11 (PCP's) order dated 04. -There was an order to meals, breakfast and surface and order for -There was an order for -There was an order for meals, hold if FSBS less extra units if FSBS mor units. Review of Resident #11 order dated 04/13/21 resum -There was an order for -There was an order to Novolog orders.	easures blood sugar levels months instead of at a est) of 10.1. According to Association, a Hemoglobin desirable in older nesses, like diabetes. 1's physician's orders ed: r Novolog (a rapid acting its/ml inject 16 units efore breakfast and before ingerstick blood sugar r Novolog Flexpen ional 4 units SQ before upper as needed for FSBS 1's Primary Care Provider's //06/21 revealed: discontinue FSBS before upper. r FSBS before all meals. discontinue Novolog r Novolog 14 units before es than 100, and give 4 re than 400 for a total of 18 1's PCP's subsequent evealed: r FSBS before meals. discontinue previous	D 358		

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Division	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					_D
		1181 004450	B. WING		R
		HAL034150	3:		04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		6010 ME	ADOWBROOK M	IALL COURT	
THE IVY A	T CLEMMONS		NS, NC 27012		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	()
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
D 050	0 " 15		D 050		
D 358	Continued From page	2 56	D 358		
	Review of Resident #	11's April 2021 medication			
	administration record				
		or FSBS before breakfast			
	,	, and an entry for FSBS			
	before dinner schedu	•			
		or Novolog Flexpen insulin			
		ve 16 units, FSBS over 400			
	_	for a total of 20 units for a			
	total of Novolog.	o loi a total oi 20 ullito loi a			
		or Novolog Flexpen insulin			
	•	s, hold if FSBS less than			
		units if FSBS more than			
	400 for a total of 18 u				
		or the order for Novolog 16 old if FSBS less than 100,			
	•	(to equal 20 units) if FSBS			
	more than 400 dated				
	· ·	administered incorrectly at			
		opportunities from 04/06/21			
	to 04/19/21 with exan				
	· ·	was 124, Resident #11			
		14 units of insulin, no			
	insulin was document				
		was 162, Resident #11			
		14 units of insulin, no			
	insulin was document				
		was 367, Resident #11			
		14 units of insulin, 16 units			
		ented as administered.			
	· ·	was 281, Resident #11			
		14 units of insulin, 16 units			
		ented as administered.			
	-	was 349, Resident #11			
		14 units of insulin, 16 units			
		ented as administered.			
		and no Novolog insulin			
	documented as admir	nistered at 12:00 pm for 13			

Division of Health Service Regulation

of 13 opportunities from 04/07/21 to 04/19/20 therefore it could not be determined if Resident #11 should have received Novolog insulin.

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DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			B WING		R	
		HAL034150	B. WING		04/20/2021	
NAME OF PI	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	MALL GOOK!		
			13, 140 27012	T		
(X4) ID	_	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD	(- /	
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		
1710		•	1,10	DEFICIENCY)		
			D 050			
D 358	Continued From page	e 57	D 358			
	-Humalog insulin was	documented administered				
	incorrectly at 5:00 pm	on 6 of 13 opportunities				
	from 04/06/21 to 04/1	9/21 as follows:				
		was 453, Resident 11 should				
	have received 18 unit	s of insulin, 20 units of				
	insulin was document					
	-On 04/10/21, FSBS \	was 459, Resident 11 should				
	•	s of insulin, 20 units of				
	insulin was document	•				
	-On 04/12/21. FSBS v	was 202, Resident 11 should				
		s of insulin, no units of				
	insulin was document					
	Interview with a medi	cation aide (MA) on				
	04/16/21 at 5:29 pm r					
		the second (3:00 pm to				
	11:00 pm shift).	inal and an comittee by the				
	_	inal orders written by the				
	Primary Care Provide					
		ager (MM) was responsible				
		n the MARs and the MAs				
	were supposed to adr					
	according to the MAR					
		sulin injections for a long				
	time.					
		some changes to her insulin				
	doses.	:-				
	-She administered Re					
	according to the MAR					
		sident #11's Novolog insulin				
		ninister 16 units before				
	_	f FSBS was less than 100				
		e MAR, therefore she did				
		ch or administer insulin to				
	the resident when she	e worked.				
	Intonuiow with the MAN	1 on 04/16/21 at 4:00 pm				
	revealed:	1 on 04/16/21 at 4:00 pm				
		on the residents' MARs for				
	-one entered orders (NI THE LESIMETITS INIALS IN	1			

Division of Health Service Regulation

insulin and any new orders until the pharmacy

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Division of Health Service Regulation

Division	of Health Service Regu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					l _	
			D 14//10		F	
		HAL034150	B. WING		04/2	20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE. ZIP CODE		
		6010 ME/	ADOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012	MALL GOOK!		
			110, 110 27012	T		1
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
1,10		,	,,,,,	DEFICIENCY)		
D 050	- · · · -		D 050			
D 358	Continued From page	e 58	D 358			
	had a chance to place	e the order on the MAR to				
	be sent out at the first	t of each month.				
	-She did not have a s	system in place to routinely				
		dministration because she				
		current position for less than				
	•	en a MA prior to being asked				
	to to be the MM.	o a po. to bog aoa				
	-There had been a lot	t of MA turnover				
		ng as a MA to fill call-outs for				
	the last 2 weeks.	ig as a wire to him sain sats for				
		w she overlooked changing				
		og insulin on 04/07/21 and				
	again on 04/13/21.	og madim om 04/01/21 and				
	ayaiii 011 04/13/21.					
	Interview with Reside	ent #11 on 04/19/21 at 9:20				
		a blood sugar that was high				
		MA did not give insulin				
	•	order on her MAR stated				
		er mealtime insulin unless				
	her FSBS was greate					
	nor rebe was greate	7 than 200.				
	Telephone interview v	with Resident #11's PCP on				
	04/19/21 at 12:43 pm					
		cility to follow the current				
	-	Resident #11's diabetes				
		g-term damage to organs				
	(kidney and eyes).	g torm damage to organic				
		v why the facility failed to				
		's insulin orders when she				
	requested the change					
		ngoing issue with her writing				
		not starting or changing the				
	orders correctly.	The starting or origing the				
	-	same orders more than one				
		got the order correct on				
	several occasions.	got the order confect on				
	several occasions.					
	Interview with the Co	ntracted Registered Nurse				
	on 04/19/21 at 3:00 p					
		ng at the facility for 3 weeks.				
	-one had been working	ng at the lability iol 3 weeks.	1			[

Division of Health Service Regulation

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Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					F	₹
		HAL034150	B. WING		04/2	20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 ME	ADOWBROOK N	MALL COURT		
	T CELIMINIONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 59	D 358			
	-She was contracted	to assist with reviewing				
		s, and auditing records.				
		ole to complete chart audits				
	because she was tryi	ng to catch up on residents'				
		Health Professional Support				
	evaluations.	4				
	orders on the residen	I was responsible to enter				
		tem to audit the medication				
	-	MM for accuracy on a				
	routine basis.	•				
		t of staffing changes within				
	the last 3 months, inc	•				
	Resident Care Direct	or.				
		t #4's current FL2 dated				
	02/14/20 revealed dia	_				
	documented on the F	L2.				
	Review of Resident #	4's previous FL2 dated				
	11/26/18 revealed dia	S .				
		onic pain syndrome, muscle				
	weakness, major dep					
	obstructive pulmonar	nxiety disorder, and chronic				
	obstructive pullionar	y disease (OOI D).				
	a. Review of Residen	t #4's FL2 dated 02/14/20				
	• • •	's orders dated 12/22/20				
		n order for lorazepam 0.5mg				
	,) two times a day, at 2:00				
	pm and 8:00 pm daily	<i>1</i> .				
	Review of Resident #	4's April 2021 Medication				
	Administration Record					
	•	for lorazepam 0.5mg tablet				
		00 pm and daily at 8:00,				
		stration at 2:00 pm and 8:00				
	pm daily.	as documented as				
	-Lorazepam 0.5mg w	สอ นบบนเทษาแบน สิริ	1			

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administered 2 times a day from 04/01/21 to

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING:		R	
		HAL034150	B. WING		04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE IVY AT CLEMMONS 6010 MEAD			OOWBROOK N	IALL COURT	
		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	e 60	D 358		
D 358	04/09/21Lorazepam 0.5mg w administered (initials MAR) beginning 04/1 2:00 pmThere were 19 doses documented as not at to 04/19/21Documentation revier revealed documentation revier reason for not adminitials reason for not adminitials reason so lorazepam per documentation or included: "needs reor "awaiting pharmacy" "	as documented as not circled on the front of the 0/21 through 04/19/21 at a of lorazepam 0.5mg dministered from 04/10/21 wed on the back of the MAR fon was not complete for the stering lorazepam 0.5mg for were circled each day. 0.5mg was not administered in the back of the MAR der" on 04/16/21 at 2:00 pm, on 04/16/21 at 8:00 pm, on 04/18/21 at 2:00 pm, on 04/18/21 at 2:00 pm, on 04/19/21 at 2:00 pm. 4's controlled substance along with controlled the facility with tracking crolled substance revealed: t CSCS for lorazepam eview. For lorazepam 0.5mg ensed on 03/05/21, received functions to take one tablet daily at 8:00 pm. with a medication technician cted pharmacy on 04/20/21 in the state of the state of the state on 03/05/21 for a with instructions to take one	D 358		
	lorazepam 0.5mg tab quantity of 60 tablets tablet daily at 2:00 pn	lets on 03/05/21 for a			

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lorazepam 0.5mg sent on 03/05/21.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
ANDILAN	AN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		GOIVII LETED
					R
		HAL034150	B. WING		04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		6010 MEA	DOWBROOK N	IALL COURT	
THE IVY AT CLEMMONS CLEMMO			NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETE
				DEFICIENCY)	
D 358	Continued From page	e 61	D 358		
	to refill lorazepam 0.5 refill the medication wannerment on 04/19/21 from Resprovider (PCP). Telephone interview would be solded at 12:51 pm she did not know Relorazepam 0.5mg for Resident #4 took lora associated with COPI The facility should coar esident was out of emailing her to let her she wanted resident hand for administration were ordered.	lent #4 needed a new order img tablet when a request to was sent to the pharmacy. It order for lorazepam 0.5mg by prior to an order received sident #4's primary care with Resident #4's PCP on revealed: It is ident #4 was out of 9 days. It is i			
	Interview with the cur (MM) on 04/19/21 at 3 -The facility was on a contracted pharmacy refilled a month suppl medications automati -Not all medications w -Narcotic medications most controlled medicand had to be reorder or faxing refill/reorder	cycle refill from the meaning the pharmacy y of residents' maintenance cally. vere on cycle fill. s, topical medications, and cations were not cycle fill red by calling the pharmacy			
	from the pharmacyShe did not know Re	sident #4 was not receiving			

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 62 of 132

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_	
	HAL034150 B. WING 04		04/2	R 20/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE		
		6010 MEA	DOWBROOK M	ALL COURT		
THE IVY A	AT CLEMMONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 62	D 358			
	lorazepam 0.5mg twiddays.	ce daily for more than 9				
	4:00 pm revealed: -The MAs were told be Manager (MM) not to pharmacy for medicar for administrationThe MAs were supposed when a resident did not maintenance medical medication orderThe MA had informe once in the past week Resident #4 did not he available for administ Interview with Reside pm revealed: -She had been out of several daysShe took lorazepam from the lack of being to her COPDHer shortness of bre anxious and her being more rapid and fueled. Telephone interview word/20/21 at 12:35 pm	ont #4 on 04/19/21 at 4:40 lorazepam 0.5mg for 0.5mg to help with anxiety gable to breath normally due ath caused her to be g anxious made her breath d her shortness of breath.				
	residents ran out of m -The current MM star been staffing medical decreased her ability and residents' records not available for admi	nedication. ted on 03/22/21 and had tion carts a lot of shifts which to audit medication carts s for medications that were				

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to ensure residents had medications available to

STATE FORM 6899 YYKO11 If continuation sheet 63 of 132

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY LETED	
7.110 1 2.11 0	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _			
		HAL034150	B. WING		I	R 20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMMONS			ADOWBROOK N ONS, NC 27012	MALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	residents electronical pharmacy. -The facility had been came early March 202 medication outages. b. Review of Resident orders dated 10/06/20 there was an order for acid reflux and hearth tablet two times a day. Review of Resident #Administration Record -There was an entry for take one-half tablet two administration at 6:300 -Famotidine 40mg was administered 2 times 04/17/21. -There were 3 doses documented as not account on the front of the MA and 4:30 pm, and on -There was no documented as not account famotidine 40mg was back of the MAR. Observation of medical administration on 04/2 there was no famotidine available for administror in the facility's over	dered medications for ly to the contracted working hard since she 21 to decrease residents' t #4's signed physician's 0 and 12/22/20 revealed r famotidine (used to treat burn) 40mg one-half (0.5) 4's April 2021 Medication d (MAR) revealed: for famotidine 40mg tablet wice a day scheduled for 0 am and 4:30 pm daily. It is documented as a day from 04/01/21 to of famotidine 40mg dministered (initials circled uR) on 04/18/21 at 6:30 am 04/19/21 at 6:30 am. Inentation for the reason not administered on the ation on hand for 19/21 at 10:00 am revealed fine 40mg for Resident #4 ration on the medication cart restock medications. With a medication technician ceted pharmacy on 04/20/21 is increased.	D 358			

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Division of Health Service Regulation

A. BUILDING:	
	R
HAL034150 B. WING	04/20/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE IVY AT CLEMMONS 6010 MEADOWBROOK MALL COURT	
CLEMMONS, NC 27012	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD TAGE CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD TAGE T	D BE COMPLETE
D 358 Continued From page 64 D 358	
famotidine 40mg on 02/10/21 for a quantity of 15 tablets (30 doses) with instructions for take one-half tablet twice a day. -On 03/10/21, the pharmacy again dispensed a quantity of 15 tablets (30 doses) with instructions for take one-half tablet twice a day. -The facility had a cycle fill for routine medications. -The cycle fill was delivered in the evening on 04/16/21 but Resident #4 did not receive a refill on famotidine 40mg tablets because there were no refills remaining. Interview with a MA on 04/19/21 at 4:00 pm revealed: -The MAs were told by the former Medication Manager (MM) not to contact the PCP or call the pharmacy for medications that were not available for administration. -The MAs were supposed to tell the former MM when a resident did not receive a cycle filled maintenance medication or needed a controlled medication order. -The MA did not know Resident #4 was out of famotidine 40mg because it was administered by third shift and she worked first shift. Interview with Resident #4 on 04/19/21 at 4:40 pm revealed: -She had been out of famotidine 40mg for two days. -She took her stomach pill (famotidine 40mg) because it helped with acid reflux and indigestion from her hiatal hernia. -She had a lot of heartburn and pain when she did not take the medication. -She asked the staff for a dose of an antacid she had on her "as needed" orders to help with the	

