PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMPLETED ANDE OF PROVIDER OR SUPPLIER STREETADDRESS, CITY, STATE, 2P CODE COMPLETED THE IVY AT GASTONIA LLC STREETADDRESS, CITY, STATE, 2P CODE COMPLETED (P4,10) ISLANDARY STATEMENT OF DEPICIENCIES D PROVIDER OR SUPPLIER STREETADDRESS, CITY, STATE, 2P CODE (P4,10) ISLANDARY STATEMENT OF DEPICIENCIES D PREEX PROVIDERS PLAN OF CORRECTION COROS-REFERENCE ON UND IS PREEX ISLANDARY STATEMENT OF DEPICIENCIES D PREEX PROVIDERS PLAN OF CORRECTION COROS-REFERENCE OF PLAN TAX ISLANDARY STATEMENT OF DEPICIENCIES D PREEX PROVIDERS ONLD BE COROS-REFERENCE OF PLAN OF CORRECTION COROS-REFERENCE OF PLAN OF CORRECTION TAX INITIAL COMMENTS F 000 NITIAL COMMENTS F 000 A n onsile complaint Investigation was conducted from 6/7/22 through 6/23/22 in conjunction with a revisit (Even ID #922X12). Repeat tags were cited. F 000 CFR 483.25 at tag F680 at a scope and severity (K); LI began on 3/9/22 and was removed on 6/18/22; CFR 483.25 at tag F680 at a scope and severity (K); LI began on 3/9/22 and was removed on 6/17/22; CFR 483.25 at tag F680 at a scope and severity (K); LI began on 3/9/22 and was removed on 6/17/22; CFR 483.25 at tag F682 at a scope and severity (K); LI began on 3/9/22 and was removed on 6/17/22; CFR 483.25	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
346307 BLWING 06/23/20 NUME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STME, ZIP CODE THE IVY AT GASTONIA LLC STREET ADDRESS. CITY, STME, ZIP CODE OPENDING PROVIDER OF MAIN SYNTEMENT OF DEPICIENCIES STREET ADDRESS. CITY, STME, ZIP CODE OPENDING PARADECONNECTION UPENDING PARADECONNECTION CODE OPENDING PARADECONNECTION CODE OPENDING PARADECONNECTION CODE PREFIX CODE OPENDING PARADECONNECTION CODE PREFIX PREFIX CODE PREFIX PREFIX CODE CODE CODE CODE AD on SIGN CONSTRUCTION MIT THE DEPICIENCES PREFIX CODE PREFIX PREFIX CODE AD on SIGN CONSTRUCTION MIT THE DEPICIENCES PREFIX CODE F 000 INTE				, í				PLETED
THE IVY AT GASTONIA LLC 4114 WILKINSON BLVD GASTONIA, NC 2805 YNJ ID PRETRX TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MIST & PRECIENCE BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OM PREFIX TAG F 000 INITIAL COMMENTS F 000 An onsite complaint investigation was conducted from 67/22 through 6/23/22 in conjunction with a revisit (Event ID #922X12). Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey. F 000 Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (K): U began on 3/92/22 and was removed on 6/18/22; CFR 483.25 at tag F686 at a scope and severity (K): U began on 3/92/22 and was removed on 6/18/22; CFR 483.25 at tag F686 at a scope and severity (K): U began on 3/9/22 and was removed on 6/18/22; CFR 483.25 at tag F686 at a scope and severity (K): U began on 3/9/22 and was removed on 6/18/22; CFR 483.25 at tag F686 at a scope and severity (K): U began on 3/9/22 and was removed on 6/18/22; CFR 483.70 at tag F885 at a scope and severity (K): U began on 3/9/22 and was removed on 6/18/22; The tag F684, F686 and F692 constituted Substandard Cuality of Care. A partial extended survey was conducted. The following intakes were investigated: NC00178474, NC00178748, NC001880511, NC00188405, NC00188163, NC00188163, NC00188405, NC00188163, NC00188163, NC00188405, NC00188163, NC00188163, NC00188405, NC00188163, NC00188163, NC00188076, NC00187164, SC00189163, NC00188076, NC001871645, NC00188716, NC001871645, NC00188716, NC00187164, NC00188076, NC00187164, NC00188163, NC00			345307	B. WING _			06	-
THE IVY AT GASTONIA LLC GASTONIA, NC 28056 (M)[0] PHEFX TXG ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROFILE TXG ID PROFILE (EACH DEFICIENCY MAT SE PROFILE (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) ID PROFILE TXG ID PROFILE (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) ID PROFILE (EACH DEFICIENCY DEFICIEN	NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CASTONIA, NC 20066 WH ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRECEDED BY PULL REQULATORY OR LSC IDENTIFYING INFORMATION) ID PRETAX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORDECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COME F 000 INITIAL COMMENTS F 000 F 000 INITIAL COMMENTS F 000 An onsite complaint investigation was conducted from 67/722 through 6/23/22 in conjunction with a revisit (Event ID #922X12). Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey. F 000 Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (K); IJ began on 3/20/22 and was removed on 6/18/22; CFR 483.25 at tag F686 at a scope and severity (K); IJ began on 3/20/22 and was removed on 6/18/22; CFR 483.25 at tag F682 at ascope and severity (K); IJ began on 3/20/22 and was removed on 6/14/22; CFR 483.25 at tag F682 at ascope and severity (K); IJ began on 3/20/22 and was removed on 6/14/22; CFR 483.70 at tag F835 at a scope and severity (K); IJ began on 3/20/22 and was removed on 6/18/22. The tags F684, F686 and F692 constituted Substandard Outality of Care. A partial extended survey was conducted. The following intakes were investigated: NC00184028, NC001840575, NC00184675, NC00184706, NC00184730, NC00184730, NC001840575, NC00184730, NC00184730, NC001840575, NC001840575, NC00184730, NC001840576, NC00184730, NC001840575, NC001840576, NC00184730, NC00184730, NC001840576, NC00184730, NC00184730, NC001840576, NC00184730, NC00184730, NC001840576, NC001845756, NC00184575, NC001845756, NC00184575, NC00184575, NC001845		T GASTONIA I I C						
Préčiv TAG IEACH DEFICIENCY MUSIT RE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉINX TAG CRASS-REFERENCES OF THE APPROPRIATE COM DEFICENCY) F 000 INITIAL COMMENTS F 000 F 000 An onsite complaint investigation was conducted from 6/7/22 through 6/23/22 in conjunction with a revisit (Event ID #922X12). Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey. F 000 Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (K); IJ began on 3/9/22 and was removed on 6/18/22; CFR 483.25 at tag F684 at a scope and severity (K); IJ began on 3/26/22 and was removed on 6/18/22; CFR 483.25 at tag F686 at a scope and severity (K); IJ began on 3/26/22 and was removed on 6/18/22; CFR 483.25 at tag F686 at a scope and severity (K); IJ began on 3/9/22 and was removed on 6/18/22; CFR 483.25 at tag F686 at a scope and severity (K); IJ began on 3/9/22 and was removed on 6/18/22; CFR 483.20 ta tag F686 at a scope and severity (K); IJ began on 3/9/22 and was removed on 6/18/22; CFR 483.20 ta tag F686 and F692 constituted Substandard Quality of Care. A partial extended survey was conducted. The following intakes were investigated: NC00179921, NC00179949, NC00185011, NC00186428, NC0018706, NC00187400, NC0018976, NC00187400, NC0018706, NC00187400, NC0018976, NC0018766, NC00187400, NC0018976, NC0018766, NC00187400, NC0018976, NC0018776, NC00187930, NC0018976, NC0018776, NC0018766, NC00187400, NC0018976, NC0018776, NC0018776, NC018776, NC0018776, NC0018776, NC018776, NC018776, NC0018776, NC018776, NC018776, NC018776, NC0018776, NC018776, NC018776, NC0018776, NC018776, NC018776, NC0018776, NC018776, NC0187776, NC0018776, NC018776, NC0187776, NC0187776, NC0018776, NC0187776					Ģ	GASTONIA, NC 28056		
An onsite complaint investigation was conducted from 6/7/22 through 6/23/22 in conjunction with a revisit (Event ID #922X12). Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (K): U began on 3/9/22 and was removed on 6/18/22: CFR 483.25 at tag F684 at a scope and severity (K): U began on 3/9/22 and was removed on 6/18/22: CFR 483.25 at tag F684 at a scope and severity (K): U began on 3/2022 and was removed on 6/17/22; CFR 483.25 at tag F686 at a scope and severity (K): U began on 3/2022 and was removed on 6/14/22; CFR 483.25 at tag F692 at a scope and severity (K): U began on 3/9/22 and was removed on 6/14/22; CFR 483.25 at tag F692 at a scope and severity (K): U began on 3/9/22 and was removed on 6/14/22; CFR 483.70 at tag F835 at a scope and severity (K): U began on 3/9/22 and was removed on 6/18/22. The tags F684, F686 and F692 constituted Substandard Quality of Care. A partial extended survey was conducted. The following intakes were investigated: NC00179921, NC00178949, NC00188701, NC00188768, NC00188706, NC00188701, NC00188768, NC00188706, NC00188700, NC00188076, NC00188706, NC00188700, NC00188076, NC00188706, NC00188700, NC00188076, NC00188706, NC00188700, NC00188076, NC00189706, NC00189163, NC00188076, NC00189163, NC00189163, NC00188016, Fifteen (15) of the 44 complaint allegations were substantiated resulting in	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE
from 6/7/22 through 6/23/22 in conjunction with a revisit (Event ID #922X12). Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (K); IJ began on 3/9/22 and was removed on 6/18/22; CFR 483.25 at tag F684 at a scope and severity (K); IJ began on 3/26/22 and was removed on 6/18/22; CFR 483.25 at tag F686 at a scope and severity (K); IJ began on 3/26/22 and was removed on 6/18/22; CFR 483.25 at tag F686 at a scope and severity (K); IJ began on 3/30/22 and was removed on 6/17/22; CFR 483.25 at tag F686 at a scope and severity (K); IJ began on 3/9/22 and was removed on 6/14/22; CFR 483.70 at tag F835 at a scope and severity (K); IJ began on 3/9/22 and was removed on 6/14/22; CFR 483.70 at tag F835 at a scope and severity (K); IJ began on 3/9/22 and was removed on 6/14/22; The tags F684, F686 and F692 constituted Substandard Quality of Care. A partial extended survey was conducted. The following intakes were investigated: NC001789721, NC00179949, NC00185011, NC00186428, NC0018675, NC00186458, NC0018675, NC00186763, NC0018706, NC0018706, NC0018706, NC0018706, NC0018706, NC0018706, NC0018706, NC0018706, NC00187063, NC00188774, NC0018774, NC00187930, NC00188774, NC0018774, NC00187930, NC00188774, NC0018774, NC00187930, NC00188774, NC0018774, NC00187930, NC00188763, NC00188774, NC0018774, NC00187930, NC00188774, NC0018774, NC00187930, NC00188774, NC0018774, NC00187930, NC00188763, NC00188774, NC0018774, NC00187930, NC00188774, NC0018774, NC00187930, NC00188774, NC0018774, NC00187930, NC001887	F 000	INITIAL COMMENTS		F	000			
NC00186780, NC00187066, NC00187400, NC00187734, NC00187774, NC00187930, NC00188076, NC00188163, NC00189163, NC00189416. Fifteen (15) of the 44 complaint allegations were substantiated resulting in		from 6/7/22 through 6 revisit (Event ID #922 cited. New tags were complaint investigation Immediate Jeopardy 9 CFR 483.10 at tag F5 (K); IJ began on 3/9/2 6/18/22; CFR 483.25 at tag F6 (K); IJ began on 3/26, 6/18/22; CFR 483.25 at tag F6 (K); IJ began on 3/30, 6/17/22; CFR 483.25 at tag F6 (K); IJ began on 3/9/2 6/14/22; CFR 483.70 at tag F6 (K); IJ began on 3/9/2 6/18/22. The tags F684, F686 Substandard Quality 6 survey was conducted The following intakes NC00179921, NC001	 also cited as a result of the ensurvey. was identified at: 580 at a scope and severity 22 and was removed on 584 at a scope and severity 722 and was removed on 586 at a scope and severity 722 and was removed on 586 at a scope and severity 722 and was removed on 592 at a scope and severity 22 and was removed on 593 at a scope and severity 22 and was removed on 593 at a scope and severity 22 and was removed on 594 at a scope and severity 22 and was removed on 595 at a scope and severity 20 and was removed on 595 at a scope and severity 20 and was removed on 595 at a scope and 595 at a scope and 595 at a scope at a scope and 595 at a scope at					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DAT		NC00186780, NC001 NC00187734, NC001 NC00188076, NC001 NC00189416. Fifteer allegations were subs deficiencies.	87066, NC00187400, 87774, NC00187930, 88163, NC00189163, n (15) of the 44 complaint stantiated resulting in					(X6) DATE

Electronically Signed

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.

