

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/05/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2020
NAME OF PROVIDER OR SUPPLIER THE IVY AT GASTONIA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments	E 000			
F 000	INITIAL COMMENTS	F 000			
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced	F 557		12/28/20	

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

TITLE

(X6) DATE

Electronically Signed

12/24/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 557	<p>Continued From page 1</p> <p>by:</p> <p>Based on record review and local Sheriff's Department staff, facility staff and resident interviews, the facility failed to protect the dignity of a resident when a staff member conducted a video conference phone call with an inmate and was observed mocking a resident while feeding said resident for 1 of 3 residents reviewed for dignity and respect (Resident #1).</p> <p>The Findings Included:</p> <p>Resident #1 was most recently admitted to the facility on 11/26/19 with diagnoses that included anoxic brain injury and anxiety disorder.</p> <p>Review of Resident #1's Quarterly Minimum Data Set Assessment dated 11/18/20 revealed the resident had severely impaired cognition. She required total assistance with activities of daily living and was always incontinent of bowel and bladder.</p> <p>During an interview with an officer from the local Sheriff's Department on 12/11/20 at 9:47 AM he reported a video conference phone call had been recorded between Nurse Aide (NA) #1 and a male who was in a correctional facility on 10/25/20. He stated he was first made aware of the conversation on 10/27/20 and forwarded the information to the local Police Department near the facility. The officer verified that a resident at the facility was visible on the video conference call while NA #1 fed her and also reported there was audio recording of the male and NA #1 mocking Resident #1. He stated he would make the audio recording and screenshot of the video conference call available for review.</p>	F 557	<p>The root cause analysis identified that the facility was utilizing agency staffing and the facility failed to ensure agency staff were educated on not using their cell phones during resident care.</p> <p>The corrective action for Resident #1 was to notify the Agency Staffing Director Lori on 12/02/2020 of incident. The further corrective action was to ensure that all staff to be reeducated on abuse, neglect, misappropriation, and dignity through in-service started on 12/16/2020 by Joy York, RN, DON with completion of all staff on 12/28/2020 by DON or UNM. No staff member or contract employee will be allowed to work until they have received education on abuse, neglect, misappropriation, and dignity. Any new employee/agency staff will be educated on the cell phone policy during orientation. Resident #1 BIMS score is 0 out of 15, she is not interviewable and there was no psychosocial harm assessed by the DON, RN, or UNM. Further discussion with the Staffing Agency Director revealed that the allegation was reported to The Healthcare Registry. Facility investigation and agency investigation substantiated the allegation on 12/17/2020. The administrator and DON were reeducated on 12/22/2020 on identifying reporting and investigating allegations of abuse, neglect, misappropriation and dignity by Jayme Cunningham, RN, RDO.</p> <p>The corrective action for all other residents was to Inservice all staff (to</p>		

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F 557	<p>Continued From page 2</p> <p>Review of a text picture obtained from a local Police Department staff member revealed NA #1 sitting at Resident #1's tray table with her back to Resident #1's bed. Both Resident #1 and NA #1 were visible on the video call and were both actively looking into the camera. Per the layout of the screen, an unknown male had the ability to view both Resident #1 in her bed while she was being fed and NA #1 while she assisted Resident #1 with eating.</p> <p>Review of the audio of the video call obtained from a local Police Department staff member revealed the unknown male on the video call mocking Resident #1 about her facial hair, laughing at her situation and cursing regarding how Resident #1 was looking into the camera. NA #1 was heard laughing at his comments and mocking Resident #1.</p> <p>Multiple interview attempts were made with the alleged NA #1 on 12/11/20 at 10:41 AM and 2:43 PM. Additional attempts were made on 12/12/20 at 9:05 AM and again at 3:38 PM. All interview attempts by phone were unsuccessful, and no return calls were made.</p> <p>During an interview with Nurse #1 on 12/11/20 at 9:11 PM, she reported she was familiar with NA #1 and had worked with her multiple times including on 10/25/20. She reported she had not noted NA #1 to use her phone while providing care to residents or using her phone on the hall while not providing care.</p> <p>Attempted interviews by phone with the nurse aide scheduled to work with NA #1 on 10/25/20 were unsuccessful and no return calls were made.</p>	F 557	<p>include dietary, laundry, housekeeping, and therapy) on abuse, neglect, misappropriation, and dignity by DON started on 12/16/2020, to be completed by 12/28/2020 by DON or UNM. No staff member or contract employee will be allowed to work until they have received education on abuse, neglect, misappropriation, and dignity. Any new employee/agency staff will be educated on the cell phone policy during orientation. All residents who have scored a 12-15 on the BIMS assessment will be interviewed on 12/26/2020 by Activity Director for issues related to abuse, neglect, misappropriation, or dignity. SW to contact all resident representatives assigned to a resident whose BIMS Assessment score is less than 12 on 12/28/2020 to inquire about concerns related to abuse, neglect, misappropriation, or dignity. The administrator and DON were reeducated on 12/22/2020 on identifying reporting and investigating allegations of abuse, neglect, misappropriation and dignity by Jayme Cunningham, RN, RDO.</p> <p>All staff were educated on abuse, neglect, misappropriation, and dignity on started on 12/16/2020 and to be completed on 12/28/2020 by DON and UNM. No staff member or contract employee will be allowed to work until they have received education on abuse, neglect, misappropriation, and dignity. Any new employee/agency staff will be educated on the cell phone policy during orientation. All residents who have scored a 12-15 on</p>		