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STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL034150	B. WING		R 04/20/202	1
THE IVY AT CLEMMONS 6010 MEAU			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 COM	X5) IPLETE ATE
D 358	Telephone interview v 04/20/21 at 12:35 pm -The MAs should be oresidents ran out of m -The current MM start staffing medication ca decreased her ability and residents' records not available for admit -The MAs and the MM to ensure residents has be administered as or -The facility's PCP or residents electronical pharmacyThe facility had been came early March 200 medication outages. c. Review of Resident orders dated 10/06/20 there was an order for major depression disc mood. Review of Resident # revealed there was no mirtazapine 30mg ava Review of Resident # 2021 Medication Adm revealed: -There was an entry f scheduled for adminis -There was a handwr mirtazapine 30mg dat documentation section	with the Administrator on revealed: ordering medications before nedication. Ited 03/22/21 and had been arts a lot of shifts which to audit medication carts is for medications that were inistration. If should be communicating and medications available to ordered. It dered medications for ly to the contracted in working hard since she can to decrease residents. If #4's signed physician's of and 12/22/20 revealed or mirtazapine (used to treat order) 30mg at bedtime for the working hard since she concern to discontinue allable for review. 4's medication orders or order to discontinue allable for review. 4's pre-printed January sinistration Record (MAR) for mirtazapine 30mg stration at 8:00 pm daily. Iten entry to stop ted 01/06/21 written on the mof the MAR. Entry for mirtazapine 30mg	D 358			

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DIVISION	n Health Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		1181 004450	B. WING		R
		HAL034150			04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
	6010 MEA		ADOWBROOK N	MALL COURT	
THE IVY A	T CLEMMONS		NS, NC 27012	MALL GOOK!	
			NS, NC 27012		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(- /
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	l l
1710		,	1,7,0	DEFICIENCY)	
			+		
D 358	Continued From page	e 66	D 358		
	Review of Resident #	4's pre-printed February			
	2021, March 2021, ar				
	revealed:	Id April 2021 MAIX			
		as not listed on the MAR for			
	administration.	as not listed on the MAR for			
		nentation for administration			
	of mirtazapine 30mg.	ientation for administration			
	or mirtazapine sorng.				
	Interview with the Me	dication Manager (MM) on			
	04/16/21 at 9:50 am r	• ,			
	-She had been working				
	03/22/21 as the MM.	ig at the facility since			
		orders on the residents'			
		nacy had a chance to place			
		to be sent out at the first of			
	each month.	to be come out at the mot of			
		ystem in place to routinely			
		dministration because she			
		current position for less than			
		en a medication aide (MA)			
	prior to being asked to	, ,			
		for ensuring all medications			
		nd for auditing MARs to			
	•	vere being administered as			
		not had a chance to audit			
	MAR's.	not had a chance to addit			
	-There had been a lot	t of MA turnover			
		g as a MA to fill call outs for			
	the last 2 weeks.	g as a wire to fin ban bats for			
	the last 2 wooks.				
	Interview with the Adr	ministrator on 04/19/21 at			
	11:27 am revealed:				
		nedications unless she had			
		ation cart when a MA called			
	out.	and it wilder a life todalled			
	-All medications go th	arough the MM			
		sible for faxing all new			
		ed pharmacy and writing all			
	new orders on the MA	· · · · · · · · · · · · · · · · · · ·			
	5.45.6 611 616 141/		1	1	

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-The MM followed up to ensure medications were

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Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED	
			A. BUILDING:			
		HAL034150	B. WING		04	R / 20/2021
		070557.40		TE 710 0005	•	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
THE IVY A	T CLEMMONS		NDOWBROOK N	IALL COURT		
		СLЕММО	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 67	D 358			
D 358	in the building to be a -The MM and a MA hat the end of the monensure the orders we -She did not know if the reviewed prior to bein cartsShe expected medicordered. Telephone interview whealth Provider (MHF revealed: -His last documented 03/12/21He was able to view his visits but not all the Head not discontin mirtazapine 30mg accommedication review on -Resident #4 should but at bedtime each night.	dministered. ad been checking the MARs th for the next month to re correct. he MARs for April 2021 were g placed on the medication ations to be administered as with Resident #4's Mental P) on 04/19/21 at 3:06 pm visit with Resident #4 was residents' MARs on some of e visits. ued Resident #4's cording to his last 03/12/21. be taking mirtazapine 30mg i. ongoing problem with	D 358			
	residents receiving m ordered due to facility	edications that he had or pharmacy issues.				
	at the facility's contrar at 10:12 am revealed -The last documented 30mg for Resident #4 from the facility's prev that was now part of t pharmacy. -The transition from the current pharmacy was records and signed pl	d dispensing for mirtazapine was 12/13/20 for 30 doses vious contracted pharmacy the current contracted the previous pharmacy to the s done from pharmacy thysicians's orders between				
	November 2020 and larger there were a few ins	December 2020. stances when medications				

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needed to be corrected on the MARs after

STATE FORM 6899 YYKO11 If continuation sheet 68 of 132

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
HAL034150		B. WING		04/2	0/2021	
	ROVIDER OR SUPPLIER	STREET ADD	PRESS, CITY, STA Dowbrook M Is, NC 27012		, , ,	
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	have mirtazapine 30n medications. -The signed physiciar not have mirtazapine pharmacy would have medication on the present pharmacy would have medication on the present pharmacy by the state of the pharmacy by the state pharmacy and state pharmacy by the state pharmacy and state pharmacy by the state pharmacy and state pharmacy by the state pharmacy	th medication profile did not anglisted as one of the or sorder at the pharmacy did 30mg listed, therefore the enot included the exprinted MARs. To documentation of an order apine 30mg was ever sent to facility. The signed physician's of an order and the second of t	D 358			

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STATE FORM 6899 YYKO11 If continuation sheet 69 of 132

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	1	
		HAL034150	B. WING		1	0/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
	T OLEMNONO	6010 MEA	DOWBROOK N	IALL COURT			
I HE IV I A	AT CLEMMONS	CLEMMON	IS, NC 27012				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 358	Continued From page	69	D 358				
	04/16/21 at 9:50 am r -She had been workir 03/22/21 as the MMShe entered all new MAR until the pharma the order on the MAR each monthShe did not have a s monitor medication ac had only been at the a month, and had bee prior to being asked to -She was responsible were in the building a ensure medications w ordered, but she had MAR'sThere had been a lot	orders on the residents' acy had a chance to place to be sent out at the first of system in place to routinely dministration because she current position for less than en a medication aide (MA) to be the MM. For ensuring all medications and for auditing MARs to were being administered as not had a chance to audit					
	Interview with the Administrator on 04/19/21 at 11:27 am revealed: -She did not handle medications unless she had to fill in on the medication cart when a MA called outAll medications go through the MMThe MM was responsible for faxing all new orders to the contracted pharmacy and writing all new orders on the MARsThe MM followed up to ensure medications were in the building to be administeredThe MM and a MA had been checking the MARs at the end of the month for the next month to ensure the orders were correctShe did not know if the MARs for April 2021 were reviewed prior to being placed on the medication carts						

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-She expected medications to be administered as

STATE FORM 6899 YYKO11 If continuation sheet 70 of 132

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Division of Health Service Regulation		ialion			1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					ا ہ	
		1101 024450	B. WING		R	V0004
		HAL034150	J		04/20)/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
		6010 MEA	DOWBROOK N	IALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012			
	OLIMANA DV OT		<u> </u>	DDO//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	I	(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	I	DATE
				DEFICIENCY)		
D 250	0	. 70	D 358			
D 358	Continued From page	e 70	D 358			
	ordered.					
	Telephone interview v	vith Resident #4's Mental				
	•	P) on 04/19/21 at 2:43 pm				
	revealed:	,				
	-His last documented	encounter with Resident #4				
	was on 03/12/21.					
		residents' MARs on some of				
	his visit and not on ot					
		ued Resident #4's melatonin				
		s last medication review on				
	03/12/21.					
		pe taking melatonin 10mg at				
	bedtime each night.	3				
	-There had been an o	ongoing problem with				
		edications that he had				
	ordered due to facility					
	,	p,				
	Telephone interview v	vith a medication technician				
		cted pharmacy on 04/20/21				
	at 10:12 am revealed	· · · · · · · · · · · · · · · · · · ·				
		d dispensing for melatonin				
		was 12/13/20 for 30 doses				
		vious contracted pharmacy				
	that was now part of t					
	•	cation was documented as				
	returned.					
		ne previous pharmacy to the				
		s done from pharmacy				
		hysicians's orders between				
	November 2020 and					
		stances when medications				
	needed to be correcte					
	transition.					
		t medication profile did not				
	have melatonin 10mg					
	medications.	, 110,000 00 010 01 010				
		he facility a cycle fill list				
		before the medications were				
	processed with the m					
	Processed with the III	orieny cycle IIII.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		_	
	HAL034150 B. WING		R 04/20/2021	1		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE NAV A	T OI EMMONIC	6010 MEA	DOWBROOK N	IALL COURT		
INE IV I A	T CLEMMONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COM	(5) PLETE ATE
D 358	Continued From page	÷ 71	D 358			
	-Review of Resident # revealed the facility m "discontinued" with the authorizationThe pharmacy had nodiscontinue melatoning pharmacy by the facilitie. Review of Resident orders dated 10/06/20 order for Vitamin B-12 deficiency of Vitamin. Review of Resident # revealed there was not vitamin B 12 1000mc. Review of Resident # 2020 Medication Admirevealed: -There was an no ent 1000mcgThere was a handwritamin B-12 1000mcg. Review of Resident # 2021 MAR revealed: -There was an no ent 1000mcg.	#4's cycle fill authorizations narked melatonin 10mg as e December 2020 cycle fill o documentation an order to a 10mg was ever sent to the ity. It #4's signed physician's orevealed there was an 2 1000mcg (used to treat a B 12) once daily. It's medication orders order to discontinue gravailable for review. It's pre-printed December sinistration Record (MAR) It's pre-printed December sinistration Record (MAR) It's pre-printed December sinistration Record (MAR) It's pre-printed January It's pre-printed January				
		4's pre-printed February				

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-Vitamin B-12 1000mcg was not listed on the

STATE FORM 6899 YYKO11 If continuation sheet 72 of 132

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLET	
			71. BOILBING.		R	
		HAL034150	B. WING		04/20	/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMMONS			DOWBROOK N	IALL COURT		
040.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	NS, NC 27012	PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 72	D 358			
	MAR for administrational articles and the communication of the communica	tion for the administration of				
	04/16/21 at 9:50 am r	- : :: - :: -				
	-She had been working 03/22/21 as the MM.					
	-She did not have a system in place to routinely monitor medication administration because she had only been at the current position for less than					
	prior to being asked to	en a medication aide (MA) o be the MM. e for ensuring all medications				
	were in the building a ensure medications w	nd for auditing MARs to vere being administered as not had a chance to audit				
	MAR's.	not had a chance to addit				
		esident #4's Vitamin B-12 ng administered as ordered.				
	11:27 am revealed:	ministrator on 04/19/21 at				
		nedications unless she had ation cart when a MA called				
	-All medications go th -The MM followed up in the building to be a	to ensure medications were				
	-The MM and a MA h	ad been checking the MARs th for the next month to				
		ations to be administered as				
	Care Provider (PCP) revealed:	with Resident #4's Primary on 04/19/21 at 12:51 pm og was still listed on her				

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current list of medications for Resident #4.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLE	
	Į		A. DOILDING		 R	,
		HAL034150	B. WING		1	0/2021
NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	AT CLEMMONS	6010 MEAD	OWBROOK M	IALL COURT		
	TI OLLIMINONO	CLEMMON	S, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	73	D 358			
	for Resident #4. -The physician's orde 2020 should have list as a current medication. The current contracted supplying medications merging with the prevunderstanding. -She had several residence from the MAI which she and the factorrect. -Apparently, Resident was one of the medication from the previous facibut then did not appeadue to turnover with significant manager position, and overlooked.	ed pharmacy had started s in December 2020 after vious pharmacy was her deents with medications that R or physician's orders cility had been working to t #4's Vitamin B-12 1000mcg rations that was on the MAR defility and being administered ar on the February 2021 and staff in the medication d nursing positions was				
	pharmacy to restart the Telephone interview wat the facility's contract at 10:12 am revealed: -Vitamin B-12 1000mc fill monthly on 11/13/2 tablet daily and a quaturbe last documented B-12 1000mcg for Re 30 tabletsThe transition from the current pharmacy was records and signed pl November 2020 and I	cg was dispensed on cycle 20 and 12/13/20 for one antity of 30 tablets. It dispensing for Vitamin esident #4 was 01/11/21 for the previous pharmacy to the s done from pharmacy hysicians's orders between December 2020.				