07/08/2022

PRINTED: 07/26/2022

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		<u>NO. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION		MPLETED
			A. BOILDING			С
		345307	B. WING		0	6/23/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2022
			4	414 WILKINSON BLVD		
THE IVY A	T GASTONIA LLC		G	GASTONIA, NC 28056		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)		COMPLETIO DATE
F 000	Continued From page	e 1	F 000			
	The facility is still out	of compliance.				
F 580	•	jury/Decline/Room, etc.)	F 580			7/16/22
SS=K	CFR(s): 483.10(g)(14)(i)-(iv)(15)				
	§483.10(g)(14) Notific	cation of Changes				
		ediately inform the resident;				
		ent's physician; and notify,				
		her authority, the resident				
	representative(s) whe	en there is-				
		ving the resident which				
		as the potential for requiring				
	physician intervention					
		ge in the resident's physical,				
	mental, or psychosoc	n, mental, or psychosocial				
		reatening conditions or				
	clinical complications					
		eatment significantly (that is,				
	a need to discontinue	an existing form of				
	treatment due to adve	erse consequences, or to				
	commence a new for					
	(D) A decision to trans					
	resident from the facil	lity as specified in				
	§483.15(c)(1)(ii).	fication under paragraph (g)				
		fication under paragraph (g) the facility must ensure that				
		on specified in §483.15(c)(2)				
		ded upon request to the				
	physician.					
		also promptly notify the				
		lent representative, if any,				
	when there is-					
		or roommate assignment				
	as specified in §483.1					
		ent rights under Federal or ns as specified in paragraph				
	(e)(10) of this section					

Facility ID: 923314

If continuation sheet Page 2 of 133

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	. ,		CONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY LETED	
		345307	B. WING _			C 06/23/2022		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
				44	14 WILKINSON BLVD			
THE IVY A	T GASTONIA LLC			G	ASTONIA, NC 28056			
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Continued From page	e 2 mailing and email) and	F 5	580				
	phone number of the representative(s).	č ,						
	§483.10(g)(15) Admission to a comp	osite distinct part. A facility						
	that is a composite d	istinct part (as defined in						
		e in its admission agreement						
		tion, including the various						
	-	se the composite distinct y the policies that apply to						
		en its different locations						
	under §483.15(c)(9).							
		Γ is not met as evidenced						
	by:							
		iews, and interviews with			(1) Address how corrective action will			
		rector, the facility failed to			accomplished for those residents found	d to		
		re Provider of significant			have been affected by the deficient			
		t's condition (Resident #9)			practice;			
	when he developed a pressure ulcer, when	-			" Resident (#10) was identified and	no		
	· ·	en he continued to have			longer a resident at the facility.			
	hypotension (low blog				 Resident (#9) was identified and n 	0		
		s fluids. The facility also			longer a resident at the facility.			
		s of a urinalysis and urine			ů ,			
	culture resulting in a	delay in treating the resident			(2) Address how the facility will identif	Γy		
	· · · ·	(urinary tract infection).			other residents having the potential to			
		pitalized on 4/5/22 for severe			affected by the same deficient practice	;		
		lue to an infected stage 4						
	•	sacrum. In addition, the			" All Residents were reweighed.	00		
		the Primary Care Provider			Reweights were completed by 7/13/202			
	loss (Resident #10).	a severe unintended weight			" Residents had head-to-toe skin au completed. Any residents with negative			
		resident #10 had a a ss of 24.4% from 1/19/22			findings their respective physician was			
	-	admitted to the hospital on			notified. Audit completed on 7/12/2022			
	-	ding tube inserted in the			Administrative nursing team.	,		
		ures were for 2 of 3 residents			" Resident charts were audited to			
		ion of changes (Resident #9			determine if any other outstanding labs	6		
	and Resident #10).	· ·	1		had not been addressed, review was			

Facility ID: 923314

If continuation sheet Page 3 of 133

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 580 Continued From page 3 F 580 completed on 7/13/2022 by Administrative Nursing Team. Respective Physician was Immediate Jeopardy began on 3/9/2022 when notified of any outstanding labs on staff failed to identify a significant weight loss of 7/13/2022 by Director of Nursing or 11.5% for Resident #10. Resident #10 continued Designee. to lose weight and had a cumulative weight loss Resident records were reviewed for of 24.4% since 1/19/2022. Immediate Jeopardy change in condition that was not began on 3/26/22 for Resident #9 when the reported/change in wound or pressure facility failed to follow up on urine culture results sore that was not communicated. Review and provide the care and services required by was completed on 7/13/2022 by Resident #9 resulting in a delayed treatment for Administrative Nursing Team. UTI (urinary tract infection). Resident #9 New lab process implemented on continued to have confusion, altered mental 6/17/2022 to include obtaining orders, status, hypotension (low blood pressure) and notification, tracking, and what steps to pressure ulcer deterioration which resulted in take in the event a lab diagnostic is Resident #9 being sent out to the emergency missed. room for evaluation and treatment of sepsis due to an infected stage 4 pressure ulcer to the (3) Address what measures will be put sacrum. The Immediate Jeopardy was removed into place or systemic changes made to on 6/18/22 when the facility implemented an ensure that the deficient practices will not acceptable credible allegation for Immediate recur: Jeopardy removal. The facility remains out of compliance at a scope and severity level of E (no Re-education was provided to actual harm with potential for more than minimal Licensed and Certified nursing staff by the harm that is not immediate jeopardy) for the Director of Nursing/Designee related to facility to continue staff education and ensure the following: monitoring systems put into place are effective. Reporting a change in resident о condition such as the following indicators: The findings included: Weight loss or gain >5 lbs. from last о documented Resident #9 was admitted to the facility on Vital signs 1. о 3/4/19 with diagnoses that included hypertension, Skin integrity 0 atrial fibrillation, and peripheral vascular disease. 0 Habits or routines 0 Atypical behavior A review of Resident #9's medical record Education will be completed by 7/15/2022 indicated a faxed result from the laboratory dated 3/23/22 at 8:46 PM for a urinalysis with the Re-education was provided to following abnormal values: cloudy appearance, Certified nursing staff by the Director of leukocytes 3+, protein 100, blood 3+, WBC (white Nursing/Designee related to the following:

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 923314

PRINTED: 07/26/2022

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · ·	E SURVEY PLETED
		345307	B. WING			C
	ROVIDER OR SUPPLIER	040007		STREET ADDRESS, CITY, STATE, ZIP CODE	06/23/2022	
	NOVIDER ON SOIT FIER			4414 WILKINSON BLVD		
THE IVY A	AT GASTONIA LLC			GASTONIA, NC 28056		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 580	Continued From page	a /	F 58			
1 500			F DC		ush sau	
	blood cells) 3+ and b	aciena 3+.		o Nurse notification of changes s		
	A uning gulturg regult	reported by the leberatory		o Any new or worsening redness		
		reported by the laboratory M indicated Resident #9's		rashes, breaks in skin, abrasion, or unusual skin area that wasn⊓t obse		
		Providencia stuartii of			erveu	
		-forming unit)/ml (milliliter).		o Complaints of pain		
		ed the different antibiotics		o Irregular heart rate (high or low	d)	
		s susceptible and resistant		o Decreased urine output)	
	to.			o Fever/Chills		
	10.			o Difficulty breathing		
	A phone interview wit	th Nurse #2 on 6/13/22 at		o Atypical mental confusion		
	-	e had taken care of Resident		Education will be completed by 7/1	5/2022	
		ift when he started to get			0/2022	
		se #2 stated she noticed a		" Re-education was provided to		
		on when he called her by		Licensed Nursing staff by Director of	of	
	-	e, and he was getting more		Nursing/Designee related to the foll		
		mbered him receiving		o New lab process	owing.	
		it she had to hold his blood		o Physician notification of change	es in	
		on 3/22/22, 3/23/22, 3/24/22,		resident condition to be documente		
		because his blood pressure		Residents record such as:		
		tated at first the low blood		¿ New or worsening of pressure		
	pressure reading did			iniuries/wounds		
		pressure fluctuated all the		¿ Newly admitted residents with	skin	
		stated she had thought		integrity issues such as wounds, an		
		ossibly having sepsis, but		pressure injuries		
		being seen by the wound		¿ Changes in skin integrity		
		e ulcer on his sacrum.		¿ Signs of infection		
	-	ed she worked on 3/23/22		¿ Any wound deterioration		
	but didn't remember			¿ Abnormal labs		
		was not aware that he had		¿ Weight loss or gain >5 lbs. fror	n last	
	-	member if it was passed on		documented		
		y were still waiting on		¿ Complaints of unrelieved pain		
	Resident #9's urinaly	sis and urine culture results.		Education will be completed by 7/1	5/2022	
	Nurse #2 also stated	she had done most of				
	Resident #9's hydroc	olloid dressing in March		Education will be included with new		
	2022 and she noticed	that the open wound on his		Licensed Nursing and Certified Nur	sing	
	buttocks had gotten v	vorse, but she didn't		Aide new hire orientation by the Dir	ector	
		nen it started to get worse.		of Nursing/Designee		
	Nurse #2 stated she	remembered Resident #9's				

Facility ID: 923314

		MEDICAID SERVICES	(X2) MULTIF	LE CONSTRUCTION		B NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	` '	3		COMPLETED
						С
		345307	B. WING			06/23/2022
NAME OF P	ROVIDER OR SUPPLIER	•	- ·	STREET ADDRESS, CITY	Y, STATE, ZIP CODE	
				4414 WILKINSON BLV	D	
	T GASTONIA LLC			GASTONIA, NC 280	56	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page	5	F 58			
1 000	• • • • • • • • • • • • • • • • • • •	smaller than the size of a	F JG		w the facility plans to	
		rted working with him but on			ormance to make sure that	
		d changed his hydrocolloid		solutions are su		
		that the wound had gotten			·,	
	bigger to the size of a	-		" Director of	Nursing/Designee will	
	draining more. Nurse	e #2 did not notify the doctor		conduct 10 resi	dent record reviews for	
		esident #9's pressure ulcer			related to change of	
		he was already being seen			on, new or worsening	
	by the wound doctor.				cant weight changes, lab	
					physician notification and	
	-	h Nurse #7 on 6/13/22 at			licated weekly for 4 weeks,	
		ne took care of Resident #9			record reviews weekly for	
		22 and had to change his on both days. Nurse #7		weekly for 4 we	l resident record review	
		Resident #9's ulcer to his			the reviews will be	
	sacrum on 3/24/22.				ig the monthly Quality	
		ized open area on Resident			eting for tracking, trending,	
	-	ed clean, pink and had no			dations from the IDT team	
		odor. Nurse #7 did not			or Designee will be	
	report this observatio	n to anyone as she thought			bringing/discussing	
	this was normal for hi	m. She also did not		reviews in mont	thly Quality Assurance	
		on report that they were		Meeting for 3 m	onths or until substantial	
	waiting on Resident # culture results.	[£] 9's urinalysis and urine		compliance is n	naintained.	
		Interim Director of Nursing		Date of complia	ance: 7/16/2022	
		10:43 PM revealed Resident				
		onfusion within the last 4 to 6				
		at the facility, but she noticed				
		a lot more confused on				
		she looked through Resident on 3/30/22 and discovered a				
		ated 3/26/22 that hadn't				
	-	e reported this to the Nurse				
		requested an order for an				
		The Interim DON also				
		ure if she had received a				
		before her that they were				
		9's urinalysis and urine				1