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F 557	<p>Continued From page 3</p> <p>During an interview with Staffing Agency Director on 12/11/20 at 10:23 AM revealed she was the owner of the staffing agency used by the facility at the time of the incident. The Staffing Agency Director stated she was notified by the facility on 12/2/20 that NA #1 had conducted a video conference call on her cell phone while she was feeding Resident #1 on 10/25/20 and immediately began an internal investigation into the allegation. She reported NA #1 admitted to being on a video conference call with another person who was located in a detention facility at the time. The Staffing Agency Director recorded a statement by NA #1 which read in part that she [NA #1] "was on a video call while feeding a resident at the facility with a person not affiliated with the facility or resident" and she admitted she "should not have been using her phone while working". The Staffing Agency Director stated after her investigation, NA #1 was terminated from her agency and a report was filed with the Healthcare Personnel Registry.</p> <p>An interview with the Director of Nursing on 12/11/20 at 3:42 revealed she was not aware of NA #1 conducting a video conference call with a person unaffiliated with the facility. She stated she was vaguely familiar with NA #1 but reported she was not in the building long after she took her position of Director of Nursing on 10/28/20. She reported telephone use while working was prohibited and NA #1 should have not been using her phone on the hall while completing care.</p> <p>During an interview with the Administrator on 12/11/20 at 3:31 PM she reported she was not familiar with NA #1 as the nurse aide had not worked in the facility since the Administrator</p>	F 557	<p>the BIMS assessment will be interviewed on 12/26/2020 by Activities Director to inquire about issues related to abuse, neglect, misappropriation, or dignity. All residents <input type="checkbox"/> representatives who are assigned to a resident who scored below 12 on their most recent BIMS will be interviewed on 12/28/2020 regarding concerns related to abuse, neglect, misappropriation, or dignity. Facility SW or designee will complete a 10% random sample of residents that have scored 12-15 on BIMS assessment weekly times 4 weeks, then monthly for 5 months and quarterly thereafter about abuse, neglect, misappropriation, and dignity. All residents that have scored below 12 on their most recent BIMS assessment, representatives will be interviewed by SW or designee on abuse, neglect, misappropriation, and dignity to determine any further issues, weekly times 4 weeks, monthly for 5 months and quarterly thereafter. All identified allegations of abuse, neglect, misappropriation, or dignity will be reported per State and Federal Regulations by the Administrator.</p> <p>The Quality Assurance Performance Improvement Committee will review the completed abuse, neglect, misappropriation, dignity questionnaires monthly for further recommendations, interventions, or performance improvement plans as indicated.</p>		

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F 557	Continued From page 4 accepted her position on 11/13/20. The Administrator reported, per her review of staffing schedules, NA #1 had not worked in the building since 11/01/20. The Administrator also reported she was not made aware of the incident until 12/01/20 when a Police Officer came to her building on an unrelated matter. She stated she immediately contacted the owner of the staffing agency NA #1 worked for and notified them of the allegation and requested NA #1 not return to her facility in the future. The Administrator stated, to her knowledge, NA #1 was eventually terminated from the staffing agency and a report was filed with the Healthcare Personnel Registry. She stated telephone use in common areas and resident rooms was prohibited. She stated NA #1 should have excused herself if she needed to take a call and should not have continued with a video call while providing care to a resident.	F 557		