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-Resident #4's current medication profile did not

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL034150	B. WING		04/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMMONS			ADOWBROOK M NS, NC 27012	IALL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETE	
iAG		,	IAG	DEFICIENCY)		
D 358	Continued From page	e 74	D 358			
	have Vitamin B-12 10 medications. -The pharmacy sent to monthly for approval processed with the management of the processed with the management of the pharmacy of the pharmacy had not be pharmacy by the sentence of the pharmacy by the sentence of the pharmacy of the ph	the facility a cycle fill list before the medications were onthly cycle fill. #4's cycle fill authorizations marked Vitamin B-12 mued" with the February zation. To documentation an order to B-12 1000mcg was ever sent me facility. It #1's current FL2 dated agnoses included stroke, constipation, chronic y disease, gastroesophageal				
	•	once daily (used to treat ly at 8:00 pm. dated 03/25/21 to 100mg at 8:00 pm.				
	instructions to discon	tinue Lamictal 100mg and 100mg one and one-half				
	administration record -There was an entry f scheduled for adminis -There was documen 8:00 pm was adminis	or Lamictal 100mg				

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DIVISION C	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			5 14/11/0		R	
		HAL034150	B. WING		04/2	0/2021
NAME OF DE	ROVIDER OR SUPPLIER	STDEET AI	DDRESS, CITY, STA	ATE ZIR CODE		
INAIVIL OI 11	TOVIDER OR SOLI LILIT					
THE IVY A	T CLEMMONS		ADOWBROOK N	MALL COURT		
		CLEMMO	NS, NC 27012			
(X4) ID	SUMMARY ST.	ATEMENT 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
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	- 75	D 358			
2 000		<i>513</i>	5 000			ı .
ļ	Review of Resident #	1's April 2021 MAR			ļ	ı .
	revealed:	·				ı .
		ritten entry for Lamictal				ı !
		tablet) daily scheduled for				ı .
	administration at 8:00					ı .
						ı
ļ		tation Lamictal 150mg was			ļ	ı .
		am from 04/10/21 through				ı .
	04/18/21.					ı
ļ	1	for Lamictal 25mg take one			ļ	ı
ļ		n with 100mg to equal			ļ	ı
ļ		administration at 8:00 am.			ļ	ı
	-There was documen	tation Lamictal 125mg was				ı
		am from 04/01/21 through				ı
		edication was discontinued				ı
	on 04/08/21.					ı
		for Lamictal 100mg at				ı
		or administration at 8:00 pm.				ı
		•				ı
		tation Lamictal 100mg was				ı
		pm after the medication was				ı
	discontinued on 03/25					ı
		:00 pm was documented as				ı
		/01/21 through 04/18/21.				ı
		ımentation Resident #1 was				ı
	administered 225mg	of Lamictal daily from				ı
	04/01/21 through 04/	10/21, which was not the				ı
ļ	correct ordered dose.				ļ	ı
	-Resident #1 was adr	ministered 275mg of				ı
		4/10/21 through 04/18/21,				ı
ļ	which was not the co				ļ	ı
ļ		11000 5. 25. 55. 25. 25.			ļ	ı
	Observation of Resid	ent #1's medications on				ı
	hand at the facility on					1
		o Lamictal available for				1
	administration.	D Lamiciai avallable ioi				I
	aummistration.					I
						ı
		ent #1 on 04/19/21 at 11:27				ı
	am revealed:					1
		hat her medications looked				1
	lika					

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-She knew when she was administered Lamictal.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	` ′	CONSTRUCTION	(X3) DATE S	
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			B WING		I	₹
		HAL034150	B. WING		04/2	20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 ME	ADOWBROOK M	IALL COURT		
11121417	ar occumiono	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 76	D 358			
	Last week the medic	ation aide (MA) started to				
		g of Lamictal in the morning				
	and 100mg of Lamict	-				
		o administer the medication				
	as ordered.					
	-This morning, she wa	as not administered Lamictal				
	_	she was out of Lamictal.				
	-She did not think tha	t she should be out of the				
		she just got a new order two				
	weeks ago.					
	Interview with the MA	on 04/19/21 at 3:15 pm				
	revealed:					
	-She administered Re	esident #1's Lamictal as				
	documented on the M					
		esident #1 Lamictal 150mg				
	plus 25mg of Lamicta					
	-She did not see Res orders.	ident #1's medication				
		ager (MM) was responsible				
	for making sure medi- were accurate.	cation orders on the MAR				
		cted by the Administrator				
		y Care Providers (PCP)				
		stration of medications.				
	-The MM was respon	sible for contacting the PCP.				
		nd MA on 04/19/21 at 4:15				
	pm revealed:	ocident #1 Lemietal 100mg				
		esident #1 Lamictal 100mg t was documented on the				
	MAR.	was documented on the				
	-She did not see the	resident's orders				
	-The MM was respon					
	I	the MAR were accurate.				
	Interview with the MM revealed:	1 on 04/19/21 at 4:50 pm				
		for ensuring orders on the				

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MAR was accurate.

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Division of	<u>of Health Service Regu</u>	llation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			_		_	_
			B. WING		F	
		HAL034150	B. WING		04/2	20/2021
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			
			<u>, </u>			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 358	Continued From page	e 77	D 358			
	-She had worked in th	he MM position for two or				
	three weeks and did r					
	independently check					
		e for contacting the PCP to				
	clarify medication ord					
	•	#1's order for Lamictal				
		but she did not contact the				
	•					
		ne Lamictal 25mg in am or				
	the 100mg of Lamicta	arin the pm should be				
	administered.	tal 450mm was delivered				
		tal 150mg was delivered				
	-	n the 3rd shift on 04/16/21.				
		the weekend, and the MA				
	•	the medication delivery tote				
	for Resident #1's Lam	nictai.				
	T					
		with a representative at the				
	· ·	harmacy on 04/20/21 at				
	11:32 am revealed:					
		armacy received an order				
		nictal 100mg at 8:00 pm.				
		t order for Lamictal was				
		, which increased Lamictal				
		50mg once daily in the am.				
	_	filled on 04/10/21 and 9				
	tablets were dispense					
	resident until the facil	ity's cycle fill date on				
	04/16/21.					
	•	armacy dispensed 30 tablets				
	of 150mg of Lamictal.	•				
		ntract Registered Nurse on				
	04/19/21 at 3:00 pm r					
	-She was contracted					
	-	nedications, and auditing				
	records.					
	_	ons she had not been able				
	to audit Resident #1's					
		the facility did not have a				
	system in place to en	sure the MM accurately				

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DIVISION	n Health Service Negu	ı				
	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		l l	20/2021
NAME OF D		OTDEET AS	NDESS CITY CTA	TE ZID CODE	, ,	
NAIVIE OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
THE IVY A	T CLEMMONS		ADOWBROOK N	MALL GOURT		
		ССЕММО	NS, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE		DATE
				DEFICIENCY)		
D 358	Continued From page	78	D 358			
D 330	. •		B 330			
	documented medicati	ions on the MARs.				
	Telephone interview v	with Resident #1's Mental				
		P) on 04/20/21 at 1:50 pm				
	revealed.					
		continued Lamictal 100mg at				
	bedtime and continue	•				
		ontinued all Resident #1's				
	•	e am and ordered Lamictal				
	150mg once daily.	A Landada Labarda ba				
	-For therapeutic effect					
	•	and not suddenly increased. tered 275mg of Lamictal				
	-	ual increase the biggest risk				
	to the resident would					
		ave contacted him to clarify				
	the order before admi	inistering 275mg of the				
	medication.	d wat ha alaw willy atamaad				
		d not be abruptly stopped. e medication without a				
		dosage could cause seizure				
	activity.	losage could cause seizure				
	•	with the Administrator on				
	04/20/21 at 2:17 pm r	evealed: sible for auditing the MARs				
		ations were administered as				
	ordered.	adono woro administrate do				
		M to contact the resident's				
		ure how an order should be				
	administered.					
	-The MM should have	e noticed the entries for				
	Lamictal on the MAR					
	pharmacy or the MHF administered.	before the medication was				
	-She did not know Re	esident #1 was not				
	administered Lamicta	ll this morning.				
	-When medications w	vere received, they were				
	checked in by the MM	If or the MA on duty on the				

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third shift.

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL034150	B. WING		04/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
THE IVY AT CLEMMONS			ADOWBROOK N	IALL COURT		
	CLIMMADY CT		ONS, NC 27012	DROWDERIC DLANLOS CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 79	D 358			
		nedications were ordered nt was without medication.				
	•					
		t #1's physician's orders n order dated 04/06/21 to				
	discontinue Xarelto o	nce daily (anticoagulant				
	used to thin the blood at bedtime (used to the	l) and to start aspirin 81mg				
	at bedfine (daed to ti	in the blood).				
	Review of Resident #1's April 2021 medication administration record (MAR) revealed:					
		for Xarelto once daily which				
	had been discontinue	ed on 04/06/21.				
	 There was an entry f for administration at 8 	for aspirin 81mg scheduled 3:00 pm.				
	-The medication aide	's (MA) initials were circled				
	from 04/08/21 through	h 04/18/21. nentation on the MAR why				
	the MA initials were c	<u> </u>				
		ent #1's medications on				
	hand at the facility on	04/19/21 at 3:01 pm g was not available for				
	administration.	y was not available for				
	Interview with Reside am revealed:	nt #1 on 04/19/21 at 11:27				
	-She previously had a	a blood clot in her lungs and				
	was ordered Xarelto.	nable to recall the exact				
	- ,	extraction with significant				
	bleeding that caused					
	 After the hospital vis one and one-half mor 	it, she refused Xarelto for nths.				
	-In April 2021, she as	ked her Primary Care				
	Provider (PCP) about -The PCP ordered as					
		04/19/21), she had not				
	received aspirin 81mg					

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 80 of 132

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL034150	B. WING		04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		ADOWBROOK N	IALL COURT	
040.45	CHIMMADV CT	ATEMENT OF DEFICIENCIES	ONS, NC 27012	DROVIDER'S DLANLOF CORRECTION	1 075
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 80	D 358		
	Telephone interview of facility's contracted pheed 11:32 am revealed: -The pharmacy did not 81mg for Resident #1 -The pharmacy still she medication and was rediscontinued. Interview with the meed 19/21 at 3:15 pm rediscontinued. Interview with the meed 19/21 at 3:15 pm rediscontinued 19/21 at 4:50 pm rediscontinu	with a representative at the narmacy on 04/20/21 at of have an order for aspirin anowed Xarelto as an active not aware Xarelto had been dication aide (MA) on evealed: inted on Resident #1's MAR as never received at the etimes order lications but she was not an edication manager (MM) do not have aspirin. The 24-hour shift reports ave aspirin 81mg available ports were given to the ay. Indication manager (MM) on evealed: some of her medications. In the 1 had ordered aspirin the 2 had ordered aspirin the 2 had ordered aspirin the 3 had ordered aspirin the 2 had ordered aspirin the 3 had ordered aspirin the 2 had ordered aspirin the 2 had ordered aspirin the 3 had			
		vith Resident #1's Primary			

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care Provider (PCP) on 04/16/21 at 2:53 pm

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL034150	B. WING		04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
THE IVY AT CLEMMONS 6010 MEA			ADOWBROOK N	MALL COURT	
	TO CELIMINO NO	CLEMMO	ONS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 81	D 358		
	revealed:				
	-Resident #1 had a hi	istory of pulmonary			
	embolism and was or				
	-On 04/09/21, she dis	scontinued Xarelto and			
		aspirin 81mg at bedtime.			
	-She was not aware F				
	administered the aspi	ry every Tuesday, so if the			
		etting Resident #1's aspirin			
	someone should have				
	•	ation to be administered as			
	ordered.				
		I not miss more than one efore she was contacted.			
		ions, she had told facility			
		when there was a problem			
	getting medication for	•			
	c. Review of Residen	t #1's current FL2 dated			
	08/12/20 revealed the				
	promethazine 25mg o				
	-	one tablet every six hours as			
	needed for nausea (u	ised to treat riausea).			
	Review of Resident #	1's April 2021 medication			
	administration record	(MAR) revealed:			
		or promethazine 25mg daily			
	scheduled for adminis				
		for promethazine 25mg			
	every six hours as ne	tation with staff circled			
		through 04/15/21 and			
	documented on the b				
	promethazine not ava	ailable - awaiting pharmacy."			
	Observation of Resid	ent #1's medications on			
	hand on 04/15/21 at 9				
	promethazine 25mg v	was not available for			
	administration.		1		

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 82 of 132

Division c	<u>of Health Service Regu</u>	ılation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		_
			D WING		R
		HAL034150	B. WING		04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	
			ADOWBROOK M		
THE IVY A	T CLEMMONS			MALL COOK!	
			ONS, NC 27012		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(- /
PREFIX	· · · · · · · · · · · · · · · · · · ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
TAG		EGO IDEIVIII TIIVO IIVI ORVINATION)	TAG	DEFICIENCY)	WAIL
				, , , , , , , , , , , , , , , , , , ,	
D 358	Continued From page	e 82	D 358		
		ent #1 on 04/15/21 at 9:24			
	am revealed:				
		f her promethazine for 12			
ļ	days.				
	-She previously had o	cancer and received			
ļ	treatments that made	e her sick and nauseated.			
	-Although the cancer	was in remission, she still			
	experienced a lot of r	nausea.			
	-It was important that				
		p from being nauseated.			
ļ		on the stomach ever since			
	the medication was o				
		ut.			
	Interview with the me	edication aide (MA) on			
	04/15/21 at 8:38 am r	` ,			
		en out of promethazine 25mg			
	for almost ten days.	-f disations was a			
		of medications was a			
	continual problem at				
		wed to call the pharmacy to			
	follow up on medicati				
	• • • • • • • • • • • • • • • • • • • •	osed to tell the MM that a			
		en there was between 5 and			
	10 doses remaining.				
		ad informed the MAs to let			
	the medication manage	ger (MM) know when a			
	resident's medication	needed to be refilled.			
	-The MM was respon	sible for contacting the			
	pharmacy to reorder	medications.			
	-She had made the M	/IM and the Administrator			
	aware that Resident #	#1 was still out of the			
	promethazine.				
	Interview with the MN	√l on 04/15/21 at 9:32 am			
	revealed:	1 011 0 17 10/21 at 0.02 att			
	-Her role was to chec	k medications on the			
	medication cart.	inedications on the			
		liantianaana admainiatanad			
J.	Sne made sure med	lications were administered	I		

as ordered.

-She notified the pharmacy of medication refills.