If continuation sheet Page 6 of 133

		D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			-		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				4	414 WILKINSON BLVD			
THEIVYA	T GASTONIA LLC			Ģ	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page culture results.	6	F	580				
	11:03 AM revealed sh on the night shift from AM on 3/31/22. Nurs waiting on his urine of aware that it had been on 3/26/22. Nurse #8 trickled down during r and not everything go noted that Resident # so she held his Metop Nurse #8 stated she p notebook about Resid they could see it when Nurse #8 stated she of							
	revealed she took car and had to hold his 8: because his blood pre stated Resident #9's I alert her because she intravenous fluids bec had been low. A phone interview wit 10:20 AM revealed sh from 7:00 AM to 7:00 Nurse #3 recalled see buttocks on 4/3/22 wh hydrocolloid dressing surprised to see how stated it was the wors	se #4 on 6/13/22 at 4:01 PM e of Resident #9 on 4/1/22 00 AM Metoprolol dose essure was low. Nurse #4 ow blood pressure didn't thought he was receiving cause his blood pressure h Nurse #3 on 6/13/22 at he took care of Resident #9 PM on 4/2/22 and 4/3/22. eing the wound on his hen she had to change the . Nurse #3 stated she was bad the wound looked and tt-looking pressure ulcer she Nurse #3 saw the wound,						

Facility ID: 923314

If continuation sheet Page 7 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	: 07/26/2022 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	() 06/2	; 23/2022
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				4414 WILKINSON BLVD			
	T GASTONIA LLC			GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	into the room and the antiseptic dressing on assumed that the form doctor of Resident #9 received an order for Nurse #3 stated she of the pressure ulcer bea former DON know and going to take care of it A phone interview wa 12:01 PM, 6/14/22 at 10:19 AM with the for A NP note dated 4/5/2 was seen by the NP for buttocks. It was docum unstageable wound to coccyx, eschar (dead sloughs off healthy sk the buttocks and there necrotic area to the rig wound, recommend h wound evaluation. Multiple attempts were but they were unsucco worked with the Medie A follow-up interview of Nursing (DON) on 6/1 the nursing staff were communicate with the messages through the not utilize a notebook Interim DON stated sl documentation/comm	Director of Nursing (DON) former DON placed an the wound. Nurse #3 ner DON had notified the 's pressure ulcer and the antiseptic dressing. did not notify the doctor of cause she had let the d she thought she was t. s attempted on 6/13/22 at 12:00 PM and 6/15/22 at mer DON with no return call. 22 indicated Resident #9 or the wound to his mented there was an o one-fourth area of the tissue that eventually in after an injury) present to a was also a 2 cm by 2 cm ght heel. Unable to stage e be sent to the hospital for e made to contact the NP, essful. The NP no longer cal Director's team. with the Interim Director of 3/22 at 3:00 PM revealed only supposed to e providers through text e tablet and the facility did for the providers. The ne did not see any	F 58				

Facility ID: 923314

If continuation sheet Page 8 of 133

		D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/26/2022 APPROVED 0: 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	_	(X3) DATE COMP	SURVEY LETED
		345307	B. WING			06/:	C 23/2022
NAME OF PR	OVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, S	STATE, ZIP CODE		
	GASTONIA LLC			4414 WILKINSON BLVD			
	GASTONIA LLC			GASTONIA, NC 28056	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	his urine culture result DON also stated that physician documented messages and there w staff that Resident #9' opened, was large an A phone interview with on 6/14/22 at 4:22 PM open areas on Reside recurred due to his no offloading and incontin sure about the pressul before he was sent ou stated he had expected deterioration/decline in though they had expected the nursing staff to represent the nursing staff to repressure ulcer and co readings even though intravenous fluids. Resident #9's hospital 4/5/22 indicated Reside Emergency Department Resident #9 was foun	a she had notified the NP of ts on 3/30/22. The Interim she checked the nurse to d communication text was no report to the medical 's wound to his buttocks had d black. In the Medical Director (MD) I revealed he was aware of ent #9's buttocks that on-compliance with nence care, but he wasn't tre ulcer that developed right at to the hospital. The MD ed to be notified of any in pressure ulcers even cted Resident #9's ulcer to non-compliance. The MD now that there was delay #9 on antibiotics for UTI, ped the nursing staff had ne culture result, so it was NP who had ordered the ulture. The MD stated he ses to have assessed acutely ill and checked his to a day. He also expected bort any decline in condition ration of Resident #9's ntinued low blood pressure he was receiving	F 5	80			

If continuation sheet Page 9 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
				4	414 WILKINSON BLVD			
	T GASTONIA LLC			G	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	injury of buttock stage cells indicating an infe encephalopathy, acut superimposed on chro intravascular volume low sodium. The surg sacral ulcer determine necrotic, and malodor erythema. Plan was f diverting colostomy. ulcer was contaminate was critically ill and at resulting in end-organ fevers were up to 103 infected sacral pressu tomography) scan of revealed extensive su (deep seeded infectio organisms) and tunne gluteal and above the #9 also had a stage 4 plantar foot and a sof stump. An interview with the on 6/13/22 at 5:34 PM supposed to complete each resident but if th ulcer, the nurses were doctor's attention. An ulcer should be referr proper treatment and follow-up interview on DON also stated that follow up on laborator with the doctor. The expected the nurses the	ulcer stage IV, a pressure e IV, elevated white blood ection, metabolic e renal failure onic kidney disease stage 3, depletion (dehydration), and gical consult for decubitus ed the ulcer was large, rous ulcer with only minimal for surgical debridement and It was suspected the sacral ed with stool. Resident #9 t risk for decompensation of dysfunction. The resident's B Fahrenheit due to an ure ulcer. A CT (computed the sacral pressure ulcer ubcutaneous gas formation on with gas forming eling upward within the e gluteal tissues. Resident • pressure ulcer to the right t tissue ulcer to the great toe Director of Nursing (DON) A revealed the nurses were e weekly skin checks on the resident had a pressure ed to the wound doctor for evaluation. During a of 6/15/22 at 1:40 PM, the she expected the nurses to ry results and address them DON further stated she	F	580				

Facility ID: 923314

If continuation sheet Page 10 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_	C 06/23/2022	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	about any acute issue The Administrator was Jeopardy on 6/15/22 a 2. Resident #10 was a 3/21/2019 with diagno intellectual disorders. Physician order initiat "weekly weights every for weight monitoring, resident's discharge of Resident #10 weighed 1/19/2022 collected b Review of January 20 Administration Record documentation of Res from 1/26/2022 throug documented in vital si Resident #10 weighed (representing an 11.5 1/19/2022) and docur Resident #10 weighed (representing an 11.5 1/19/2022) and docur Resident #10 weighed #10 refused to be wei 3/30/2022. Attempts were made entered the weights for and 3/23/2022, via tel Nurse #1 was assigned	r shift and to call the doctor es or change in condition. s notified of Immediate at 1:41 PM. admitted to the facility on osis of cerebral palsy and ed on 4/21/2021 read in part y day shift every Wednesday " The order was active on late of 4/8/2022. d 125.7 pounds on y mechanical lift. 22 Medication d (MAR) revealed no sident #10's weekly weights gh 3/2/2022. The weight igns revealed on 3/9/2022, d 111.2 pounds % weight loss since nented on 3/23/2022 d 112.3 pounds. Resident ghed on 3/16/2022 and to interview Nurse #1 who or Resident #10 on 022 when Resident #10	F	580				
	refused to be weighed Review of Nursing Pro							

If continuation sheet Page 11 of 133

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			-		C 23/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Resident #10's refusa Review of Physician F 2022 revealed no phy Resident #10's weigh Attempts were made via telephone were un Resident #10 weighed undocumented how th (representing a 24.4% 1/19/2022). Review of Nursing Pro- revealed no document notified of Resident # An interview was composed P.M. with the Unit Ma #10's weight into the of 4/6/2022. During the in revealed when the we computer system, if the inaccurate, she reque completed by the assist came back with a sign physician and the dief Resident #10's chart of Manager, the Unit Ma reweigh was not composed was not notified about change. Nurse Practitioner Pro- revealed the reason for	ent #10's weight change or als to be weighed. Progress Notes for March risician note that addressed t loss. to interview the Physician nsuccessful. d 95 pounds on 4/6/2022, ne weight was collected. 6 weight loss since ogress Notes for April 2022 tation the physician was 10's weight loss. ducted on 6/8/2022 at 3:11 nager who entered Resident electronic medical chart on interview the Unit Manager eights were entered into the ne weight appeared ested a reweigh be igned nurse. If the reweigh nificant weight change, the	F	580				
	revealed the reason for #10 was documented	or the visit with Resident						

Facility ID: 923314

If continuation sheet Page 12 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/26/2022 RM APPROVED IO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DA	TE SURVEY MPLETED
		345307	B. WING		0	C 6/23/2022
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO		
			4414	4 WILKINSON BLVD		
	T GASTONIA LLC		GA	STONIA, NC 28056		
(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 ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	loss. The note reads in Requires assistance williving). Monitor weight meals." Attempts were made Practitioner via teleph An interview was com A.M. with Nurse#2. N 4/7/2022 at the start of she entered Resident "Hello". She revealed Resident #10, he did Nurse #2 stated this willing #10 and she went to b Nurse #2 stated this willing #10 and she went to b Nurse #2 stated she of signs which were with range. During the inter to Resident #10's lack felt something was will physician and Reside Resident #10 was ser department for evalual Resident #10 was add 4/7/2022 with a chief status. The physician the emergency depar P.M. revealed Reside A nutrition consultatio #10 was admitted to the a primary diagnosis of sodium level). The me showed Resident #10 through his nose to his tube). On 4/10/2022 at	0 had a 16-pound weight in part "Periods of agitation. with ADL's (activities of daily t. Monitor consumption of to interview Nurse none were unsuccessful. ducted on 6/11/2022 at 8:08 urse #2 revealed on of her 7 P.M. to 7 A.M. shift, #10's room and told him when she spoke to not respond to her greeting. vas not normal for Resident his bedside to assess him. completed a set of vital hin Resident #10's normal erview, Nurse #2 stated due c of a verbal response, she rong. After talking to the nt #10's responsible party, ht to the emergency	F 580			

Facility ID: 923314

If continuation sheet Page 13 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Resident #10's stoma course indicated their successful PEG tube placed directly into the The resident was disc another skilled nursin a discharge weight of An interview was com 5:02PM with the Regi revealed expectations weights, provide inter notify responsible par RP. On 6/12/2022 at 1:55 Nurse Consultant and were informed of the The facility provided t credible allegation of removal. Credible Allegation of Removal for F580. 1. Identify those recip are likely to suffer, a s a result of the noncom The identified residen longer a resident of the a 24.4% weight loss f notification to Primary The other identified residen	e. The x-ray findings el feeding tube ended in ich. A review of the hospital esident underwent a placement (feeding tube e stomach) on 4/18/2022. charged on 4/19/2022 to g facility. Resident #10 had 104 pounds. ducted on 6/11/2022 at onal Nurse Consultant s would be to monitor ventions for weight loss and ties to include the MD and P.M., the facility's Regional d Director of Nursing (DON) immediate jeopardy. he following acceptable Immediate Jeopardy Immediate Jeopardy ients who have suffered, or serious adverse outcome as npliance: t (Resident #10) is no he facility. Resident #10 had rom January to April with no	F 580				

If continuation sheet Page 14 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
	T GASTONIA LLC			44	414 WILKINSON BLVD			
	IT GASTONIA LEC			G	ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	delay in treatment wit physician of results of pressure ulcer and co status and condition. All other residents har affected by the deficie were identified as hav had 1 resident refuse will ask them again ar if they can assist in er weighed. The Primar notified by the DON o hours for those reside loss. All other residents har affected by the deficie were identified as hav resident charts will be other outstanding labs initiating 6/15/2022 ar The Primary Care Pro DON or DON designe identified residents wi have not been previou outstanding labs. that All residents' records condition that was not or pressure sore that completed by 6/16/20 DON Designee.	h failure to notify the i urinalysis, deterioration of intinued decline in mental we the potential to be ent practice. Other residents ring weight loss. We have weight to be obtained. We hd will contact family to see neouraging them to be y Care Provider will be r DON designee within 24 ents identified to have weight we the potential to be ent practice. Other residents ring skin integrity issues. All a audited to determine if any s. have not been addressed, hd completed by 6/15/2022. wider will be notified by the se by 6/16/2022 with any th skin integrity issues that usly identified and any have not been addressed. were reviewed for change in t reported/change in wound was not communicated and 22 by the DON and the y audit of all residents was hd completed 6/15/2022. les identified will be reported	F	580				

Facility ID: 923314

If continuation sheet Page 15 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/26/2022 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	06/2	C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			4	414 WILKINSON BLVD			
THE IVY A	T GASTONIA LLC		G	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	DON and/or the DON any labs. have not be completed by 6/15/20 Provider was notified 2. Actions taken to alt failure to prevent adve occurring or recurring Immediate in-service completed on 6/14/20 immediate in-service observed skin integrit 6/15/2022 and any lat the Director of Nursin Corporate Nurse Con nursing staff to ensure or DON designee of a 6/11/2022; skin integri have not been address completion of lab. in-service conducted in person, sign in sheet in-service communication conve- text will have to be pro- they report to work pro- Also, signage at the ti named that received to Designee prior to taki Nursing staff will have	6/15/2022 conducted by the Designee to determine if en addressed and will be 22. The Primary Care of all labs. test results. The process or system erse outcome from : initiated 6/11/2022 and 22 for weight loss and initiated 6/14/2022 for y issues with completion on bs. not being addressed by g (DON) and/or the sultant to the Licensed e that they inform the DON any weight loss initiated ity issues; or any labs. that used initiated 6/15/2022 with servicing 6/16/2022.	F 580		DEFICIENCY)		
	have the in-person in- working shift with sigr	-					

If continuation sheet Page 16 of 133

ATEMENT ((* * * * *			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	IPLE CONSTRUCTION	· · ·	E SURVEY IPLETED
						С
		345307	B. WING			6/23/2022
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
HE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD GASTONIA, NC 28056		
04015						()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 580	Continued From page	<u>•</u> 16	F 5	80		
		e responsible for tracking	1.5			
	0	t educated and ensuring				
		or to them working after				
		hired nurses along with any				
		ve the information contained				
	in the in-service prior	to working with residents.				
	The DON and/or DON	N Designee initiated				
		22 with the Licensed nurses				
	and nurse aides to re					
		ty, eating habits or any				
		not typical of the individual				
		n-service training initiated for				
		2022 regarding any changes				
		nge in habits and routines the nurse. The Nurse Aide				
		icensed Nurse and the				
	•	ld assess the resident and				
	report and notify the F	Primary Care Provider of any				
	-	ducation provided by the				
		signee and completed by				
		and/or DON designee will				
		cking employees who aren't ng they are educated prior to				
		17/2022. This education will				
	-	hired Licensed Nursing staff				
		r to taking their resident				
	assignment.					
	lisses and assume in a state	6				
	the Primary Care Pro	f will be educated to notify				
		ure wound or open area, any				
	signs of wound infecti					
		as initiated on 6/14/2022, by				
	the DON and/or RN c	ertified wound nurse and				
		he nursing staff to include				
		and agency nursing staff				
	and will be completed	1 by 6/16/2022. This				

Facility ID: 923314

If continuation sheet Page 17 of 133

		D HUMAN SERVICES				FORM	07/26/2022
STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				LETED
		345307	B. WING		_		C 23/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	T GASTONIA LLC		4	414 WILKINSON BLVD			
			0	SASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	. 17	F 500				
1 300	Nursing staff and age	ncy staff prior to taking their	F 580				
	resident assignment.						
		be educated to notify the					
		es in skin integrity promptly ent's nurse. Such changes					
		ny skin break, abrasions, or					
	any unusual skin integ	grity observations that were					
		servation during prior care					
	•	s will also be educated on					
		of sepsis to include: faster ine output, fever and chills,					
	difficulty breathing, me	-					
	hyperventilation. In-se	ervice education initiated on I and/or the DON designee					
		any changes from baseline					
		example, any changes in					
		eating habits, changes in					
		complaints of pain to the					
		DON and/or DON designee					
	•	referencing the list posted at at of current staff to include					
		urse aides. The DON					
		will be responsible for					
	•	ho aren't educated and					
		cated prior to them working					
		education will be given to					
		ed Nursing staff and agency eir resident assignment.					
	stall prior to taking the	en resident assignment.					
	If any residents are id	entified to have greater than					
	•	or greater, the MD will be					
		nd/or DON Designee and					
	prompt interventions w prevent further weight						
	If any residents are id						
	integrity issues or labs addressed, the DON a	s. that have not been and/or DON designee will					

Facility ID: 923314

If continuation sheet Page 18 of 133

	MENT OF HEALTH AN					FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345307	B. WING				C 23/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
	AT GASTONIA LLC		4	414 WILKINSON BLVD			
			G	SASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 580	notify the Primary Car skin observation Repor- reviewed during clinic and/or DON Designed Designee will also rec- information from the li- calls the Licensed nur the Nurse notifies the promptly. A Lab. book will be im- nurses' station that wi notification of Primary results have been obt the resident's name, to the ordered lab., the of critical labs. noted, the the ordered lab., the of critical labs. noted, the the Primary Care Prov Nurse receiving lab. of lab. book. The Nurse will notify Primary Car Lab. results and docu notification. All critical Nurse at the facility fro Nursing staff to includ In-service education a 6/16/2022 by DON and completed by 6/17/20 designee will be respo- employees who aren't they are educated prio 6/17/2022. This educ newly hired Licensed prior to taking their re- The DON and/or Desi book every morning to have not been address	re Provider promptly. The ort and Labs. will be al meeting by the DON e. The DON or DON seive the skin integrity icensed nurse. The Lab. rse of any critical labs, and Primary Care Provider plemented and kept at the Il reflect ordered labs. and r Care Provider when lab. ained. The book will reflect he date of the lab. ordered, date results obtained and if e notification date and time wider was notified. The order will place lab. in the who receives lab. results re Provider of any Critical ment in lab. book of doing I labs. are called to the om the Lab. All Licensed le agency to receive and was initiated on ad/or DON Designee and 22. The DON and/or DON onsible for tracking t educated and ensuring or to them working after iation will be given to all Nursing and agency staff	F 580				

Facility ID: 923314

If continuation sheet Page 19 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	DON Designee find at Designee will notify th The weekend supervi and has been informer regard. The facility will conduct with the Interdisciplina resident weight losses any abnormal labs. or reviews of lab. book to and will discuss the in determine if the intervi- the resident meets the skin assessments, wo wound healing progre- healing; and lab. issue by the DON or DON D are not reflective of ac Primary Care Provide interventions will be re add or eliminate and r appropriate to achieve healing goals; notifica Completion Date - 6/1 The credible allegatio jeopardy removal was removal date of 6/18/2 A review of in-service 6/11/22 to 6/17/22 rev provided to nurses an included reporting any and the Unit Manager	the lab. book on the e same. If the DON and/or ny issues, the DON or DON e Primary Care Provider. sor was educated 6/16/2022 ad of her responsibility in this ct weekly Focus meetings ary team to discuss any s, skin integrity issues, and any issues with morning o determine if any trends terventions put in place and entions are beneficial until eir or desired body weight; ound measurements with ss or issues with wound es noted in morning reviews Designee. If interventions chieving desired results, the r will be notified, and e-addressed and potential to replace interventions as e weight gain goals; wound tion of labs. 8/2022 In for the immediate s validated on 6/23/22 with a 22. education records from	F	580				

Facility ID: 923314

If continuation sheet Page 20 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 07/26/2022 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	change in activity, sm daily habits to the nur changes in residents' loss, skin integrity issu that have not been ad communicated timely the Director of Nursing Interviews with the nur had been educated of change in condition as change in condition as change in condition to different signs of char what observations to l the residents at the fa they had been educate Care Provider of char pressure wound or op wound infection and a This notification to the included reporting we the residents' condition The laboratory book w station, and it included resident's name, labo laboratory test ordere obtained, any critical I the date and time the notified. A weekly focus meetin which included the Ad Nursing, and the Infection	nges in the residents' ch change in vital signs, oking habits and change in se. Any new orders, conditions, reports, weight ues and laboratory results dressed need to be to the physician, family, and g. rsing staff revealed they n when to report a resident's s well as who to report the b. They also verbalized the toges including sepsis and ook for while working with cility. The nurses stated ed on notifying the Primary tiges such as a new en area, any signs of iny wound deterioration. e medical provider also ight loss and any changes in n. vas observed at the nurses' d an audit tool developed by ed information on the ratory test order date, d, date the results were aboratory test results and medical provider was	F 580				

Facility ID: 923314

If continuation sheet Page 21 of 133

		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY IPLETED
						С
		345307	B. WING		06	6/23/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD GASTONIA, NC 28056		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 580	Continued From page	e 21	F 58	30		
	review/notification, we conditions and acute	eight loss, change of				
F 641	Accuracy of Assessm		F 64	11		7/16/22
SS=D	CFR(s): 483.20(g)					
		of Assessments. t accurately reflect the				
	resident's status. This REQUIREMENT by:	「 is not met as evidenced				
	Based on record rev	iew and staff interviews, the		(1) Address how corrective action		
	30 days of the Minim	. ,		accomplished for those residents for have been affected by the deficient		
	Assessment Referen of the look back peric	ce Date (ARD, the last day od) for 1 of 4 MDS		practice;		
	assessments reviewe			" Resident (#10) was identified a	ind no	
	Eindingo includod:			longer a resident at the facility.		
	Findings included:			(2) Address how the facility will ide	entify	
	Resident #10 was ad	mitted to the facility on		other residents having the potential		
		osis of cerebral palsy and		affected by the same deficient pract	tice;	
	seizures.			" Review of MDS open assessm	ents	
	A physician order init	iated on 4/21/2021 read in		for Section(K)0200: Height and We		
	part "weekly weights			ensure the weight was obtained wit	hin 30	
		nt monitoring." The order		days of the Assessment Reference		
	was active through th 4/8/2022.	ie discharge date of		(ARD) and documented accurately submission will be completed by the		
	4/0/2022.			administrative nursing team by 7/15		
	Resident #10's weigh					
		ectronic medical record		(3) Address what measures will be		
	. ,	On 1/19/2022 his weight oounds. There were no		into place or systemic changes made ensure that the deficient practice wi		
		nented until 3/09/2022 noted		recur;	II HOL	
		th weights had been noted				
	as measured by using	-		" Re-education was provided to	the	
				Interdisciplinary Team (MDS, Dietar		
	Resident #10's annua	al MDS dated 3/5/2022		Manager, Registered Dietician, Soc	lal	

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 22 of 133

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 22 F 641 indicated Resident #10 weighed 126 pounds and Services, Activities Director, Therapy had no weight loss of 5% or more in the last Manager) and other department heads month or loss of 10% or more in the last 6 responsible for completing sections of the months. MDS by the Director of Nursing/Designee related to the following: An interview with the with the facility's Consultant Accurate resident status is reflected in 0 Registered Dietician (RD) was conducted on each section of the MDS assessment 6/13/2022 at 10:28 A.M. The RD stated it was her 0 Section(K)0200: Height and Weight to responsibility to complete the weight section for ensure the weight was obtained within 30 annual MDS assessments and she used the days of the Assessment Reference Date weight last entered in the EMR. During the (ARD) and documented accurately interview, the RD reviewed Resident #10's chart. Education to be provided by Director She read the weight on 1/19/2022 as 125.7 of Nursing/ Designee education will be completed by 7/15/2022. pounds and the next weight documented was 3/9/2022 as 111.2 pounds. The RD stated she did Education will be added to Department not request to have a new weight measured for head orientation. Education will be Resident #10 when she completed Resident provided by Director of nursing/Designee. #10's annual MDS assessment in March. Dietary will be responsible for completing Section (K)0200: Height and An interview with the Regional Nurse Consultant was conducted on 6/13/2022 at 12:17 P.M. Weight section of the MDS assessment. During the interview the Regional Nurse Dieatry will be informed of this responsibility by 7/15/2022. Consultant stated she would expect the MDS assessment to accurately reflect the resident's weight. (4) Address how the facility plans to monitor its performance to make sure that solutions are sustained; Administrator/Designee will conduct 10 MDS assessment reviews to confirm Section (K)0200: Height and Weight have a weight that was obtained within 30 days of the Assessment Reference Date (ARD) and documented accurately prior to submission weekly for 4 weeks, then 5 MDS assessment reviews for weekly for 4

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 23 of 133

PRINTED: 07/26/2022

		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVE NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345307	B. WING		0	C 6/23/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				4414 WILKINSON BLVD		
THE IVY A	T GASTONIA LLC			GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
F 641	Continued From page	≥ 23	F 64	weeks, then 1 MDS Asses weekly for 4 weeks. "Results of the review discussed during the mon Assurance meeting for tra and recommendations fro	s will be thly Quality icking, trending, m the IDT team.	
F 657 SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)		F 6	Date of Compliance 7/16/ 57	2022	7/16/22
	 be- (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lime (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and their resident and their resident reproduces the resident of the resident reproduces the resident of the resid	orehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that ited to ysician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident resentative is determined a development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the				