STATE FORM 6899 YYKO11 If continuation sheet 83 of 132

	on				
	1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	∄D
				R	
	HAL034150	B. WING		04/20/2	2021
NAME OF PROVIDED OR OVERLYED	070557.44		T. TID 00DF		
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
THE IVY AT CLEMMONS		ADOWBROOK M	ALL COURT		
	CLEMMO	ONS, NC 27012			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETE DATE
D 358 Continued From page 83	3	D 358			
the pharmacy if there was available. -She did not know Resid promethazineIf there was a problem of MA should have made her lift the resident's Primary needed to be contacted a contacting the PCP. Interview with Resident # 2:53 pm revealed: -Resident #1 had chronic previous cancer treatments. She ordered Resident # scheduled daily in the mere every six hoursShe expected Resident administered as ordered -On Tuesday, 04/13/21, a Resident #1 that the resi promethazine for almost -She was in the facility wher aware Resident #1 who promethazineShe wanted to be notified getting medications for her the pharmacy received resident.	o order medications from as a prescription lent #1 was still out of getting the medication the er aware. Care Provider (PCP) she was responsible for #1's PCP on 04/16/21 c nausea as a result of nt. If promethazine 25mg orning and as needed #1's medications to be she found out from ident had been without two weeks. I weekly, and no one made was not administered ed if there was a problem her residents. In a repreentative from the macy on 04/20/21 at an order on 01/21/21 for zine 25mg once daily and				

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-On 01/25/21, the pharmacy dispensed 150

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SUR	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLET	ED
	HAL034150	B. WING		R 04/20/	/2024
				1 04/20/	2021
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	•		
THE IVY AT CLEMMONS		DOWBROOK M IS, NC 27012	IALL COURT		
PREFIX (EACH DEFICIENCY	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		D 358			
refill request for prome -The pharmacy denier new prescription was -The pharmacy repres prescription denial to a prescription was denied Telephone interview was out 2:17 pm re -She did not know Re promethazineThe MA should have was out to the MMThe MM was respons residents' medications administrationShe expected all resi in-house and available d. Review of Resident dated 12/22/20 reveal 8.6mg 2 tablets twice constipation). Review of Resident # administration record -There was an entry fo scheduled for adminis pmThere was document (MA) circled initials at 03/26/21 through 03/3	hazine 25mg dated any refills. ility sent the pharmacy a ethazine 25mg. d the request because a needed. sentative faxed a the facility anytime a ed. with the Administrator on evealed: sident #1 was out of reported the medication sible for ensuring that s were available for ident's medications to be e for administration. t #1's physician's order led an order for senokot-s daily (used to treat 1's March 2021 medication (MAR) revealed: or senokot-s 8.6mg stration at 8:00 am and 6:00 tation the medication aide 8:00 am and 6:00 pm 81/21. lation on the back of the				

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Review of Resident #1's April 2021 MAR

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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 04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		ADOWBROOK M	IALL COURT	
	I		NS, 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 85	D 358		
	revealed:				
	revealed: -There was an entry for senokot-s 8.6mg scheduled for administration at 8:00 am and 6:00 pmThere was documentation the MA circled initials at 8:00 am and 6:00 pm from 04/01/21 through				
	04/19/21.				
	-There was documentation on the back of the MAR "awaiting pharmacy - on order." Observation of Resident #1's medications on hand at the facility on 04/19/21 at 3:01 pm revealed senokot-s 8.6mg was not available for administration.				
	Interview with Reside am revealed: -She did not realize the	ent #1 on 04/15/21 at 9:24			
	senokot-s.				
	not being available.	g to her about the senokot-s			
	-She had taken senol due to certain medica sometimes have a dif movements.	<u> </u>			
	-She had been sick o was related to not ge	n the stomach but thought it tting a nausea medication. that her bowel movements			
	were more difficult that	an usual.			
	04/15/21 at 8:38 am r -Resident #1 had bee one month. -She had made the m and the Administrator out of some of her me senokot-s.	dication aide (MA) on revealed: en out of senokot-s for over nedication manager (MM) r aware that Resident #1 was redications, including the Resident #1's senokot-s			

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because the MM was responsible for re-ordering

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					-	,
		1181 004450	B. WING		F	
		HAL034150			04/2	20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		6010 ME	ADOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	, ID	PROVIDER'S PLAN OF CORRECTIO	N.	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	e 86	D 358			
	medications.					
		some of her medications				
	that were less expens					
	-She was not sure if F	Resident #1 ordered the				
	senokot-s.					
	•	sible to ensure medications				
	were available for adı					
		not available the MM was				
		rough to find out why the				
	medication was not a	vailable.				
		1 on 04/19/21 at 4:50 pm				
	revealed:					
	-Her role was to chec					
	medication cart daily.					
		ications were administered				
	as ordered.					
	-	macy of medication refills.				
		d a refill for Resident #1's				
		ne did not know the resident				
	was out of senokot-s.					
	T-1	.::4- D:				
		with Resident #1's PCP on				
	04/16/21 2:53 pm rev					
		ered senokot-s because the				
		several medications that				
	caused constipation.	ations and so do be				
	-She expected medic					
	administered as orde	esident to miss more than				
	one dose of medication					
	one dose of medicalio	JIIS.				
	Telephone interview v	vith a representative from				
		ed pharmacy on 04/20/21 at				
	11:32 am revealed:	a phannady on 07/20/21 at				
		/ed an order for senokot-s				
	8.6mg twice daily on					
		filled on 10/20/20 and a				
	quantity of 120 tablets					
		g was not on automatic refill.				
	- 1116 96110401-9 0.01116	y was not on automatic renil.	- 1			

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 87 of 132

DIVISION	of Health Service Regu	lation			
	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		04/20/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	
	1011211 011 001 1 21211				
THE IVY A	T CLEMMONS		DOWBROOK N	IALL COURT	
		ССЕММО	NS, NC 27012		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	SIATE DATE
D 358	Continued From page 87		D 358		
	-The facility had to ca				
	medication to be refill	ed.			
	-Senokot-s 8.6mg had	d not been filled since			
	10/20/20.				
	Telephone interview v	vith the Administrator on			
	04/20/21 at 2:17 pm r	evealed:			
	-She did not know Re	esident #1 was out of			
	senokot-s.				
	-Resident #1 should r	not be ordering her			
	medications.	3			
		A to inform the MM when a			
	resident had one wee				
		sed to check the medication			
		nedications were available			
	for administration.	ledications were available			
		idental medications to be			
		idents' medications to be			
	available for administ	ration.			
	C Daview of Desider	t #015			
		t #2's current FL2 dated			
		agnoses included bipolar			
	· ·	anxiety, chronic pain, kidney			
		inusitis, chronic obstructive			
	pulmonary disease (C	COPD), and vitamin D			
	deficiency.				
		t #2's current FL2 dated			
	01/19/21 revealed the				
	tramadol 50mg with n	o frequency (used to treat			
	pain).				
	Review of Resident #	2's previous physician's			
	order dated 12/22/20	revealed there was an order			
	for tramadol 50mg 1 t	ablet four times daily.			
	J	•			
	Review of Resident #	2's April 2021 medication			
	administration record				
	-There was an entry f	•			
		···-·	1		1

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scheduled for administration at 8:00 am, 12:00

pm, 4:00 pm, and 8:00 pm.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
			A. BUILDING			_
		HAL034150	B. WING		04/2	20/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY	AT CLEMMONS		DOWBROOK N NS, NC 27012	MALL COURT		
(X4) ID PREFIX TAG	(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)	ULD BE	(X5) COMPLETE DATE
D 358	-There was documen (MA) circled initials of 8:00 pm; on 04/12/21 pm and 8:00 pm, 04/14:00 pm and 8:00 pm 12:00 pm, 4:00 pm, a 04/15/21 at 8:00 am a -There was documen MAR the medication "reordered." Observation of Resid hand on 04/15/21 at 9:00 pm was not available Interview with Reside am revealed: -She had not received. The MA told her they pharmacy to send he -Without tramadol, she she felt shaky and had Telephone interview with facility's contracted 12:01 pm revealed: -Resident #2's tramacrefillThe pharmacy require each refillTramadol 50mg four 03/22/21 and 83 tabled -If tramadol 50mg was the medication would -The facility requesters.	tation the medication aide in 04/11/21 at 4:00 pm and at 8:00 am, 12:00 pm, 4:00 13/21 at 8:00 am, 12:00 pm, and 04/14/21 at 8:00 am and 12:00 pm, and 12:00 pm. tation on the back of the was not administered ent #2's medications on 2:03 am revealed tramadolole for administration. Int #2 on 04/15/21 at 9:15 Ind tramadol in several days. It were waiting for the ramadolole was in so much pain that in a difficult time sleeping. With a representative from and pharmacy on 04/19/21 at dol was not on automatic and a new prescription for times daily was filled on the sets were dispensed. It is administered as ordered, have lasted 20 and ½ days. It is a refill of tramadol 50mg, ause a new prescription was sentative faxed a	D 358	DETIGINATION OF THE PROPERTY O		

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 89 of 132

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL034150	B. WING		04/20/	2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS		DOWBROOK N	IALL COURT		
	CLIMMADY CT		IS, NC 27012	DROVIDERIO DI ANI OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 89	D 358			
	resident's Primary Ca 04/15/21. -The pharmacy filled in dispensed 29 tablets. Telephone interview v 04/16/21 at 2:53 pm r -She did not know Re tramadol 50mg until 0 the pharmacy needed	vith Resident #2's PCP on revealed: esident #2 was out of 04/15/21 when staff told her d a refill request because a				
	new prescription was neededShe called the verbal order directly to the pharmacyShe did not want Resident #2 to be without her medications at a minimum of 24 hours.					
	revealed: -Resident #2 was out -The medication had -She told the medicat Resident #2 out of tra -It was the facility's po when there was at lea leftShe had reminded th out of tramadol daily s	been out for almost 4 days. ion manager (MM) that imadol. blicy to reorder medications ast one week of medications he MM that Resident #2 was since 04/12/21. M about Resident #2 being				
	revealed: -She was responsible had medications avai -She had contacted the refill of Resident #2's	on 04/19/21 at 4:50 pm for ensuring the residents lable for administration. The pharmacy regarding a tramadol but was unable to she contacted the pharmacy.				

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Telephone interview with the Administrator on

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL034150	B. WING		04/2	R 20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
	T CLEMMONS	6010 ME/	ADOWBROOK M	ALL COURT		
	I CELIMINIONS	СЕММО	NS, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page		D 358			
D 358	04/20/21 at 2:17 pm. Resident #2 should it tramadol. She expected the Maa medication was down-The MM should also cart daily to ensure more administration. b. Review of Resident dated 12/24/20 there 5mg three times daily spasms (used to must administration record - There was an entry for daily as needed for more the administered on 04/10. There was no further the administration of the damagnetic of the da	As to let the MM know when wn to a one-week supply. The checking the medication hedications were available of the thick that t	D 358			
		with a representative at the harmacy on 04/19/21 at				

Division of Health Service Regulation

12:01 pm revealed:

STATE FORM 6899 YYKO11 If continuation sheet 91 of 132

Division o	Division of Health Service Regulation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY
						В
		HAL034150	B. WING		l l	R / 20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
THE NOVA	T OL FMMONO	6010 ME <i>F</i>	DOWBROOK N	IALL COURT		
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	91	D 358			
D 3300	-Resident #2's flexeril needed for muscle sp and a quantity of 90 ta-Flexeril 5mg was fille quantity of 90 tablets -The medication was 04/16/21 at 10:43 pm medication aide on do Telephone interview v 04/16/21 at 2:53 pm r -She did not know Reflexeril 5mgWhen she ordered mathem to be administer -Resident #2 should r for more than 24 hour Interview with the MA revealed: -Resident #2's medicareordered when there -She was not sure ab an as-needed medicareordered. Interview with the MM revealed: -The Administrator tol manager (MM) know to be reordered. Interview with the MM revealed: -She was not aware F and it was not adminis-Resident #2's flexeril facility in the medicati after 10:00 pm by the -She usually checked delivered by the pharm	I 5mg three times daily as pasms was filled on 02/27/21 ablets was dispensed. Ed on 04/16/21 and a was dispensed. Idelivered to the facility on and signed for the named uty. With Resident #2's PCP on revealed: Esident #2 had been without medications, she expected red. In ever be without medication rs. A on 04/19/21 at 3:38 pm actions were usually experted because it was action. Id MAs to let the medication when medications needed M on 04/19/21 at 4:50 pm Resident #2 asked for flexerill stered. I 5mg was delivered to the ion tote that was delivered a pharmacy 04/16/21. If in the medications macy.	D 336			
	-When Resident #2's	macy. flexeril was delivered it was day, 04/16/21, and she was				

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off the weekend.