Facility ID: 923314

If continuation sheet Page 24 of 133

PRINTED: 07/26/2022

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		ATE SURVEY
		345307	B. WING				C 06/23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657		e 24 「 is not met as evidenced	F	657			
	medical record review review and revise a re accurately reflect the of 2 residents reviewe resident to resident in The findings included Resident #1 was adm 9/18/19 with reentry of The resident's cumula non-Alzheimer 's der A review of Resident	intervention(s) required for 1 ed for an inappropriate nteraction (Resident #1).			 (1) Address how corrective action will accomplished for those residents four have been affected by the deficient practice; Resident (#1) was identified, order reviewed and discontinued, care plan updated. (2) Address how the facility will ident other residents having the potential to affected by the same deficient practice Residents receiving 1:1 Supervisions reviewed for continued need, care plan updated as appropriate 	id to er was ify be e; ion	
	was assessed to have cognitive skills for dat behavioral symptoms MDS assessment dat resident to have intact behavioral symptoms	e moderately impaired ily decision making; no were reported. A quarterly ted 5/19/21 assessed the ct cognition with "other not directed towards 4 to 6 days, but less than			 New orders will be reviewed by the IDT in the Daily Clinical Meeting, care plans will be updated as needed. Review of resident care plans to ensure they are accurate and up to dare Review conducted by Administrative Nursing Team and will be completed by 7/15/2022. 	ate.	
	focus which addresse related to his diagnos (initiated 1/10/20) and inappropriate behavio 4/13/21). On 7/21/21, Resident	or problems (initiated t #1 was reported by staff as			 (3) Address what measures will be p into place or systemic changes made ensure that the deficient practice will r recur; Re-education was provided to Licensed nursing staff by the Director Nursing (DON) / Designee related to t following: 	to not of he	
	resident. The resider	ate interaction with another nt was placed on one-on-one times. His plan of care			o Ensure care plans are updated w every completion of comprehensive assessment that are completed and w		

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 25 of 133

		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
					с
		345307	B. WING		06/23/2022
NAME OF P	ROVIDER OR SUPPLIER	•	· ·	STREET ADDRESS, CITY, STATE, ZIP CODE	•
				4414 WILKINSON BLVD	
	AT GASTONIA LLC			GASTONIA, NC 28056	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLÉTIC
F 657	Continued From pag	e 25	F 65	7	
	was updated on 7/26 focus regarding this	/21 to include an area of behavior. The interventions		any MDS assessment except a Di assessment	-
	included, "Will provid monitoring at all time	e one on one care / s" (also initiated on 7/26/21).		Re-education on the compon regulation F657 related to: o Care plan accuracy	ents of
	8/15/21 assessed the			o Care plan revision• Education will be completed I	ру
	decision making; no	cognitive skills for daily behavioral symptoms were trea Assessment (CAA)		7/15/2022 Education will be included with ne and MDS staff orientation. Orienta	
	drug use read, "He	-		be provided by Director of Nursing/Designee.	
	inappropriate behavi	ecently on one on one for ors"		MDS will be responsible for e care plans are updated when com comprehensive assessments for e	pleting
	assessments include	#1's subsequent MDS d quarterly assessments 1/21. Both assessments		resident and on as needed basis. will be educated on this by 7/15/2	
	reported the resident	had moderately impaired havioral symptoms noted.		Director of Nursing/Designee.(4) Include how the facility plans	to
	Quarterly MDS asses 1/22/22, and 4/24/22	ssments dated 1/1/22, indicated Resident #1 had		monitor its performance to make s solutions are sustained;	
	severely impaired co decision making; no reported on these as	behavioral symptoms were		Director of Nursing/Designee conduct 10 residents care plan re	
		t plan of care continued to		ensure care plans are up to date a accurate weekly for 4 weeks, then	15
	was being implemen	care / monitoring at all times ted as an intervention for the ate behavior noted on		resident care plan reviews weekly weeks, then 1 resident care plan r for 4 weeks.	
	7/21/21. This interve discontinued since it	ention had not been was first initiated on 7/26/21.		Results of the reviews will be discussed during the monthly Qua	ality
		en made to the care plan area of focus since 7/26/21.		Assurance meeting for tracking, tr and recommendations from the ID	-
	revealed Resident #7	ucted on 6/7/22 at 12:35 PM I was sitting in the dining n meal. No staff members		Date of compliance: 7/16/2022	

Facility ID: 923314

If continuation sheet Page 26 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/26/2022 APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345307	B. WING			_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page resident at that time.	26	F	657				
	AM with Nurse #2. D nurse reported the res her during the shift ar She reported inappro residents had not bee would only go to the c	ducted on 6/11/22 at 8:10 uring the interview, the sident typically stayed near ad stated, "That's his job." priate interactions with other an a problem as the resident doorway of other residents' ated she "just had to explain						
	on 6/12/22 at 4:50 PM they knew Resident # care for him on multip assignment (in addition	The NAs reported the el his wheelchair and throughout the facility. ed the resident was						
	AM as Resident #1 w his room in a wheelch breakfast meal. No s	onducted on 6/13/22 at 8:00 as observed to be sitting in pair while eating his taff member was in the in sight of him at the time of						
	PM with the Regional 6/13/22 at 1:17 PM. I Consultant recalled th involving Resident #1 was initially placed or (hours) / 7 (days a we	During the interview, the						

Facility ID: 923314

If continuation sheet Page 27 of 133

	S FOR MEDICARE &					D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
345307		A. BUILDING		С		
		B. WING		06/23/2022		
AME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
			44	14 WILKINSON BLVD		
THE IVY A	T GASTONIA LLC		GA	ASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 657	Continued From pag	e 27	F 657			
1 007		eeks, then every 30 minute	F 037			
	checks for weeks; ar					
	monitoring from staff	-				
	follow-up interview c	onducted with the Regional				
		6/13/22 at 4:43 PM, the				
		it would have typically been				
		esponsibility to update the				
		entions for Resident #1. She es had the ability to update a				
	care plan as needed	• •				
	An interview was cor	nducted on 6/13/22 at 8:07				
		interim Administrator in the				
		Administrator and Director of				
		e interim Administrator at the facility at the time of				
		involving Resident #1 and he				
		ident and interventions put				
		ked if Resident #1 was still				
		toring, both the DON and				
		stated, "No." A follow-up				
	interview was condu					
		3/22 at 2:04 PM. During the istrator was asked what his				
		ted to Resident #1's care				
		Iministrator reported he				
	would have expected	d the one-on-one monitoring				
		ed from the care plan as				
		mined this was no longer				
E 604	necessary.					7/16/22
F 684 SS=K	Quality of Care CFR(s): 483.25		F 684			1/10/22
	§ 483.25 Quality of c	are				
		undamental principle that				
	applies to all treatme	ent and care provided to				
	facility residents. Bas	sed on the comprehensive				
		ident, the facility must ensure				

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 28 of 133

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-039
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDIN		с		
		345307	B. WING			06	6/23/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				114 WILKINSON BLVD ASTONIA, NC 28056		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 28	F 6	84			
		e treatment and care in	10				
		essional standards of					
		nensive person-centered					
	care plan, and the res						
	· ·	⊺ is not met as evidenced					
	by:						
		iews, and interviews with			(1) Address how corrective action will		
		Physician Assistant and			accomplished for those residents found	d to	
		facility failed to identify the			have been affected by the deficient		
	-	cant changes in a resident's			practice;		
		9), complete and document			" Desident (#0) was identified and it		
		sessments and identify the ntion when the resident's			" Resident (#9) was identified and is	s no	
		ntinued to deteriorate. This			longer a Resident at the facility.		
		treatment for UTI (urinary			(2) Address how the facility will identit	fv	
	-	ospitalization for sepsis due			other residents having the potential to	-	
	to an infected stage 4	t pressure ulcer. This failure the reviewed for quality of			affected by the same deficient practice		
	care (Resident #9).	its reviewed for quality of			" Resident records were reviewed b	NV.	
					Administrative Nursing Team for any	· J	
	Immediate Jeopardy	began on 3/26/22 when the			outstanding labs that have not been		
		up on Resident #9's urine			addressed. Physician notification and		
		ovide the care and services			follow up occurred as indicated. Review	N	
		#9 resulting in a delayed			was completed on 7/14/2022.		
	treatment for UTI (uri				" Licensed nurses and nurse aides		
		d to have confusion, altered			were interviewed by Nursing		
		ension (low blood pressure)			Administrative Team to determine if an	У	
		eterioration which resulted in			current residents had any significant	to	
	-	nt out to the emergency nd treatment of sepsis due			changes of their conditions, no residen were noted with a significant change or		
		pressure ulcer to the			condition. This was completed on	1	
	-	Jeopardy was removed on			7/14/2022.		
		ility implemented a credible			 Licensed Nurses obtained vital sig 	ins	
		ate Jeopardy removal. The			on current residents to ensure they we		
		f compliance at a lower			all within normal limits for the resident		
	-	vel of E (no actual harm with			was completed on 7/14/2022.		
		e than minimal harm that is					
		dy) to complete employee			(3) Address how the facility will be put		
	education and ensure	e monitoring systems in			into place or systemic changes made t	0	

Facility ID: 923314

If continuation sheet Page 29 of 133

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 684 Continued From page 29 F 684 place are effective. ensure that the deficient practice will not recur; The findings included: Re-education was provided to Resident #9 was admitted to the facility on Licensed and Certified nursing staff by the 3/14/19 with diagnoses that included atrial Director of Nursing/Designee related to fibrillation, peripheral vascular disease, peripheral the followina: artery disease, and hypertension. 0 Any changes in Resident⊡s skin integrity must be reported promptly A physician order dated 10/14/20 in Resident #9's 0 Wound deterioration Report any changes in Resident s medical record indicated an order for Metoprolol о tartrate - give 25 mg (milligrams) by mouth two eating habits or meal consumption times a day related to hypertension. Give 3 half 0 Report any Resident with Altered tablets if blood pressure is over 140/90. mental status Report any observations that are not ο Resident #9's care plan revised on 4/18/21 typical of the individual resident indicated he had hypertension. Interventions Any change of condition with a 0 included to give anti-hypertensive medications as resident need to be reported promptly ordered, monitor for side effects such as orthostatic hypotension (low blood pressure that Education will be completed by 7/15/2022 happens when standing up from sitting or lying down) and increased heart rate and effectiveness Re-education was provided to Licensed Nursing staff by the DON/ and report significant changes to the physician. Designee related to the following: The quarterly Minimum Data Set (MDS) Abnormal Labs must be called in 0 assessment dated 1/17/22 indicated Resident #9 when received to Medical Provider was cognitively intact, had no rejection of care New Admit Residents with 0 behaviors, required extensive physical assistance Wounds/open area Medical Provider must with bed mobility, transfer and personal hygiene, be notified and was totally dependent on staff assistance Any Resident with a new wound/open 0 with toilet use. He had impairment to both sides area Medical Provider must be notified of lower extremities and used a wheelchair. He promptly along with Responsible party was always incontinent of both urine and bowel. 0 Any signs and symptoms of wound The MDS further indicated he was at risk of infection must be reported to the medical provider developing pressure ulcers/injuries, but he did not have any unhealed pressure ulcers/injuries. 0 Weekly skin assessments must be completed in Point Click Care per weekly A progress note written by Nurse #1 on 3/21/22 at Schedule 6:18 PM indicated Resident #9 was little bit Weekly wound measurements must 0

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 923314

If continuation sheet Page 30 of 133

PRINTED: 07/26/2022

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY	
ID PLAN OF CORRECTION IDENTIFICATION NUMBER:				· · ·	COMPLETED		
				С			
		345307	B. WING		06	6/23/2022	
IAME OF PF	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP CODE			
				4414 WILKINSON BLVD			
	T GASTONIA LLC			GASTONIA, NC 28056			
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 684	Continued From page	e 30	F 68	4			
		ing. His vital signs were as	1 00	be completed either by wound	physician		
		ure (BP) at 139/60, pulse at		or Wound Nurse weekly.			
		t 20, temperature at 97.9		Education will be completed by	7/15/2022		
		n at 97% on room air.					
		pain, was diaphoretic and					
		was 225 mg/dL (milligrams		Education will be added to Lice			
	• •	s refusing to go back to bed. I went out for smoke. BP		Nursing and Certified Nursing	staπ new		
		0/80 manually and pulse at		hire orientation by Directed of Nursing/Designee			
		er (NP) was informed and		Nursing/Designee			
		: CBC (complete blood					
		ehensive metabolic panel),					
		d UA (urinalysis). Resident					
		oper. Resident #9's family					
	condition.	regarding his present					
		h Nurse #1 on 6/12/22 at					
		e noticed Resident #9 had a		(4) Address what measures w			
		ecause he was not eating		into place or systemic changes			
		ed to eat. He was also had been having episodes		ensure that deficient practice w	/iii not		
		as not normal for him.		recur;			
		ally alert and oriented.		" Director of Nursing /Desig	nee will		
	Nurse #1 informed th			conduct 10 resident skin review			
	bloodwork, chest x-ra	ay and urinalysis with urine		ensure skin checks are comple	eted per		
	culture. Nurse #1 sta	ited she obtained the urine		schedule weekly for 4 weeks, t			
		aight catheterization and		resident skin reviews weekly fo			
		ry on 3/21/22. Nurse #1		then 1 resident skin review we	ekly for 4		
		at Resident #9's urine was nen she obtained his urine		weeks.			
	sample, so she obtain			conduct 10 resident lab review			
		ecause she had a hard time		labs were obtained as ordered			
	-	e from him and she thought		followed up as appropriate wee			
	he might have urinary	retention. Nurse #1 stated		weeks, then 5 resident lab revi			
		hat Resident #9 might have a		for 4 weeks, then 1 resident la	o review		
1							
	urinary tract infection confusion.	given the new onset of		weekly for 4 weeks. Results of the reviews will			

Facility ID: 923314

If continuation sheet Page 31 of 133

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SU	JRVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		B. WING		C 06/23/2022			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20			
THE IVY AT GASTONIA LLC							
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETIO DATE		
A physician progress Resident #9 was seen and he noted Resider alert per nurse. He a no acute distress note breakfast and was dri pressure low for him t Metoprolol was held. pressure normally ran 140/80. Skin tenting of dehydration) was p ordered. A review of the Physic Resident #9's medicat following: *Dextrose-Sodium Ch 75 ml (milliliters)/hour dehydration. *Insert an indwelling of urine bag for urinary r Further review of Ress indicated a faxed rest 3/23/22 at 8:46 PM for following abnormal val leukocytes 3+, proteir blood cells) 3+ and ba A urine culture result on 3/26/22 at 11:22 A urine had a growth of >100,000 cfu (colony- The report also outline	note dated 3/22/22 indicated n by the Medical Director nt #9 was afebrile and more ppeared to not feel well but ed. Resident #9 ate nking some but blood his morning (110/64). Resident #9's blood nged between 110/60 and (skin abnormality indicative resent. Intravenous fluids cian Orders dated 3/22/22 in I record indicated the shoride Solution 5-0.9% - use for 2 days x 3 liters for catheter and connect to etention. ident #9's medical record ult from the laboratory dated r a urinalysis with the shores: cloudy appearance, n 100, blood 3+, WBC (white acteria 3+. reported by the laboratory M indicated Resident #9's Providencia stuartii of forming unit)/ml (milliliter). ed the different antibiotics	F 684	4 Assurance meeting for tracking, and recommendations from the "DON and/or Designee will b responsible for bringing/discussi reviews in monthly Quality Assu	IDT team be ng rance			
	A physician progress Resident #9 was seer and he noted Resider alert per nurse. He al no acute distress note breakfast and was dri pressure low for him t Metoprolol was held. pressure normally ran 140/80. Skin tenting of of dehydration) was p ordered. A review of the Physic Resident #9's medica following: *Dextrose-Sodium Ch 75 ml (milliliters)/hour dehydration. *Insert an indwelling of urine bag for urinary r Further review of Res indicated a faxed resu 3/23/22 at 8:46 PM fo following abnormal va leukocytes 3+, proteir blood cells) 3+ and ba A urine culture result fo on 3/26/22 at 11:22 A urine had a growth of >100,000 cfu (colony- The report also outline that the organism was to.	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345307 ROVIDER OF SUPPLIER T GASTONIA LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 A physician progress note dated 3/22/22 indicated Resident #9 was seen by the Medical Director and he noted Resident #9 was afebrile and more alert per nurse. He appeared to not feel well but no acute distress noted. Resident #9 ate breakfast and was drinking some but blood pressure low for him this morning (110/64). Metoprolol was held. Resident #9's blood pressure normally ranged between 110/60 and 140/80. Skin tenting (skin abnormality indicative of dehydration) was present. Intravenous fluids ordered. A review of the Physician Orders dated 3/22/22 in Resident #9's medical record indicated the following: *Dextrose-Sodium Chloride Solution 5-0.9% - use 75 ml (milliliters)/hour for 2 days x 3 liters for dehydration. *Insert an indwelling catheter and connect to urine bag for urinary retention. Further review of Resident #9's medical record indicated a faxed result from the laboratory dated 3/23/22 at 8:46 PM for a urinalysis with the following abnormal values: cloudy appearance, leukocytes 3+, protein 100, blood 3+, WBC (white blood cells) 3+ and bacteria 3+. A urine culture result reported by the laboratory on 3/26/22 at 11:22 AM indicated Resident #9's urine had a growth of Providencia stuartii of >100,000 cfu (colony-forming unit)/ml (milliliter). The report also outlined the different an	OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING A BUILDING 345307 B. WING ROVIDER OR SUPPLIER T ID T GASTONIA LLC ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 31 A physician progress note dated 3/22/22 indicated Resident #9 was seen by the Medical Director and he noted Resident #0 was afebrile and more alert per nurse. He appeared to not feel well but no acute distress noted. Resident #9 ate breakfast and was drinking some but blood pressure low for him this morning (110/64). Metoprolol was held. Resident #9's blood pressure normally ranged between 110/60 and 140/80. Skin tenting (skin abnormality indicative of dehydration) was present. Intravenous fluids ordered. A review of the Physician Orders dated 3/22/22 in Resident #9's medical record indicated the following: "Dextrose-Sodium Chloride Solution 5-0.9% - use 75 ml (milliliters)/hour for 2 days x 3 liters for dehydration. "Insert an indwelling catheter and connect to urine bag for urinary retention. Further review of Resident #9's medical record indicated a faxed result from the laboratory dated 3/23/22 at 8:46 PM for a urinalysis with the following abnormal values: cloudy appearance, leukocytes 3+, protein 100, blood 3+, WBC (white blood cells) 3+ and bacteria 3+. A urine culture result reported by the laboratory on 3/26/22 at 11:22 AM indicated Resident #9's urine had a growth of Providencia stuartii of >100,000 cfu (colony-forming unit/ml (milliliter)	IF DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLICERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING SWIDER OR SUPPLIER IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING T GASTONIA LLC STREET ADDRESS, CITY, STATE, ZIP CODE 414 WILKINSON BLVD GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 414 WILKINSON BLVD GASTONIA, NC 28056 Continued From page 31 A physician progress note dated 3/22/22 indicated Resident #9 was seen by the Medical Director and he noted Resident #9 was afebrile and more aleft per nurse. He appared to not feel well but no acute distress noted. Resident #9 shood pressure normally ranged between 110/60 and 140/80. Skin tenting (skin abnormality indicative of dehydration) was present. Intravenous fluids ordered. F 684 Areview of the Physician Orders dated 3/22/22 in Resident #9's medical record indicated the following: Detroze-Sodium Chloride Solution 5-0.9% - use 75 ml (millitlers)/hour for 2 days x 3 liters for dehydration. "Insert an indwelling catheter and connect to urine bag for urinary retention. Date of compliance: 7/16/2022 date of Resident #9's medical record indicated a faxed result from the laboratory on 3/26/22 at 11-22 AM indicated Resident #9's unine had a growth of Providencia starti of >100, 000 dt, (Colony-forming unit/)m (milliter). The reportable of the different antibiotics that the organism was susceptible and resistant to. Interview of the offerent antibiotics that the organism was susceptible and resistant to. Interview of the offerent antibiotics tha	preprioremotions (x1) PROVIDERSUPPLIERCLIA DENTIFICATION NUMBER (x2) MULTIFIC CONSTRUCTION A BUILDING (x3) DATE TO A BUILDING (x3) DATE TO BUILDING (x3) DATE TO A BUILDING (x3) DATE TO BUILDING (x3) D		

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD			
				G	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	reported to the Nurse Medical Director. Resident #9's Vital Sig 4/5/22 indicated his te not checked on 3/26/2 3/29/22, 3/30/22, 4/1/2 4/5/22. The progress notes a Administration Record record indicated his M the following dates an pressure was less tha 3/22/22 at 8:44 AM (E AM (BP-109/54), 3/23 3/24/22 at 9:44 PM (E PM (BP-118/52), 3/30 3/31/22 at 10:16 PM (8:17 AM (BP-98/48). A phone interview with 2:12 PM revealed she #9 on the evening shi sick on 3/21/22. Nurse change in his condition another nurses' name confused. She remer intravenous fluids, but pressure medication of 3/25/22 and 3/31/22 te was low. Nurse #2 st pressure reading didn Resident #9's blood p time. Nurse #2 also st	eceived on 3/26/22 were Practitioner or to the gns Record from 3/21/22 to emperature and pulse were 22, 3/27/22, 3/28/22, 22, 4/2/22, 4/4/22 and nd the Medication d in Resident #9's medical Metoprolol dose was held on nd times because his blood an 140/90: 3P-110/64), 3/23/22 at 8:54 3/22 at 9:19 PM (BP-116/57), 3P-105/43), 3/25/22 at 8:40 0/22 at 8:38 PM (BP-96/50), (BP-98/48) and 4/1/22 at h Nurse #2 on 6/13/22 at e had taken care of Resident ift when he started to get se #2 stated she noticed a on when he called her by e, and he was getting more mbered him receiving t she had to hold his blood on 3/22/22, 3/23/22, 3/24/22, because his blood pressure tated at first the low blood	F	684		DEFICIENCY)		
	she assumed he was	ssibly having sepsis, but being seen by the wound e ulcer on his sacrum.						

If continuation sheet Page 33 of 133

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE SURVE COMPLETED	
		345307	B. WING			-		C 23/2022
NAME OF PROVIDER OR	SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	-	
THE IVY AT GASTON	IA LLC				414 WILKINSON BLVD GASTONIA, NC 28056			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
Nurse #2 but didn't urinalysis UTI. She during re Resident Nurse #2 Resident 2022 and buttocks remembe Nurse #2 wound be quarter w 3/30/22 v dressing, bigger to draining r of the wo because by the wo A phone 12:18 PM on 3/24/2 hydrocoll stated sh sacrum o observed #9's botto drainage report this this was n remembe waiting o culture re	remember se result and w couldn't rem port that they #9's urinalys also stated #9's hydrocol she noticed had gotten w er exactly wh stated she r eing slightly s when she had she noticed the size of a more. Nurse rsening of R she thought bund doctor. Interview with revealed she 2 and 3/25/2 oid dressing e first saw R n 3/24/22. N a quarter-si bom that looke and no foul s observation normal for hi er receiving c in Resident # esults.	e 33 ed she worked on 3/23/22 seeing Resident #9's vas not aware that he had nember if it was passed on y were still waiting on sis and urine culture results. she had done most of olloid dressing in March that the open wound on his vorse, but she didn't en it started to get worse. remembered Resident #9's smaller than the size of a rted working with him but on d changed his hydrocolloid that the wound had gotten baseball, and it was e #2 did not notify the doctor esident #9's pressure ulcer he was already being seen h Nurse #7 on 6/13/22 at ne took care of Resident #9 22 and had to change his on both days. Nurse #7 esident #9's ulcer to his Nurse #7 stated she zed open area on Resident ed clean, pink and had no odor. Nurse #7 did not in to anyone as she thought m. She also did not on report that they were e9's urinalysis and urine	F	684				