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DIVISION	of Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			-			
			D 14//NO		F	
		HAL034150	B. WING		04/2	20/2021
NAME OF D	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZID CODE		
TV-IVIL OF T	NOVIDEN ON OUT FIEN		, ,	,		
THE IVY A	THE IVY AT CLEMMONS			MALL COURT		
		ССЕММО	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 DATE
TAG	REGULATURY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIE	DATE
D 358	Continued From page	e 92	D 358			
	The MA that receive	d the tote should have				
	opened it and put the	medications on the				
	medication cart.					
	Tolophono intonvious	with the Administrator on				
	04/20/21 at 2:17 pm r	with the Administrator on				
		As to let the MM know when				
		wn to a one-week supply				
	even as-needed med	,				
		have never been denied the				
	administration of flexe					
		e MA on the second received				
	**	and left the medication in				
		put on the medication cart				
	on Monday morning.					
		vere received, she expected				
		heck the tote and put the				
	medications on the m	nedication cart.				
	7 Poviou of Posidon	nt #6's current FL2 dated				
	02/16/21 revealed dia					
		•				
	encephalopathy, diab	• •				
		ognitive impairment, chronic				
		y disease (COPD), coronary				
	,	disease, major depressive				
	disorder, falls, and m	uscie weakness.				
	- Di	+ #01				
		nt #6's current FL2 dated				
	02/16/21 revealed the					
		reat gastroesophageal				
	, •	a day at 6:00 am and 4:30				
	pm.					
	Barden (B. 11 1"	tola Marrala 0004 Marris				
		6's March 2021 Medication				
	Administration record	` ,				
	1	for famotidine 20mg 1 tablet				
		ed for administration at 6:00				
	am and 4:30 pm daily					[
	-Famotidine was not					
	administered (by circl	led initials indicating not				

Division of Health Service Regulation

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DIVISION	n nealth Service Regu	ialion	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						,
		1181 004450	B. WING		F	
		HAL034150	B: Will 5		04/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, 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 PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
D 250	0	- 00	D 358			
D 358	Continued From page	93	D 356			
	administered) 36 of 6	0 opportunities.				
	-There was a docume					
		pharmacy" for 33 of 60				
		and a documented reason				
	of "resident refused" f					
	opportunities.					
	• •					
	Review of Resident #	6's April 2021 MAR				
	revealed:	·				
	-There was an entry f	or famotidine 20mg 1 tablet				
	_	ed for administration at 6:00				
	am and 4:30 pm daily					
	-Famotidine was not o	documented as				
	administered (by circl	ed initials indicating not				
	administered) 15 of 3					
	-There was a docume	ented reason of "drug				
	unavailable/awaiting	pharmacy" for 3 of 60				
	opportunities.	•				
	-There was no docum	nented reason for famotidine				
	not being administere	ed for 12 of 30 missed				
	opportunities.					
	Observation of Reside	ent #6's medications on				
	hand on 04/16/21 at 4	4:30 pm revealed:				
	-There was 1 partially	filled blister packs of				
	famotidine 20mg table	ets with instructions to take				
	1 tablet (20mg) 2 time	es a day at 6:00 am and				
	4:30 pm.					
	-The famotidine had a	a dispense date of 04/06/21.				
	-There were 14 of 60					
	Interview with a medic	cation aide (MA) on				
	04/16/21 at 10:30 am	revealed:				
	-She administered me	edications to Resident #6				
	and circled the dose of	of famotidine several times				
	on Resident #6's Mar	ch and April MAR.				
		MAR meant the medication				
	was not administered					
	-Resident #6 did not h	nave any famotidine for a				

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few weeks because the contracted pharmacy had

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL034150	B. WING		04/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 MEA	ADOWBROOK N	IALL COURT		
	TO CELIMINO NO	CLEMMO	NS, 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	94	D 358			
D 358	not sent any. -She had called the p (she did not document pharmacy), but they famotidine from the corpharmacy), but they famotidine from the corpharmacy), but they famotidine from the corpharmacy (MM) was responsible. The MM was responsible and called in the building and audit medications were administered. She had administered and circled a dose Resident #6's March and circled initials on the was not administered. Resident #6 did not he was not administered. Resident #6 did not he was not administered a refill. -The MAs were supported a refill.	harmacy in March 2021 at when she called the still did not receive any contracted pharmacy. To call the primary care use the Medication Manager the for doing that. Sible for auditing the asure medications were in sing the MARs to ensure all ministered as ordered. Ind MA on 04/19/21 at 10:21 Ind medications to Resident The of famotidine one time on and April MAR. The MAR meant the medication The may any famotidine I not let hospice know the sill on medication when they tablets of any medication. The called the pharmacy) to the called the pharmacy) to the call the primary care the medication Manager the for doing that.	D 358			
	the building and audit medications were adr	ing the MARs to ensure all				

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11:27 am revealed she did not know Resident #6

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVE	.Y
			A. BUILDING: _			
		HAL034150	B. WING		R 04/20/20	24
					04/20/20	21
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
THE IVY A	T CLEMMONS		ADOWBROOK M NS, NC 27012	ALL COURT		
(VA) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTIO	N	(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 APPROP DEFICIENCY)	BE CO	(X5) DMPLETE DATE
D 358	Continued From page 95		D 358			
	had missed 6 doses of famotidine in March 2021 or 15 doses in April 2021.					
	b. Review of Resident #6's current physician's order dated 01/05/21 revealed there was an order for gabapentin (used to treat diabetic neuropathy)					
	Review of Resident #6's March 2021 MAR revealed: -There was an entry for gabapentin 100 mg 1 tablet 3 times daily scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm daily. -Gabapentin was not documented as administered (by circled initials indicating not administered) 27 of 90 opportunities. -There was a documented reason of "drug unavailable/awaiting pharmacy" for 9 of 27 missed opportunities and a documented reason of "resident refused for 3 of 27 opportunities. -There was no documented reason for					
	hand on 04/16/21 at 4 -There was 1 partially gabapentin 100mg ta	filled blister packs of blets with instructions to 3 times a day at 8:00 am, a daily. a dispense date of				
		revealed: edications to Resident #6 of gabapentin several times				

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-Circled initials on the MAR meant the medication

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Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL034150	B. WING		04/20/2021
NAME OF D	20//DED OD 01/DD1/ED	OTREETAN	NDDE00 01TV 0TA	TE 710 000E	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, 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	V (X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 358	Continued From page	06	D 358		
2 000	Continued From page	, 30			
	was not administered				
	-Resident #6 did not h	nave any gabapentin for a			
		he contracted pharmacy had			
	not sent any.	p ,			
		harmacy in March 2021			
	•	nt when she called the			
	,				
		still did not receive any			
	gabapentin from the o				
		to call the primary care			
	. ,	ise the Medication Manager			
	(MM) was responsible				
	-The MM was respon	sible for auditing the			
	medication carts to er	nsure medications were in			
	the building and audit	ing the MARs to ensure all			
	_	ministered as ordered.			
	Interview with a secon	nd MA on 04/19/21 at 10:21			
	am revealed:				
		edications to Resident #6			
		gabapentin on Resident			
		• .			
	#6's March and April				
	-Resident #6 did not I				
		I not let hospice know she			
	needed a refill.				
		osed to let hospice know the			
		ill on medication when they			
	had 8 or 9 remaining	tablets of any medication.			
	-She had called hosp	ice in March 2021 (she did			
	not document when s	he called the pharmacy) to			
	let them know that Re	esident #6 was out of			
	gabapentin.				
	-The MM was respon	sible for auditing the			
	·	nsure medications were in			
		ting the MARs to ensure all			
	_	ning the MARS to ensure all ministered as ordered.			
	medications were aur	iiiiiistereu as Ulueleu.			
	Indometric control of the Control	MA == 04/40/94 =± 40:94 ==			
		MA on 04/19/21 at 10:21 am			
	revealed:				
	-She administered me	edications to Resident #6			

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and circled a dose of gabapentin one time on

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HAL034150 B. WING		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUF COMPLET	
NAME OF PROVIDER OR SUPPLIER THE IVY AT CLEMMONS SUMMARY STATEMENT OF DEFICIENCIES B. WING O4/20/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012 (X5)	7.1101 12.110	or connection	IBENTII IOMITON NOMBER.	A. BUILDING: _		OOM! LET	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			HAL034150	B. WING		1	/2021
THE IVY AT CLEMMONS 6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS CITY STA	TE ZIP CODE	•	-
THE IVY AT CLEMMONS CLEMMONS, NC 27012 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)							
(AT) ID	THE IVY A	AT CLEMMONS					
	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE
D 358 Continued From page 97 D 358	D 358	Continued From page	97	D 358			
Resident #6's March and April MAR. -Circled initials on the MAR meant the medication was not administered. -Resident #6 did not have any gabapentin because the MAs did not never supposed to. -She had called the pharmacy in March and April 2021 (she did not document when she called the pharmacy). -She was not allowed to call the primary care provider (PCP) because the Medication Manager (MM) was responsible for doing that. Interview with the Administrator on 04/19/21 at 11:27 am revealed she did not know Resident #6' had missed 27 doses of gabapentin in March 2021. c. Review of Resident #6's current physician's order dated 03/26/21 revealed there was an order for prednisone (used to treat COPD) 10mg tablets with the following taper dosages: 4 tablets daily for 2 days, then 3 tablets daily for 2 days, then 1 tablet daily or 2 days then discontinue. Review of Resident #6's March 2021 MAR revealed: -There was an entry for prednisone 10mg tablets with the following taper dosages: 4 tablets daily for 2 days, then 3 tablets daily for 2 days, then 2 tablets daily for 2 days, then 1 tablet daily or 2 days scheduled for administration at 8:00 am beginning on 03/30/21. -Prednisone was documented as administered 1 time on 03/30/21 at 8:00 am (and should have)	D 358	Resident #6's March and Circled initials on the was not administered and Resident #6 did not he because the MAs did pharmacy when they and called the paramacy. She had called the paramacy. She was not allowed provider (PCP) becaut (MM) was responsible and missed 27 doses and missed 27	and April MAR. MAR meant the medication have any gabapentin not reorder from the were supposed to. harmacy in March and April cument when she called the I to call the primary care use the Medication Manager of or doing that. Ininistrator on 04/19/21 at the did not know Resident #6 of gabapentin in March It #6's current physician's revealed there was an order to treat COPD) 10mg ring taper dosages: 4 tablets 3 tablets daily for 2 days, or 2 days, then 1 tablet daily tinue. I tablet daily for 2 days, then 1 tablets daily lets daily for 2 days, then 2 s, then 1 tablet daily or 2 dministration at 8:00 am 1. umented as administered 1	D 358			

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DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					F	,
		HAL034150	B. WING		1	20/2021
		11/12004100			1 04/2	.0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
THE IVV A	T CLEMMONS	6010 ME	ADOWBROOK N	MALL COURT		
11121417	TOLLINIO NO	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 CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	D/(IL
			 			
D 358	Continued From page	98	D 358			
	Review of Resident #	6's April 2021 MAR				
	revealed:	•				
	-There was no entry f	or prednisone 10mg tablets				
	with the following tap	er dosages: 4 tablets daily				
	for 2 days, then 3 tab	lets daily for 2 days, then 2				
		s, then 1 tablet daily or 2				
	•	dministration at 8:00 am				
	beginning on 03/30/2					
		en 7 remaining doses				
	administered the first	week of April.				
	Observation of Resid	ent #6's medications on				
	hand on 04/16/21 at 4					
		pack of prednisone 10mg				
	-	ns to take 4 tablets daily for				
		daily for 2 days, then 2				
		s, then 1 tablet daily or 2				
	days.	•				
	-There were 20 predr	nisone 10mg tablets				
	dispensed on 03/30/2	21 and 20 prednisone 10mg				
	tablets remained in th	ie blister pack.				
	Interview with a medi	,				
	04/16/21 at 10:30 am					
		edications to Resident #6.				
	tablets on the cart.	ck of prednisone 10mg				
		dispensed on 03/30/21.				
		y the prednisone 10mg had				
	not carried over to the					
		sible for ensuring that all				
		and updated before going				
		inning of the month, but she				
		MARs for the fourth floor.				
	-	esident #6's MAR at the				
	• • •	21 and she was not sure if				
	the MM had reviewed	I the April MAR for Resident				
	#6.					
	-The MM was respon					
	medication carts to er	nsure medications were in				

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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
					1 _	, l
			B WING		F	
		HAL034150	B. WING		04/2	20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		6010 ME	DOWBROOK M	MALL COURT		
THE IVY A	T CLEMMONS		NS, NC 27012	IALL GOOK!		
			110,110 27012			1
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
1710		,	17.0	DEFICIENCY)		
			D 050			
D 358	Continued From page	99	D 358			
	the building and audit	ting the MARs to ensure all				
	<u> </u>	ministered as ordered.				
	Interview with anothe	r MA on 04/19/21 at 10:21				
	am revealed:					
	-She had administere	ed medications to Resident				
	#6.					
	-She did not recall ad	ministering prednisone to				
	Resident #6.					
	-She believed prednis	sone fell off the MAR				
	because April MAR cl	hecks were not completed				
	by the MM.	·				
	-April MARs were not	put on the medication cart				
	until the second or thi	ird day of April.				
	-The MM was respon	sible for transposing all				
	orders onto the MAR	and ensure they were				
	correct.					
		ensure the MARs were				
		were not allowed to see the				
	orders.					
	-The MM was respon	•				
		nsure medications were in				
		ting the MARs to ensure all				
	medications were adr	ministered as ordered.				
		1 on 04/16/21 at 9:50 am				
	revealed:					
		orders on the residents'				
	•	acy had a chance to place				
		to be sent out at the first of				
	each month.					
		system in place to routinely				
		dministration because she				
		current position for less than				
		en a MA prior to being asked				
	to be the MM.					
		for ensuring all medications				
		nd for auditing MARs to				
	ensure medications w	vere being administered as	1			

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ordered but she had not had a chance to audit

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL034150	B. WING		R 04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
THE NOVA	THE NOVAT OF EMMONS			IALL COURT	
THE IVY AT CLEMMONS CLEMMO			NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 100	D 358		
	MAR'sThere had been a lot of MA turnoverShe had been staffing as a MA to fill call outs for the last 2 weeks. Attempted interview with the MM on 04/19/21 and 04/20/21 was unsuccessful.				
	11:27 am revealed: -She did not know whadministered to Resid-She did not know whathe MAR for April 202-She did not handle not fill in on the medicationAll medications go the The MM was responders to the contract new orders on the MA-The MM followed up in the building to be another the orders we she did not know if the reviewed prior to bein cartsShe expected medicordered.	ny or how prednisone fell off 1.1. Inedications unless she had ation cart when a MA called arough the MM. Isible for faxing all new led pharmacy and writing all lares. It o ensure medications were dministered. In ad been checking the MARs the for the next month to be correct. In the MARs for April 2021 were leg placed on the medication ations to be administered as			
	administered as orde prescribing provider f #8 and #9) sampled of medication pass on 0 with chronic pain not treat anxiety (#8), and	or 2 of 2 residents (Resident			