If continuation sheet Page 34 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/26/2022 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	06/2	C 23/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			44	414 WILKINSON BLVD			
THE IVY A	T GASTONIA LLC		G	ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	received a report that Resident #9's urinalys She did not see Resid on the fax machine. It took care of Resident and had only checked those dates to determ Metoprolol dose. She temperature and was at that time. A progress note writte Nursing (DON) on 3/3 she called Resident # update and informed confused again today (intravenous catheter) Resident #9 appeared confusion comes and back indicating UTI w stuartii. The Interim ID Practitioner through e antibiotic was request An interview with the 6/6/22) on 6/13/22 at #9 had intermittent co weeks when he was a that Resident #9 was 3/30/22. She stated F of his head and he wa morning when he wou first morning smoking Interim DON rememb (NP) saying that Resi which was why he wa fluids. She stated she	n 3/26/22 but she never they were waiting on sis and urine culture results. dent #9's urine culture result Nurse #5 stated she also #9 on 3/27/22 and 3/28/22 this blood pressure on sine if she could give his e did not check his not aware that he had a UTI en by the Interim Director of 60/22 at 1:00 PM indicated 9's family member for an him that Resident #9 was and had pulled his midline) out last night on third shift. d to be delirious as goes. Urinalysis came ith >100,000 Providencia DON notified the Nurse lectronic message and an ted. Interim DON (DON through 10:43 PM revealed Resident onfusion within the last 4-6 at the facility, but she noticed a lot more confused on Resident #9 was talking out	F 684				

If continuation sheet Page 35 of 133

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	: 07/26/2022 APPROVED . 0938-0391	
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
	345307	B. WING		_	C 06/2	, 23/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
THE IVY AT GASTONIA LLC			4414 WILKINSON BLVD				
			GASTONIA, NC 28056				
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
requested an order for The Interim DON states reported results to then alert directly in the elect notify them of any new member opened up the but that wouldn't neces had followed up on it. stated she was not sum report from the nurse b waiting on Resident #9 culture results. A phone interview with 11:03 AM revealed she on the night shift from 7 AM on 3/31/22. Nurse dose of antibiotic inject because he had pulled Nurse #8 thought they urine culture results an been reported by the la Nurse #8 stated things during report between f everything got followed check his temperature that his blood pressure Metoprolol dose for 8:0 she put a note in the pr Resident #9's blood pre when they come the ne she didn't think it was s report right then and di message through the ta a provider.	And a state of the	F 68					

Facility ID: 923314

If continuation sheet Page 36 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING			_	C 06/23/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				44	414 WILKINSON BLVD			
	T GASTONIA LLC			G	ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	medical record indica Sodium Solution Reco intravenously every 2 2 gram/50 ml (millilite is a cephalosporin any variety of bacterial infi- bacteria or preventing A Nurse Practitioner r Resident #9's general he was being treated assessment or mention Multiple attempts were but they were unsucce worked with the Media An interview with Nurse revealed she took car and had to hold his 8: because his blood pre- check the rest of his w temperature and puls- indicated on the Medi Record. Nurse #4 sta pressure didn't alert h was receiving intraver blood pressure had be A phone interview witt 10:20 AM revealed sh from 7:00 AM to 7:00 Nurse #3 recalled see buttocks on 4/3/22 wf hydrocolloid dressing surprised to see how stated it was the wors had ever seen. Nurse	ted an order for Cetriaxone onstituted - use 2 grams 4 hours for UTI for 7 days, in rs) in dextrose. Ceftriaxone tibiotic used to treat a wide ections. It works by killing their growth. note dated 3/31/22 of medical condition indicated for UTI. There was no on of the buttocks wound. e made to contact the NP, essful. The NP no longer cal Director's team. se #4 on 6/13/22 at 4:01 PM e of Resident #9 on 4/1/22 00 AM Metoprolol dose essure was low. She didn't vital signs including his e because it wasn't cation Administration ated Resident #9's low blood er because she thought he nous fluids because his een low. h Nurse #3 on 6/13/22 at he took care of Resident #9 PM on 4/2/22 and 4/3/22.	F	584				

Facility ID: 923314

If continuation sheet Page 37 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345307	B. WING _				C / 23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	T GASTONIA LLC			4	414 WILKINSON BLVD		
	IT GASTONIA LEO			G	GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	red in some areas and Nurse #3 saw the woo Director of Nursing (D former DON placed a wound. Nurse #3 ass had notified the docto ulcer and received and dressing. Nurse #3 s doctor of the pressure the former DON know going to take care of it A phone interview wa 12:01 PM, 6/14/22 at 10:19 AM with the for A phone interview witt member on 6/7/22 at visited Resident #9 at to him by phone. Wh 4/1/22, he noticed Re then on 4/5/22, he did Resident #9's family r concerned that Resid so he asked the staff to the hospital. At the Resident #9 had a wo was black and smelle A follow-up interview Nursing (DON) on 6/1 the nursing staff were communicate with the messages through the not utilize a notebook Interim DON stated s documentation/comm Resident #9's worsen	d had a foul odor. After und, she called the former DON) into the room and the n antiseptic dressing on the sumed that the former DON or of Resident #9's pressure order for the antiseptic tated she did not notify the e ulcer because she had let y and she thought she was it. s attempted on 6/13/22 at 12:00 PM and 6/15/22 at mer DON with no return call. h Resident #9's family 12:15 PM revealed he t the facility and often talked en he visited Resident #9 on sident #9 was out of it and dn't even recognize him. member stated he was ent #9 had developed a UTI, to go ahead and send him e ER (emergency room), ound on his buttocks that d of dead tissue. with the Interim Director of 13/22 at 3:00 PM revealed e only supposed to e providers through text e tablet and the facility did for the providers. The he did not see any	F	584			

Facility ID: 923314

If continuation sheet Page 38 of 133

PRINTED: 07/26/2022

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 07/26/2022 APPROVED 0. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		345307	B. WING		_		_ 23/2022	
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	DON also stated that physician documenter messages and there y staff that Resident #9 opened, was large an An interview on 6/14/2 Physician Assistant (F facility revealed the p keeping an eye out fo had ordered. Whene ready, they automatic electronic medical rec ordered Resident #9's should have followed available. The PA state expected the nurses to vital signs because the typically go down as to because of the fluids to fight the infection. A phone interview witt on 6/14/22 at 4:22 PM with Resident #9 and routine work-up for all included CBC. CMP, stated he didn't know starting Resident #9 co would have hoped the up on the urine culture communicated to the urinalysis and urine c also expected the nur Resident #9 who was vital signs at least one the nursing staff to re	ts on 3/30/22. The Interim she checked the nurse to d communication text was no report to the medical 's wound to his buttocks had d black. 22 at 12:25 PM with the PA) currently working at the rovider should have been r laboratory results that they ver laboratory results were ally populated in the cord and the NP who had s urinalysis and urine culture up when it became ted she would have to monitor Resident #9's e blood pressure would he infection worsened trying to get into the tissues h the Medical Director (MD) A revealed he was familiar remembered him having a tered mental status which CXR and UA. The MD that there was delay with on antibiotics for UTI, but he e nursing staff had followed	F 684					

If continuation sheet Page 39 of 133

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		<u>O. 0938-039</u> E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED	
						С	
		345307	B. WING		06/23/2022		
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD	E		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(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)	I SHOULD BE	(X5) COMPLETIO DATE	
F 684	pressure ulcer and co readings even though intravenous fluids.	ontinued low blood pressure he was receiving	F 684				
	4/5/22 indicated Resid Emergency Departme Resident #9 was four sepsis/septic shock w an infected decubitus injury of buttock stage cells indicating an infe encephalopathy, acut superimposed on chru- intravascular volume low sodium. The surg sacral ulcer determine necrotic, and malodor erythema. Plan was diverting colostomy. ulcer was contaminat was critically ill and at resulting in end-organ fevers were up to 103 infected sacral press tomography) scan of revealed extensive su (deep seeded infectio organisms) and tunne gluteal and above the #9 also had a stage 4	vith acute organ dysfunction, ulcer stage IV, a pressure e IV, elevated white blood ection, metabolic te renal failure onic kidney disease stage 3, depletion (dehydration), and gical consult for decubitus ed the ulcer was large, rous ulcer with only minimal for surgical debridement and It was suspected the sacral ed with stool. Resident #9 t risk for decompensation of dysfunction. The resident's B Fahrenheit due to an ure ulcer. A CT (computed the sacral pressure ulcer ubcutaneous gas formation					
	on 6/15/22 at 1:40 PM nurses to follow up or	Director of Nursing (DON) /I revealed she expected the n laboratory results and e doctor. While waiting on					

Facility ID: 923314

If continuation sheet Page 40 of 133

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/26/2022 M APPROVED O. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345307	B. WING			06	C 6/23/2022	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
				4	4414 WILKINSON BLVD			
	T GASTONIA LLC			0	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 684	so they knew to moni The DON stated she monitor acutely ill res of vital signs at least of call the doctor about a in condition. The Administrator wa Jeopardy on 6/15/22 The facility provided t Plan with the correction 1. Identify those recip are likely to suffer, a se a result of the noncorr The identified residen a resident of the facilit complete thorough ar resident after a signifi and failed to report un deterioration of press Care Provider. All other residents ha affected by the deficient charts were audited to outstanding labs. hav initiated on 6/15/2022 6/15/2022. The Prime notified by the Director designee on 6/15/2022 residents with skin int been previously ident Provider will be notified designee by 6/16/2021	 v the nurses to each other, tor for the laboratory result. expected the nurses to idents by obtaining a full set once during their shift and to any acute issues or change s notified of Immediate at 1:41 PM. he following IJ Removal on date of 6/18/22. ients who have suffered, or serious adverse outcome as npliance: tt (Resident #9) is no longer ty. The facility failed to ad ongoing assessment of a cant change in condition inalysis results and ure ulcer to the Primary ve the potential to be ent practice. All resident to determine if any other e not been addressed, and completed on ary Care Provider was or of Nursing (DON) or DON to the Primary Care address that have not ified. The Primary Care addressed to the prima	F	684				

Facility ID: 923314

If continuation sheet Page 41 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING			_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				4414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S (EACH CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Aides interviewed to or residents have had an their conditions, if so designee will assess significant change has Primary Care Provide An audit of all residen Care system was com DON and/or DON des labs. have not been a 2. Actions taken to all failure to prevent advo occurring or recurring Immediate in-service observed skin integrit being addressed by th Designee to the Licer Aides, and any ageno residents with any cha report any deterioration Primary Care Provide and/or DON Designee 6/15/2022 with the Lice aides to report any chai integrity, eating habits any observations that individual resident. T to the Licensed Nurse should assess the res the Primary Care Prov findings. * Licensed nursing s notify the Primary Care	ensed Nurses and Nurse determine if any current by significant changes of DON and/or the DON the resident to determine if a s occurred and will notify the r of change by 6/16/2022. tts' charts via Point Click hapleted on 6/15/2022 by the signee to determine if any ddressed. The process or system erse outcome from the DON and/or the DON used nursing staff, Nurse by staff regarding assessing ange in condition and to on of pressure ulcer to the r immediately. The DON the initiated in-service on censed nurses and nurse hanges in a resident's skin s, altered mental status or are not typical of the he Nurse aide should report the and the Licensed Nurse sident and report and notify vider of any abnormal	F	684		DEFICIENCY)		