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 101 of 132

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING B. WING COMPLETED NAME OF PROVIDER OR SUPPLIER THE IVY AT CLEMMONS (X3) DATE SURVEY COMPLETED R Q4/20/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012 (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 101 The resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and (#44) A bit of the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and (#44) A bit of the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and (#44) A bit of the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and (#44) A bit of the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and (#44) A bit of the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and (#44) A bit of the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and (#44) A bit of the resident at risk for uncontrolled pain (#9); and (#44) A bit of the resident at risk for uncontrolled pain (#9); and (#44) A bit of the resident at risk for uncontrolled pain (#9); and (#45) A bit of the resident at risk for uncontrolled pain (#9); and (#45) A bit of the resident at risk for uncontrolled pain (#9); and (#45) A bit of the resident at risk for uncontrolled pain (#9); and (#45) A bit of the resident at risk for uncontrolled pain (#9); and (#45) A bit of the resident at risk for uncontrolled pain (#9); and (#45) A bit of the resident at risk for uncontrolled pain (#9); and (#45) A bit of the resident at risk for uncontrolled pain (#9); and (#45) A bit of the resident at risk for uncontrolled pain (#9); and (#15) A bit of the resident at risk for u	DIVISION	of Health Service Regu	ilation				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 101 the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and				1 ` ′			,
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 101 the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and			HAL034150	B. WING			21
THE IVY AT CLEMMONS CLEMMONS, NC 27012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 101 the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and 6010 MEADOWBROOK MALL COURT CLEMMONS, NC 27012 ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) D 358 Continued From page 101 the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and	NAME OF D		CTDEET AL		710,0005		
CLEMMONS, NC 27012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 101 the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and	NAME OF P	PROVIDER OR SUPPLIER					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 358 Continued From page 101 the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and	THE IVY A	AT CLEMMONS			LL COURT		
the resident at risk for uncontrolled pain (#9); and 6 of 9 sampled residents (#1, #2, #4, #6, #7, and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE CON	MPLETE
#11) which resulted in a resident with a history of pulmonary embolism placed at risk for a blood clot due to not receiving a medication used to thin the blood, at risk for increased behaviors due to not receiving a medication to treat bipolar disorder, increased risk for abdominal discomfort due to a history of constipation and not receiving a laxative (#1); a resident experiencing continued pain due to not receiving a medication for pain, and a medication for muscle spasms (#2); a resident experiencing continued pain due to not receiving a medication for pain, and a medication for muscle spasms (#2); a resident with a history of hiatal hemia, chronic obstructive pulmonary disease (COPD), depression and insomnia experiencing abdominal and esophageal pain due to not receiving a medication for acid reflux, unnecessary anxiety from breathing difficulty associated with COPD and not receiving a medication for amxiety, and increased depression due to not receiving a medication for insomnia, and a medication to treat depression (#4); a medication for diabetic neuropathy causing increased pain requiring a stronger pain reliever, and not receiving a steroidal medication post hospitalization for a COPD exacerbation (#6); and two residents with elevated blood sugars and nerve and organ damage (#7 and #11). The facility's failure to administer medications as ordered placed the residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/20 for this violation.	D 358	the resident at risk for 6 of 9 sampled reside #11) which resulted in pulmonary embolism clot due to not receivithe blood, at risk for in not receiving a medic disorder, increased ridue to a history of cora laxative (#1); a resimpain due to not receiving a medication for resident with a history obstructive pulmonary depression and inson and esophageal pain medication for acid refrom breathing difficuland not receiving a mincreased depression medication for insomit treat depression (#4); neuropathy causing in stronger pain reliever steroidal medication properties to compare the following compares and nerve and #11). The facility's farmedications as order substantial risk of phy which constitutes a Tyle The facility provided a accordance with G.S.	r uncontrolled pain (#9); and ents (#1, #2, #4, #6, #7, and in a resident with a history of placed at risk for a blooding a medication used to thin increased behaviors due to eation to treat bipolar sk for abdominal discomfort instipation and not receiving dent experiencing continued ving a medication for pain, muscle spasms (#2); a y of hiatal hernia, chronic y disease (COPD), innia experiencing abdominal due to not receiving a efflux, unnecessary anxiety lty associated with COPD inedication for anxiety, and in due to not receiving a inia, and a medication to gram a medication for diabetic increased pain requiring a repost hospitalization for a (#6); and two residents with its not receiving a short acting esult in elevated blood dorgan damage (#7 and illure to administer ed placed the residents at ysical harm and neglect ype A2 Violation.	D 358			

Division of Health Service Regulation

CORRECTION FOR THE TYPE A2 VIOLATION

SHALL NOT EXCEED MAY 20, 2021.

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAI 024450	B. WING		R
		HAL034150			04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA ADOWBROOK N		
THE IVY A	T CLEMMONS		NS, NC 27012	IALL GOOK!	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 367	(j) The resident's me record (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for ador treatment; (5) reason or justifica medications or treatmedocumenting the resumedications or treatmedocumenting the resumedications or treatmedications or treatmedications or treatmedications or treatmedications or treatmedications or treatmedication or	Medication Administration dication administration e accurate and include the cation or treatment order; age or quantity of medication ministering the medication tion for the administration of nents as needed (PRN) and alting effect on the resident; administration; any omission of nents and the reason for the efusals; and, the person administering atment. If initials are used, a to those initials is to be ntained with the medication (MAR).	D 367		
	This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 1 of 6 sampled residents (#1) for a sleep medication.				
	The findings are:				
	08/12/20 revealed:	1's current FL2 dated #1's current FL2 dated			

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 103 of 132

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			, 551251110.		R
		HAL034150	B. WING		04/20/2021
NAME OF P	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	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	e 103	D 367		
D 367	-Diagnoses included constipation, chronic disease, gastroesoph hyperthyroidismMelatonin 5mg (a suinsomnia) with no free Review of Resident #12/22/20 revealed the melatonin 5mg, 2 table Review of Resident #02/01/21 revealed me (10mg) at bedtime wa (9mg) at bedtime wa (9mg) at bedtime. Review of Resident #administration record -There was an entry fischeduled for administration at 9-There was an entry for administered 13 of 18 -There was an entry for administered 18 of 18 -There was documen administered 18 of 18 -There was a total of tablets left.	stroke, bipolar, chronic pain, obstructive pulmonary ageal reflux disease, and pplement used to treat quency for administration. 1's physician's orders dated are was an order for lets (10mg) at bedtime. 1's physician's orders dated elatonin 5mg, 2 tablets as changed to 3mg, 3 tablets as changed to 3mg, 3 tablets or melatonin 10mg stration at 9:00 pm. tation melatonin 10mg was 3 opportunities. 3 opportunities. 3 opportunities. 4 opportunities. 5 opportunities. 6 opportunities. 6 opportunities. 7 melatonin 9mg was 3 opportunities. 8 opportunities. 8 opportunities. 9 opportunities. 10 pm	D 367		
		vith a representative from			

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 104 of 132

Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			_		1 _	
			B WING		F	
		HAL034150	B. WING		04/2	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TO WILL OF TH	TO VIDER OR OUT FIER					
THE IVY A	T CLEMMONS		DOWBROOK N	MALL COURT		
		CLEMMOI	NS, NC 27012			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(IATE	DATE
				22.16.2.16.1		
D 367	Continued From page	e 104	D 367			
	the facility's contracted pharmacy on 04/19/21 at 12:01 pm revealed: -The pharmacy received an order on 02/01/21 for					
	melatonin 3mg, 3 tab	lets (9mg) at bedtime.				
	-The pharmacy filled	and dispensed 90 tablets on				
	02/01/21.	·				
		4/19/21, the facility had not				
		ne melatonin 3mg, 3 tablets				
	at bedtime.	io molatoriii omg, o tabloto				
		lets were last dispensed on				
		tity of 60 tablets dispensed.				
		•				
		e the pharmacy dispensed				
	meiatonin 5mg 2 table	ets at bedtime was 10/05/20.				
	Intomiau with Dasida	t #4 04/40/24 -t 44:07				
		ent #1 on 04/19/21 at 11:27				
	am revealed:					
		ninistered three tablets of				
	melatonin 3mg for a t	•				
	~	etting the 9mg, the 10mg				
	was stopped.					
		nce between the 9mg and				
		ng was three tablets with a				
	number 3 on the table	et.				
	-The 10mg was two 5					
	-She was sure that sh	ne was administered 9mg of				
	melatonin at bedtime.	-				
	Interview with a media	cation aide (MA) on				
	04/20/21 at 4:09 pm r					
	-She worked the second shift and usually					
		nt #1's melatonin at bedtime.				
		esident #1 the melatonin that				
	was available in the n					
		ager (MM) was responsible				
		n the MAR were accurate.				
	_					
		tion why she documented				
	the administration of I	meiatonin 9mg and				
	melatonin 10mg.					

Division of Health Service Regulation

Telephone interview with the Administrator on

STATE FORM 6899 YYKO11 If continuation sheet 105 of 132

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL034150	B. WING		R 04/20/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 04/20/2021
			DOWBROOK N		
THE IVY	T CLEMMONS	CLEMMON	IS, NC 27012		<u>, </u>
(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 APPROPE DEFICIENCY)	BE COMPLETE
D 367	Continued From page	105	D 367		
	daily to ensure medic were accurate. -The MM should have orders for melatonin of the facility did not have an two orders for Reside MAR. -She expected the MA label before administer signing the MAR. -The MA should have	revealed: sible for auditing the MARs ation orders on the MARs e identified there were two on Resident #1's MAR. ave a system to audit behind dication orders on the MAR explanation why there were int #1's melatonin on the A to review the medication rering the medication and identified there were two on the MAR and notified the			
D 392	MM. D 392 10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of		D 392		

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		_
		HAL034150	B. WING		R 04/20/2021
NAME OF D			DECC CITY CTA	TE 710 000E	1 04/20/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
THE IVY A	T CLEMMONS		DOWBROOK N IS, NC 27012	IALL COURT	
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	,	PROVIDER'S PLAN OF CORRECTIO	N (VE)
(X4) ID PREFIX TAG	´		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 392	Continued From page	2 106	D 392		
	controlled substances for 1 of 7 residents sampled (#4) who received medication for severe pain.				
	The findings are:				
	Review of Resident #4's current FL2 dated 02/14/20 revealed diagnoses were not completed on the FL2.				
	Review of Resident #4's previous FL2 dated 11/26/18 revealed diagnoses included encephalopathy, chronic pain syndrome, muscle weakness, major depressive disorder, abnormality of gait, anxiety disorder, chronic obstructive pulmonary disease (COPD).				
	Review of Resident #4's physician's orders revealed an order dated 03/02/21 for 25 tablets of hydrocodone/acetaminophen (a narcotic pain reliever used to treat moderate to severe pain) 5/325mg take 1 tablet every 6 hours as needed (prn) for up to 7 days for severe pain.				
	at the facility's contrar at 10:00 am revealed -The pharmacy dispe hydrocodone/acetami tablet every 6 hours a days for severe pain of -The pharmacy delives medication aide at the 10:40 pm. -The pharmacy routing substances count she medications to be use administration and tras substance inventory.	nsed 25 tablets of inophen 5/325mg take 1 as needed (prn) for up to 7 on 03/03/21. Ery ticket was signed by a er facility on 03/03/21 at ely sends a control eets (CSCS) with narcotic ed by the facility for logging			

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
		1141 024450	B WING		R	(0004
		HAL034150	B: *******		04/20/	/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		6010 ME	ADOWBROOK M	IALL COURT		
THE IVY A	T CLEMMONS		ONS, NC 27012	IALE GOOK!		
			7N3, NC 27012			
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
D 000			B 000			
D 392	Continued From page 107		D 392			
	return of any hydrocodone/acetaminophen					
	5/325mg for Resident #4.					
	5/525/fig for Resident #4.					
	Review of Resident #	4's March 2021 Medication				
	Administration Record					
	-There was a handwr					
		inophen 5/325mg take 1				
	-	as needed (prn) for pain with				
	-	tion indicated from 03/02/21				
		ave been 03/02/21 to				
	03/08/21 to allow for					
		ninophen 5/325mg had prn				
	scheduled as the time					
		minophen 5/325mg was				
	_	nistered for 11 doses on the				
		n 03/03/21 to 03/07/21.				
		for "STOP" handwritten on				
	_					
	days 03/08/21 throug					
		equent documentation for				
		rocodone/acetaminophen				
	5/325mg in March 20					
	-A total of 14 tablets of					
	=	inophen 5/325mg should be				
	remaining.					
	Povious of Posidont #	14's April 2021 MAP				
	Review of Resident # revealed:	TO APIN 2021 WAR				
	-There was a preprint	tod ontry for				
		inophen 5/325mg take 1				
	scheduled as time for	as needed for pain with prn				
		r administration. ninophen 5/325mg was not				
	-					
		nistered from 04/01/21				
	through 04/19/21.					
	Deview of Deside 11	441a aanstual audastanaa aan 1				
		4's control substances count				
	, ,	alled there was no CSCS for				
		aminophen 5/325mg tablets				
	dispensed on 03/03/2	21 available for review.				

Division of Health Service Regulation

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL034150	B. WING		04	R J/ 20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
			ADOWBROOK MA			
THE IVY A	AT CLEMMONS		ONS, NC 27012			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	0 392 Continued From page 108		D 392			
	Observation of Resid hand on 04/19/21 rev hydrocodone/acetam hand for the resident	ent #4's medications on				
	pm revealed: -She received some of after she had surgery -She remembered sh available for a few da provider wrote the ord-She did not rememb	dose or exactly how many only she had the pain				
	4:45 pm revealed: -The Administrator straccording to a medic facility's contracted Phydrocodone/acetam signed for by a staff von 03/03/21Controlled substance placed on the medical and the CSCS was sucontrolled medication -The controlled medication -The controlled medication between shift change -When the CSCS was documentation or administration or a	cation technician for the harmacy, Resident #4's inophen 5/325mg was when received by the facility e were supposed to be ation cart under double lock upposed to be placed in the log binder on the cart. Cation was logged out on the care and reconciled is secompleted for ministration for the quantity sed, the completed sheet				
	trackingControlled substance	es discontinued for use were				

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 109 of 132

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL034150	B. WING		R 04/20/2021
		HAE034130			04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
THE NAVA	T CL EMMONE	6010 MEA	DOWBROOK N	MALL COURT	
I TE IVI A	T CLEMMONS	CLEMMOI	NS, NC 27012		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	NATE DATE
			1	,	
D 392	392 Continued From page 109		D 392		
	pulled from the medication cart by the Resident Care Coordinator (RCC), logged on a pharmacy				
	-	ed in a locked controlled			
		ntainer until picked up by the			
	contracted pharmacy				
	-	19/21, the Administrator,			
		d Medication Manager had			
		sident #4's current supply of			
	medications on the medication cart, including any overstock, and the facility's control substance				
		drocodone/acetaminophen			
	5/325mg dispensed of				
	~ .	e to locate the remaining			
		inophen 5/325mg dispensed			
	on 03/03/21.				
	-The medication aide	(MA) that signed for			
	Resident #4's hydroco	odone/acetaminophen			
	5/325mg dispensed of	on 03/03/21 no longer			
	worked at the facility.				
		Coordinator (RCC) at the			
		n the staff that removed			
		ions from the medication			
	cart and would have b	•			
	completing a Controll				
	-	on back to the contracted			
		left the facility 4 weeks ago.			
		I not answered attempted			
		ided to telephone messages			
	left by the Administrat				
	•	has a Medication Manager			
	•	ving medications from the			
	medication cart and the				
		and the Controlled Drug			
	were unable to be fou	pe available for review but			
		d contacted the contracted			
	for return of Resident	1 requesting documentation #//s			

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hydrocodone/acetaminophen 5/325mg dispensed

on 03/03/21 but was told there was no

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Division of Health Service Regulation

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			_		R	
		HAL034150	B. WING		1	0/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	THE IVY AT CLEMMONS			IALL COURT		
			S, 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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 110	D 392			
D 392	documentation for the Resident #4's hydroco 5/325mg dispensed of CSCS and the remain administration docum accounted for. Interview with the Me 04/19/21 at 5:00 pm reshe started working 03/11/21 while the for at the facility. She had not seen an hydrocodone/acetamic Resident #4. She would have come Substance Return for to the pharmacy if she returning the discontinuation of the pharmacy is she retu	e return of the medication. codone/acetaminophen on 03/03/21 was missing the ning 14 tablets, with no ented, could not be dication Manager (MM) on evealed: at the facility on 03/10/21 or mer RCC was still working by inophen 5/325mg for apleted a Controlled m and sent the medication had been responsible for nued medication. chifft medication aide (MA) on evealed: nt #4 had some inophen 5/325mg on the her surgery in March 2021. Sheet in the controlled log on cart. would have been her the CSCS and the c CSCS was documenting a edication card was empty. Insible to remove completed bin for the RCC or MM to wen or who removed	D 392			
		odone/acetaminophen dication cart. she did not				

Division of Health Service Regulation

The facility failed to ensure a readily retrievable

STATE FORM 6899 YYKO11 If continuation sheet 111 of 132

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
					R
		HAL034150	B. WING		04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
	T CLEMMONS	6010 MEAD	OWBROOK N	IALL COURT	
CLEMMON			S, 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 392	2 Continued From page 111		D 392		
D 451	the administration and #4's hydrocodone/ace 14 tablets unaccounter facility to locate the C Sheets or documental were returned to the puthe safety, health, and constitutes a Type B V The facility provided a accordance with G.S. this violation. CORRECTION FOR SHALL NOT EXCEED	a plan of protection in 131D-34 on 04/19/20 for THE TYPE B VIOLATION	D 451		
	and Incidents 10A NCAC 13F .1212 Incidents (a) An adult care hor department of social sincident resulting in reaccident or incident resident requiring refeevaluation, hospitalization other than first aid. This Rule is not met Based on interviews a facility failed to notify Social Services (DSS sampled residents (#incidents requiring refeevaluation or treatme	Reporting of Accidents and me shall notify the county services of any accident or esident death or any esulting in injury to a erral for emergency medical ation, or medical treatment as evidenced by: and record reviews the the county Department of (1) of incidents for 2 of 2 4 and #6) related to 2 ferral for emergency medical int for Resident #4 and ferral for emergency medical			

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 112 of 132

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
					F	,
		HAL034150	B. WING			20/2021
		11AE034130			04/2	.0/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
no	T 01 T1110110	6010 MEA	ADOWBROOK N	MALL COURT		
THE IVY A	T CLEMMONS	CLEMMO	NS, NC 27012			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON NC	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
D 451	Continued From page	e 112	D 451			
	1 3					
	Tl 6:1:					
	The findings are:					
	Peview of the facility	Reporting of Accidents and				
	Incidents Policy (not	· ·				
		the county department of				
		event of any accident or				
		njury to a resident requiring				
	referral for emergence					
		treatment other than first				
	aide.	,				
		de the following information:				
		e of staff who discovered				
	the accident or incide					
		when, where, and how the				
	· · · · · ·	occurred, nature of the injury,				
	what was done for the					
	notification to the resi	dents responsible party, and				
	signature of the admi					
	-The report will be se	nt to the county within 48				
	hours after the accide	ent or incident.				
	1. Review of Residen	t #4's current FL2 dated				
	02/14/20 revealed:					
	0	completed on the FL2.				
		nentation for cognitive				
		owel or bladder status, or				
	care assessment.					
	Deview of Deside 17	Ma mandana FI O data d				
		4's previous FL2 dated				
	11/26/18 revealed:	oneonhalonathy shranic				
	_	encephalopathy, chronic				
	pain syndrome, musc					
		abnormality of gait, anxiety tructive pulmonary disease				
		uucuve puimonary disease				
	(COPD).	ni ambulatory, continent to				
		ni-ambulatory, continent to nd had continuous oxygen at				
		nd nad continuous oxygen at				
	3 liters.					

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 113 of 132

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		SURVEY PLETED
		HAL034150	B. WING		04	R / 20/2021
NAME OF PROV	IDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
THE IVY AT C	LEMMONS		ADOWBROOK MA	LL COURT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1112.01		(X5) COMPLETE DATE	
Rose -T	ervices reports (EM There was a patient ocumenting Reside e facility at 7:30 and there was a patient ocumenting Reside e facility at 1:54 pm eview of the facility ocident (I/A) Report the binders was divided by the month in ompleted. There were no I/A resident #4 document of 02/12/21. There were instructive of Resident #4 document of the primary diagnost the primary diagnost of the prim	#4's emergency medical (S) revealed: care report dated 02/05/21 int #4 was transported out of in for "left wrist pain". care report dated 02/12/21 int #4 was transported out of in for "fiberglass cast". 's binder for Incident and its on 04/19/21 revealed: rided into months of the year. pleted for residents were which the I/A report was eports filed in the binder for enting incidents on 02/05/21 #4's hospital encounter form aled: sis was left wrist pain. ons for self care of a led. ons for care of a cast or #4's hospital encounter form aled: sis for the encounter was left	D 451			

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 114 of 132

	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		04/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	JE ZIP CODE	•	
TW WILL OF T	NOVIBER OR SOLVEIER		DOWBROOK N			
THE IVY A	AT CLEMMONS		NS, NC 27012	IALL COOK!		
	I		NS, NC 27012	I		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 451	Continued From page 114		D 451			
	Refer to interview with a medication aide (MA) on 04/20/21 at 1:30 pm.					
	Refer to interview with a second MA on 04/20/21 at 2:04 pm. Refer to interview with the Resident Care Director (RCD) on 04/20/21 at 4:35 pm. Refer to interview with the Administrator on 04/19/21 at 12:42 pm. 2. Review of Resident #6's current FL2 dated 02/16/21 revealed: -Diagnoses included encephalopathy, diabetes mellitus type II, hypertension, mild cognitive					
	disease (COPD), core	obstructive pulmonary onary artery disease, heart ssive disorder, falls, and				
	-Resident #6 was inte -Resident #6 was ser	ermittently disoriented. mi-ambulatory.				
	reports revealed:	6's incident/accident (I/A)				
		pm, Resident #6 yelled for on the floor beside her bed				
		been asleep and fell out of				
		ead on the nightstand.				
		tation of two skin tears on				
	her right arm.					
		Services (EMS) was called				
		sident, but she refused to go				
	to the emergency roo	om.				
	Review of Resident #	6's care notes revealed				
	there were no care no					

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01/15/21.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					F	₹	
		HAL034150	B. WING		04/2	20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
THE IVY AT CLEMMONS			ADOWBROOK NONS, NC 27012	MALL COURT			
()(1) ID	OUR MADE VOTATEMENT OF DEFINITION			PROVIDER'S PLAN OF CORRECT	ION	(VE)	
(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 APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE	
D 451	1 Continued From page 115		D 451				
	Social Services (DSS revealed: -The county had not rincident/accident reportated 01/15/21 Review of Resident # -On 01/16/21 at 7:40 help and was found of sitting "Indian style". -She stated she fell of our there was documented from her chin from a light long, and she complated the summary dated 01/19. Review of Resident # there was no report a 01/19/21. Review of Resident # summary dated 01/26.	the local department of b) on 04/19/21 at 3:18 pm received any orts from the facility. Illy for an incident/accident but did not have one. 6's I/A reports revealed: pm, Resident #6 yelled for on the floor beside her bed ut of the bed again. tation she was bleeding acceration about 2 inches ined of head and back pain. 6's EMS report dated e was transported to a local R) due to a chin laceration 6's hospital discharge 9/21 revealed: R visit was documented as gnosed with a contusion of w back pain. 6's I/A reports revealed vailable for the fall on 6's hospital discharge					

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-Resident #6 was diagnosed with a contusion of

STATE FORM 6899 YYKO11 If continuation sheet 116 of 132

	of Health Service Regu					
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		HAL034150	B. WING		04/20/202	21
NAME OF D		OTDEET A	ADDDESS SITV STAT	F 7/D 00DF	•	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT			
THE IVY	AT CLEMMONS		EADOWBROOK MA	ALL COURT		
	T	CLEMM	ONS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE CON	(X5) MPLETE DATE
D 451	Continued From page	e 116	D 451			
	her scalp and back, and while at the ER, the stitches from a previous injury were removed. Review of Resident #6's I/A reports revealed there was no report available for the fall on 01/26/21.					
	04/19/21 revealed:	s binder for I/A Reports on vided into months of the				
	yearThe I/A reports completed for residents were filed by the month in which the I/A report was					
	completed.					
		ports filed in the binder for nting incidents on 01/19/21				
	Telephone interview with the local DSS AHS on 04/19/21 at 3:18 pm revealed she had not received any notification from the facility of Resident #6's referral for emergency medical evaluation or treatment for incidents that occurred on 01/15/21, 01/16/21, 01/19/21, or 01/26/21.					
	Refer to interview with a medication aide (MA) on 04/20/21 at 1:30 pm.					
	Refer to interview with a second MA on 04/20/21 at 2:04 pm.					
	Refer to interview wit (RCD) on 04/20/21 at	h the Resident Care Director t 4:35 pm.				
	Refer to interview wit 04/19/21 at 12:42 pm	h the Administrator on ı.				
	Interview with a MA or revealed:	on 04/20/21 at 1:30 pm				

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-The MAs fill out the incident/accident reports

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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		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COIVIE	LETED
		HAL034150	B. WING		04	R / 20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE NO.	T OI FMMONO	6010 MEA	DOWBROOK N	IALL COURT		
THE IVY	AT CLEMMONS	CLEMMO	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 451	Continued From page	e 117	D 451			
	after an incident/accident and against a medication manager. The MM or RCD revithe incident/accident. The Administrator was the reports to the couband-aid.	dent. cident/accident report to the (MM) or the RCD. iewed the incident and gave report to the Administrator. as responsible for sending anty for anything above a				
	Interview with a second MA on 04/20/21 at 2:04 pm revealed: -The MAs completed the incident/accident reports and placed them in a mailbox for the MM or the nurse to review. -The MAs were not responsible for sending the incident/accident reports to the county and had never been asked or instructed to do so.					
	on 04/20/21 at 4:35 p -She was just hired a 04/19/21. -She would be responded incident/accident repo					
	12:42 pm revealed: -She did not have fax incidents/accident rep-She did not know the had not been sent to -The medication aide completing an incider was an incident or acceptance.	e incident/accident reports the county. s were responsible for nt/accident report when there cident. nt report was supposed to t happened, who was				

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL034150	B. WING		04/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		DOWBROOK N IS, 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 451	responsible for ensuring the county for anythin	ager and the RCD were ng the reports were sent to	D 451		
D912	G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate relevant federal and s regulations. This Rule is not met a Based on observation reviews, the facility fa	e, and in compliance with tate laws and rules and as evidenced by: as, interviews and record iled to ensure residents	D912		
	appropriate and in confederal and state laws related to medication implementation, hous controlled substances supervision and Ach rand competency.	ekeeping and furnishings,			
	reviews, the Administ overall management, procedures and total were implemented, m compliance with the re and maintain rules rel furnishings, personal medication administra	ions, interviews, and record rator failed to ensure the operations, policies and operations of the facility aintained, and in substantial ules and statutes to meet ated to housekeeping and care and supervision, ation, controlled substances, Medication Aide training			

Division of Health Service Regulation

STATE FORM 6899 YYKO11 If continuation sheet 119 of 132

Division c	<u>of Health Service Regu</u>	lation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	_
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL034150	B. WING		04/20/2021	
					1 0 112012021	\neg
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	,		
THE IVY A	AT CLEMMONS		ADOWBROOK M	MALL COURT		
		СLЕММО	NS, NC 27012			_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D912	Continued From page	e 119	D912			
	and competency. [Refer to Tag D0980, G.S. D131-25 Implementation (Type A2 Violation)].					
		tions, interviews, and record				
	reviews, the facility fa					
		red for 2 of 4 residents				
	medication pass on 0	sampled during the 8:00 am				
		nxiety (#8), and a medication				
		opathy (#9); and 6 of 9				
		1, #2, #4, #6, #7, and #11)				
		lated to a medication used to				
	· ·	lication to treat bipolar				
	· ·	n for nausea, and a laxative r pain, and a medication for				
	, ,	a medication for acid reflux,				
	a medication for anxie					
	insomnia, a vitamin si	-				
		epression (#4); a medication				
	· ·	medication for diabetic				
	neuropathy, and a ste					
	• , ,	medication to treat diabetes				
		o Tag D0358, 10A NCAC tion Administration (Type A2				
	Violation)].	Jon Administration (1990 AZ				
	Vic.3/j.					
	3. Based on observa	ations, interviews and record				
		iled to provide adequate				
	· ·	sampled residents (#6) with				
		Iting in a laceration requiring				
	I	emergency room (ER) sions. [Refer to Tag D0270,				
		sions. [Refer to Tag D0270, 1(b) Personal Care and				
	Supervision (Type A2	` '				
		7-				
		vs and record reviews, the				
	I	re the completion of the 5,				
	10, or					
ļ	15-hour medication a	ide training and the	,			

Division of Health Service Regulation

medication aide clinical skills validation for 2 of 3

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D WING		R	
		HAL034150	B. WING		04/20/2021	\dashv
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
THE IVY A	T CLEMMONS		OOWBROOK N S, NC 27012	IALL COURT		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J (X5)	\dashv
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	≣
D912	Continued From page	e 120	D912			
	sampled staff (Staff A and B) who administered medication. [Refer to Tag D0935, G.S. 131D-4.5B(b) Ach Medication Aides; Training And Competency (Type B Violation)].					
	5. Based on observations and interviews, the facility failed to ensure doors and floors were kept clean and in good repair in 3 of 14 resident bedrooms (301, 307, and 311) on the third floor. [Refer to Tag D0074, 10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings (Type B Violation)].					
	reviews, the facility fa retrievable record tha receipt, administration controlled substances	s for 1 of 7 residents seived medication for severe 0392, 10A NCAC 13F				
D935	G.S.§ 131D-4.5B(b) A	ACH Medication Aides; ency	D935			
	G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					F	1
		HAL034150	B. WING		1	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 MEAI	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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D935	Continued From page	e 121	D935			
	in all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monitobleeding occurs or the exists. (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days froindividual must have a. An additional 10-hodeveloped by the Deptraining and instruction 1. The key principles administration. 2. The federal Center Prevention guidelines applicable, safe inject procedures for monitobleeding occurs or the exists. b. An examination deby the Division of Heaccordance with substitute and the procedure of the exists. This Rule is not metal trype B VIOLATION Based on interviews a facility failed to ensure 10, or 15-hour medication aimedication aide clinical and the substitute of the exists of the exists.	of medication s for Disease Control and on infection control and, if tion practices and pring or testing in which the potential for bleeding aluation consistent with 10A 10A NCAC 13G .0503. In the date of hire, the completed the following: pur training program partment that includes in in all of the following: of medication s of Disease Control and on infection control and, if tion practices and poring or testing in which the potential for bleeding weloped and administered alth Service Regulation in section (c) of this section. as evidenced by: and record reviews, the testing the completion of the 5,				

Division of Health Service Regulation

The findings are:

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DIVISION	n nealth Service Negu	ialion				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			_			
					R	
		HAL034150	B. WING		04/2	0/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ALE, ZIP CODE		
	T CLEMMONS	6010 MEA	DOWBROOK N	MALL COURT		
INCIVIA	II CLEININIONS	CLEMMO	NS, NC 27012			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(Y5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
			+			
D935	Continued From page	e 122	D935			
	1 Davieur of Choff No	mandiantian side (MAA)				
		, medication aide (MA),				
	personnel record reve					
		was 03/22/21 as a personal				
	care aide (PCA).					
	-She accepted the Me	edication Manager (MM)				
	position on 04/09/21.					
	-There was no docum	nentation Staff A completed				
		10 or 15 hour medication				
	training.					
	_	tation of employment for the				
		another facility as a MA.				
		tation she passed the state				
	approved medication	aide written exam in				
	December 2014.					
	Review of a Medication	on Administration Record				
	(MAR) revealed Staff	A administered medication				
	04/02/21 and 04/04/2	1.				
	Telephone interview v	vith Staff A on 04/20/21 at				
	3:57 pm revealed:					
	•	rch 2021 as a PCA and took				
	the MM position on 04					
	· ·	ining and passed the test in				
		0 .				
	another facility in 201					
	-She worked as a MN	-				
		ions as a MA to residents as				
	needed when staffing					
		e medication training with				
	the facility contract nu	irse at the end of March				
	2021.					
	-The facility contract r	nurse printed the completed				
		id not know if she filed them				
	in her personnel reco					
	Interview with the Adr	ministrator on 04/19/21 at				
		mmsuator on 04/13/21 at				
	4:10 pm revealed:	-ini-tt 00/00/04				
	ighter a secame the Adn	ninistrator on 03/03/21.				

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-All missing MA training, Medication

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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 04/20/2021
NAME OF D		OTDEET A	DDDEGG OITY OTA	TE 310 000E	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
THE IVY A	T CLEMMONS		ADOWBROOK N DNS, NC 27012	ALL COURT	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D935	D935 Continued From page 123		D935		
	medication exams co have it". -The MAs personnel is and they were unable. -The previous Reside Administrator was restraining and validation prior to passing medic. -There had not been at the facility during the received Medication Administration and 5 hour. -The new RCD would Medication Administration 5, 10 and 15 hour me. -She validated emplo previous 6 months at they both were previous.	nt Care Director (RCD) and sponsible for making sure all a were completed by MAs cations. a qualified nurse employed the time Staff A should have administration Clinical Skills medication aide training. The ired to begin 04/19/21. be responsible for ation Clinical Skills Validation dication aide training. Syment for Staff A for the a previous facility, where			
		n facility's Contract Nurse on			
	Refer to interview with 4:25 pm.	n the RCD on 04/19/21 at			
	personnel record reverses a staff B's date of hire -There was no docum a Medication Adminis Validation Checklist.	was 02/07/21. nentation Staff B completed tration Clinical Skills nentation Staff B had passed			

training. Division of Health Service Regulation

-There was no documentation Staff B had completed the state approved 5 hour medication

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
			A. BOILDING		Б
		HAL034150	B. WING		R 04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
THE IVY A	T CLEMMONS		ADOWBROOK M	IALL COURT	
		CLEMMO	NS, NC 27012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D935	Continued From page	e 124	D935		
	-There was no verification of employment as a MA at another Adult Care Home for the previous 24 months. Review of a Medication Administration Record (MAR) revealed Staff B administered medication				
	04/02/21 through 04/00/16/21.	05/21, 04/14/21 and			
	revealed: -She was hired in Fel care aide (PCA)The previous Adminithe medication cart arangement of the was trained on the previously employed and as a she was not familiar Administration Clinical She did not complete				
	medication trainingShe did not take the state approved medication aide written examShe did not know she needed to be checked off and have 5 hour medication training from a nurse before she could administer medications to residents.				
	Interview with the Administrator on 04/19/21 at 4:10 pm revealed: -She became the Administrator on 03/03/21All missing MA training, Medication Administration Clinical Skills Validation, and state medication aide written exams could not be found, We don't have itThe MAs personnel records had been reviewed and they were unable to find themThe previous Resident Care Director (RCD) and Administrator was responsible for making sure all				

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training and validation were completed by MAs

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	· ,	E SURVEY PLETED
			7 501251110.			В
		HAL034150	B. WING		04	R 4/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
THE IVY A	AT CLEMMONS		DOWBROOK MA	ALL COURT		
	T	СLЕММО	NS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D935	Continued From pag	e 125	D935			
D935	prior to passing media. There had not been at the facility during the received Medication. Validation and 5 hours and the End of training. Staff B was hired by Staff B was working Administrator in Marcashe did not know Staff and the Staff B was working. Administration Clinically and the Staff B was working and the Staff B was working administrator in Marcashe did not know Staff and the Staff B was a temporar 2021 to help train Markashe was a temporar 2021 to help train Markashe within the facility. The Administrator geneeded to complete training or Licensed evaluations for reside evaluations for reside she did not know Staff approved 5 hour media. She did not know Staff approved 5 hour media. She did not know Staff approved 5 hour media.	a qualified nurse employed the time Staff B should have Administration Clinical Skills and medication aide training. The previous Administrator as a MA when she became the 2021. The stills Validation and Skills Validation as a MA when she became the 2021. The stills Validation are stills Validation at Skills Validation. The stills Validation are stills validation are stills validation. The stills validation are stills as well as other tasks are she for the facility, such as MA Health Professional Support tents. The staff A did not have state dication aide training. The stills validation Checklist.	D933			
	04/19/21 at 4:25 pm -She had a hire date -MAs should have M	ent Care Director (RCD) on revealed: of 04/19/21 as the RCD. edication Administration				

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medications to residents.

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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		
					R	
		HAL034150	B. WING		04/20/2021	
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) ID	SHIMMARY STA	ATEMENT OF DEFICIENCIES	<u>, </u>	PROVIDER'S PLAN OF CORRECTION	J (VE)	
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D935	Continued From page	e 126	D935			
	-She was responsible for 5, 10 and 15 hour MA trainingA contracted nurse would assist with MA training when needed. The facility failed to ensure the Medication Administration Clinical Skills Validation was completed for 1 of 3 staff and the 5 hour training for 2 of 3 staff prior to administering medications to the residents, placing the residents at risk for medication administration errors. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation.					
	The facility provided a accordance with G.S. this violation.	a plan of protection in 131D-34 on 04/19/21 for				
	CORRECTION DATE VIOLATION SHALL N 2021.	FOR THE TYPE B IOT EXCEED JUNE 04,				
D980	G.S. § 131D-25 Imple	ementation	D980			
	G.S. 131D-25 Implem	nentation				
	Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.					
	This Rule is not met as evidenced by: TYPE A2 VIOLATION					
	reviews, the Administ overall management,	ns, interviews, and record rator failed to ensure the operations, policies and operations of the facility				

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STATE FORM 6899 YYKO11 If continuation sheet 127 of 132

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUI	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLET	
		HAL034150	B. WING		R 04/20	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T CLEMMONS	6010 MEA	OOWBROOK N	IALL COURT		
	AT OLLIMINIONO	CLEMMON	IS, NC 27012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D980	Continued From page	e 127	D980			
	were implemented, m compliance with the r and maintain rules re- furnishings, personal medication administra	naintained, and in substantial ules and statutes to meet lated to housekeeping and care and supervision, ation, controlled substances, a Medication Aide training				
	The findings are:					
	4:01 pm revealed: -She had begun her r March 2021The building had a loworking onIt was everyone's residents were super responsible for ensuring the Medication Man Care Director (RCD) everything clinical but responsible for ensuring correctlyThe RCD and hersel the facility was adequently was responsible with of the rules and residently.	t she was ultimately ing they did their job f were responsible to ensure lately staffed. e for ensuring compliance regulations within the facility. esponsible for all staff and				
	training.	le for administering ed. sible for ensuring all				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	F 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 04/20/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
	T OI FMM:01:0		OWBROOK N		
THE IVY A	THE IVY AT CLEMMONS CLEMMO				
(X4) ID PREFIX TAG	PREFIX (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
D980	Continued From page	e 128	D980		
	facility.				
	revealed: -She had just started -She was responsible included ensuring me building and administ and cart audits, training ensuring the care tean the residentsThe Administrator was the entire facility. Interview with the RC revealed the Administ employed at the facilit Non-Compliance was in the following rule and 1. Based on observat reviews the facility fai supervision for 1 of 2 a history of falls resul sutures and required evaluation on 3 occase	ered as ordered, medication ing medication aides, and improvided supervision for as ultimately responsible for in a ultimately responsible for it is dentified at violation level reas: It is identified at violation required in a laceration requiring emergency room (ER) It is identified at violation level reas: It is identified at violation level reas:			
	reviews, the facility farmedications as order (Resident #8 and #9) medication pass on 0 medication to treat ar to treat diabetic neuro sampled residents (# for record reviews rel	ed for 2 of 4 residents sampled during the 8:00 am			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
			B WING		R
		HAL034150	B. WING		04/20/2021
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 COMPLETE
D980	Continued From page	e 129	D980		
Dago	disorder, a medication (#1); a medication for muscle spasms (#2); a medication for anxie insomnia, a vitamin simedication to treat deto treat acid reflux, a neuropathy, and a stebreathing (#6); and a (#7 and #11). [Refer t 13F .1004(a) Medicat Violation)]. 3. Based on observat facility failed to ensure kept clean and in good bedrooms (301, 307, [Refer to tag 0074 10 Housekeeping and Fuviolation)]. 4. Based on observat reviews, the facility faretrievable record that receipt, administration controlled substances sampled (#4) who receipt administration controlled Substances sampled (#4) who rec	n for nausea, and a laxative pain, and a medication for a medication for acid reflux, ety, a medication for upplement, and a expression (#4); a medication medication for diabetic eroidal medication for medication to treat diabetes o Tag D0358, 10A NCAC cion Administration (Type A2 diabetes in 3 of 14 resident and 311) on the third floor. A NCAC 13F .0306 (a)(1) urnishings (Type B diabetes in a disposition of a for 1 of 7 residents evived medication for severe 0392, 10A NCAC 13F .1008 nces (Type B Violation)]	Dago		
	medication. [Refer to 131D-4.5B(b) Ach Me Competency (Type B	edication Aide; Training and			

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PRINTED: 05/11/2021

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	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	' '		COMPL		
					_	_	
			B. WING		F		
		HAL034150	B. WING		04/2	20/2021	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE			
THE IVV A	AT CLEMMONS	6010 ME.	ADOWBROOK N	MALL COURT			
INCIVIA	T CLEWINIONS	CLEMMO	ONS, NC 27012				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)		
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		E COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIE	DAIL	
			+	<u> </u>		-	
D980	Continued From page	e 130	D980				
	The facility failed to e	ensure responsibility for the					
	•	, administration, supervision					
	_	facility which resulted in a					
		alls which resulted in multiple					
		cy room with a chin laceration					
		ches, a scalp contusion, a					
		skin tears; medications were					
		ordered for 6 of 9 sampled					
		Ited in a resident with a					
		embolism placed at risk for a					
		receiving a medication used					
		receiving a medication to					
	treat bipolar disorder	_					
	increased behaviors,	not receiving a laxative					
	which could result in i	increased abdominal					
	discomfort and consti	ipation (#1); a resident not					
	_	on for pain and a medication					
		esulting in increased pain					
	, ,	eceiving a medication for					
		ulted in abdominal and					
		receiving a medication to					
		Ilting in unnecessary anxiety					
	_	Ilty associated with COPD					
		nedication for insomnia, and					
		in increased depression					
	, ,,	eceiving a medication for					
		resulting in increased pain					
	requiring a stronger p	•					
	receiving a steroidal r						
		COPD exacerbation (#6); and					
	two residents with ele	evated blood sugars not	1				

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receiving a short acting insulin which could result in nerve and organ damage (#7 and #11); failed to ensure floors were kept clean and in good repair as evidenced by a sewage leak from underneath a toilet in a resident room causing sewage stains on the flooring, and ongoing exposure to raw sewage in the bathroom increasing the risk of infection; failed to ensure a readily retrievable record of controlled substances

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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	
			D MANAG		R
		HAL034150	B. WING		04/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
THE IVY A	AT 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D980	of hydrocodone/aceta resulting in 14 tablets to ensure the Medicat Skills Validation was and the 5 hour training administering medical placing the residents administration errors. residents at substantineglect which constitute. The facility provided a accordance with G.S.	unaccounted for; and failed cion Administration Clinical completed for 1 of 3 staff g for 2 of 3 staff prior to tions to the residents which at risk for medication This failure placed al risk of physical harm and utes a Type A2 Violation.	D980		

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