If continuation sheet Page 42 of 133

UMAN SERVICES				FORM	: 07/26/2022 APPROVED	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COMPI	SURVEY LETED	
345307	B. WING		_	C 06/23/2022		
		STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
		4414 WILKINSON BLVD				
		GASTONIA, NC 28056				
ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE	
itiated on 6/14/2022, by ied wound nurse will be staff to include nurses, nursing staff and will be The DON and/or DON ble for tracking ucated and ensuring them working after n will be given to all sing staff and agency esident assignment. to included agency will Primary Care Provider if is noted to have open by new resident with ave orders to conduct and measurements on initiated on 6/14/2022, ed wound nurse and will 22. This education will d Licensed Nursing staff aking their resident to include agency will symptoms of sepsis to reduced urine output, oreathing, mental ation. This education 2, by DON and/or RN i will be completed by l/or DON designee will g employees who aren't ey are educated prior to 022. This education will d Licensed Nursing staff aking their resident	F 68-					
	ICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345307 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) itiated on 6/14/2022, by ed wound nurse will be staff to include nurses, nursing staff and will be The DON and/or DON ble for tracking ucated and ensuring them working after in will be given to all sing staff and agency esident assignment. to included agency will Primary Care Provider if is noted to have open y new resident with ave orders to conduct and measurements on initiated on 6/14/2022, ed wound nurse and will 2. This education will Licensed Nursing staff aking their resident to include agency will symptoms of sepsis to reduced urine output, preathing, mental ation. This education P, by DON and/or RN will be completed by /or DON designee will g employees who aren't ey are educated prior to D22. This education will Licensed Nursing staff	ICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345307 B. WING	ICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345307 B. WING 345307 B. WING STREET ADDRESS, CITY, ST 414 WILKINSON BLVD GASTONIA, NC 28056 ENT OF DEFICIENCIES IT DE PRECEDED BY FULL PREFIX (EACH CORREC Itiated on 6/14/2022, by ed wound nurse will be staff to include nurses, nursing staff and will be The DON and/or DON be for tracking ccated and ensuring them working after n will be given to all sing staff and agency sident assignment. to include agency will Primary Care Provider if is noted to have open y new resident with ave orders to conduct and measurements on initiated on 6/14/2022, td wound nurse and will 2. This education will Licensed Nursing staff aking their resident to include agency will symptoms of sepsis to </td <td>UMAN SERVICES ICAD SERVICES ICAD SERVICES ICAN DERVICES ICAN DERVICES ICAN DERVICES ICAN DEVENTION NUMBER: 345307 B. WING 345307 B. WING 345307 B. WING TO C DEFICIENCIES IT DE PRECEDED BY FUIL PREFIX CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY F 684 F 684 F F 6</td> <td>UMAN SERVICES FOOMS ICAD SERVICES OMB NO PROVIDERSUPFLERCLA DENTIFICATION NUMBER: 345307 B. WING 345307 B. WING 345307 B. WING 345307 B. WING 345307 B. WING 345307 B. WING 345307 B. WING THEEF ADDRESS, CITY, STATE, ZIP CODE 4114 WILKINSON BLVD GASTONIA, NC 23056 ENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 Itilated on 6/14/2022, by ed wound nurse will be thatfl to include nurses, tursing staff and will be The DON and/or DON be for tracking ccated and ensuring them working after the morking after the included agency will primary Care Provider if is noted to have open y new resident with axe orders to conduct and measurements on initiated on 6/14/2022, y awe orders to conduct and measurements on initiated on 6/14/2022, to include agency will 2. This education will Licensed Nursing staff ation. This education to include agency will symptoms of sepsis to reduced urine output, oreathing, mental ation. This education by are educated prior to D22. This education will Licensed Nursing staff</td>	UMAN SERVICES ICAD SERVICES ICAD SERVICES ICAN DERVICES ICAN DERVICES ICAN DERVICES ICAN DEVENTION NUMBER: 345307 B. WING 345307 B. WING 345307 B. WING TO C DEFICIENCIES IT DE PRECEDED BY FUIL PREFIX CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY F 684 F 684 F F 6	UMAN SERVICES FOOMS ICAD SERVICES OMB NO PROVIDERSUPFLERCLA DENTIFICATION NUMBER: 345307 B. WING 345307 B. WING 345307 B. WING 345307 B. WING 345307 B. WING 345307 B. WING 345307 B. WING THEEF ADDRESS, CITY, STATE, ZIP CODE 4114 WILKINSON BLVD GASTONIA, NC 23056 ENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 Itilated on 6/14/2022, by ed wound nurse will be thatfl to include nurses, tursing staff and will be The DON and/or DON be for tracking ccated and ensuring them working after the morking after the included agency will primary Care Provider if is noted to have open y new resident with axe orders to conduct and measurements on initiated on 6/14/2022, y awe orders to conduct and measurements on initiated on 6/14/2022, to include agency will 2. This education will Licensed Nursing staff ation. This education to include agency will symptoms of sepsis to reduced urine output, oreathing, mental ation. This education by are educated prior to D22. This education will Licensed Nursing staff	

If continuation sheet Page 43 of 133

CAID SERVICES					APPROVED . 0938-0391
ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:				(X3) DATE COMPI	SURVEY LETED
345307	B. WING		_		; 23/2022
	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	4	414 WILKINSON BLVD			
	G	GASTONIA, NC 28056			
IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
	F 684				
educated to notify the skin integrity al resident's nurse. rashes, any skin usual skin integrity noted with skin e provided. Nurse on signs and de: faster heart rate, and chills, difficulty and hyperventilation. I on 6/14/2022, by bund nurse and will he DON and/or DON e for tracking ated and ensuring nem working after will be given to all ng staff and agency ident assignment. Tute Charting Board Medication cart for iew and chart on each will include any cute episode or event to chart a thorough the condition of the w onset antibiotic, fall new or worsening tatus, change of ute Charting Board will I Nurse taking care of ute change or event nee will ensure ed on the 24-hour ig. This will be The Licensed Nurse					
	ENTIFICATION NUMBER: 345307 T OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) educated to notify the skin integrity al resident's nurse. rashes, any skin usual skin integrity noted with skin e provided. Nurse on signs and de: faster heart rate, and chills, difficulty o and hyperventilation. I on 6/14/2022, by bund nurse and will he DON and/or DON e for tracking ated and ensuring nem working after will be given to all ng staff and agency ident assignment. sute Charting Board Medication cart for iew and chart on each will include any cute episode or event to chart a thorough the condition of the w onset antibiotic, fall new or worsening tatus, change of ute Charting Board will Nurse taking care of ute change or event ee will ensure ed on the 24-hour ig. This will be	ENTIFICATION NUMBER: A. BUILDING_ 345307 B. WING	ENTIFICATION NUMBER: A BUILDING	ats307 A. BUILDING 345307 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 414 WILKINSON BLVD GASTONIA, NC 28056 T OF DEFICIENCIES BE PRECEDED BUT PULL WIFFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) aducated to notify the skin integrity il resident's nurse. rashes, any skin usual skin integrity noted with skin e provided. Nurse on signs and de: faster heart rate, and chills, difficulty and hyperventilation. I on 6/14/2022, by yund nurse and will he DON and/or DON a for tracking ated and ensuring nem working after will be given to all ng staff and agency ident assignment. wite Charting Board Medication cart for iew and chart on each will include any cute episode or event to chart a thorough he condition of the w onset antibiotic, fall new or worsening fatus, change of ute Charting Board will I Nurse taking care of ute charge or event ee will ensure ed on the 24-hour g. This will be	ENTIFICATION NUMBER: A BUILDING COMP 345307 B: WING STREET ADDRESS. CITY. STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056 TT OF DEFICIENCIES BE PRECEDED BY FULL TAG DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 sducated to notify the kin integrify in resident's nurse. rashes, any skin usual skin integrify noted with skin e provided. Nurse on signs and de: faster heart rate, and chills, difficulty and dhyperventilation. I on 6/14/2022, by und nurse and will he DON and/or DON e for tracking ated and ensuring nem working after will be given to all ng staff and agency ident assignment. ute Charting Board Medication cart for iew and chart on each will include any cute episode or event to chart a thorough he condition of the w onset antibiotic, fall new or worsening tatus, change of ute charting Board Will Nurse taking care of ute charting Board Will Nurse taking care of ute charting Board Will Nurse taking care of ute charting care o

If continuation sheet Page 44 of 133

DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8					FORM	: 07/26/2022 APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED	
	345307	B. WING		_	C 06/23/2022		
NAME OF PROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
		4	414 WILKINSON BLVD				
THE IVY AT GASTONIA LLC		0	GASTONIA, NC 28056				
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
until the Resident is only be removed fro the Weekend Super Designee when the of acute charting. T charting will have a so the nurses will kn acute charting and a during the shift will b oncoming shift. In-s initiated on 6/16/202 Designee and comp DON and/or DON da tracking employees ensuring they are ed after 6/16/2022. Thi all newly hired Licen staff prior to taking the * In-service educat by DON and/or DON 6/16/2022. A thorou aspects related to the and monitoring. For nurses were in-servi symptoms of Sepsis Care Provider if the symptoms of Sepsis in-serviced on weigh loss greater than 5 p there will be notificat and RD. The licens on any resident with and to send out to h resident cognitive st obvious injury as lac pupillary changes, a	ge 44 ery shift their assessment stable and the Resident can im the Acute charting book by visor/DON and/or the DON resident is no longer in need he residents in the acute list of resident names on a list ow who to chart on. The any assessments or changes be communicated with the ervice education will be 22 by DON and/or DON leted by 6/16/2022. The esignee will be responsible for who aren't educated and ducated prior to them working s education will be given to ased Nursing staff and agency heir resident assignment.	F 684					

Facility ID: 923314

If continuation sheet Page 45 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	2: 07/26/2022 1 APPROVED 2: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(06/)	C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				4414 WILKINSON BLVD			
	T GASTONIA LLC			GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	notify if any change in normal cognitive beha habits, routines or any The licensed nurses of change in vital signs s decrease in temperate pressure and respirat are exhibited with cha the Primary Care Prov were in-serviced as to size, changes in color be reported to the Prin resident on IV fluids w every shift while on IV DON designee will be employees who aren't they are educated prin 6/17/2022. This educ newly hired Licensed staff prior to taking the Facility will implement station Interact Care F Workbook/SBARs (Si Assessment, Recomm Tool and Reference fo Specific Symptoms TI Care Transfer." This instructions on what s to be reported immed Provider, what can way when a resident need Medical Provider, this 6/16/2022. In-service on 6/16/2022 by the D and completed by 6/1 DON designee will be employees who aren't	ses were in-serviced to the resident from their wior baseline or typical y changes in food intake. were in-serviced as to any such as increase or ure, heart rate, blood ons and any symptoms that nge of vital signs to notify yider. The licensed nurses of any changes in wound d, drainage, odor, or pain to mary Care Provider. Any yill have vital signs taken therapy. The DON and/or responsible for tracking educated and ensuring for to them working after ation will be given to all Nursing staff and agency eir resident assignment. and keep at the nurses' Path Tools tuation, Background, nendation). An "education or Guiding Evaluation of nat Commonly Cause Acute tool guide provides clear igns and symptoms needs iately to the Primary Care ait until the following day and	F 684				

Facility ID: 923314

If continuation sheet Page 46 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345307	B. WING		_		C 23/2022	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	newly Licensed Nurse nurses prior to taking This education was prion 6/16/22 and 6/17/2 * The DON and/or Dichange of conditions SBARs were complete Physician and family of responsible party). If designee find any issue Designee will notify the Clinical meetings will morning after the more The weekend RN or Dichaeler the resident condition notification to the Prinary responsible party. The the 24-hour report and the resident condition notification to the Prinary responsible party. The the 24-hour report was training. * Lab. book will be im- nurses' station that win notification of Primary results have been obtic the resident's name, to the ordered lab., the of critical labs. noted, the the Primary Care Pro- Nurse receiving lab. of lab. book. The Nurse will notify Primary Care Lab. results and docu doing notification. All the Nurse at the facility	ation will be given to all es and agency licensed their resident assignment. rovided to licensed nurses 22. ON designee will review all in clinical meeting to ensure ed along with Primary Care notification (if they are the DON and/or DON ues, the DON or DON he Primary Care Provider. be held every weekday ming stand up meetings. DON Designee will review d will ensure any changes in is addressed and proper nary Care Provider and the he needed documentation for s included in the in-service hell reflect ordered labs. and of Care Provider when lab. tained. The book will reflect he date of the lab. ordered, date results obtained and if e notification date and time wider was notified. The order will place lab. in the two receives lab. results re Provider of any Critical ment in the lab. book of critical labs. are called to ty from the Lab. In-service ated on 6/16/2022 by DON	F 684					

If continuation sheet Page 47 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	2: 07/26/2022 APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING	_	C 06/23/2022		
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	T GASTONIA LLC		4	414 WILKINSON BLVD			
	AT GASTONIA LLC		0	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	 6/17/2022. The DON be responsible for trace educated and ensuring them working after 6/2 be given to all newly hagency staff prior to ta assignment. * The DON and/or D book every morning to have not been address Provider notified. The supervisor will check for weekend to ensure th DON Designee find at Designee will notify the the weekend superviand has been informer regard. The in-service will be telephone, or text. The aides that have in-ser conducted in person, sign in in-service sheet communication convertext will be provided 1 report to work prior to signage at the time cluthat received text to s designee prior to takin Nursing staff will have completed by 6/16/20 in-person in-service p with signatures on the working their shift. Al aides along with any a staff. 	and/or DON designee will cking employees who aren't g they are educated prior to 17/2022. This education will hired Licensed Nursing and aking their resident esignee will review the lab. to determine if any labs. used and/or Primary Care e DON and/or Weekend the lab. book on the e same. If the DON and/or my issues, the DON or DON the Primary Care Provider. sor was educated 6/16/2022 ed of her responsibility in this conducted in person, hose Nurses and Nurse vice that was not able to be will be acknowledged on the et as to the method of eyed. The staff that received :1 in-service when they caring for residents. Also, tock will alert those named ee the DON or DON ng care of the residents. e evidence of in-service ed by 6/15/2022 and	F 684				

Facility ID: 923314

If continuation sheet Page 48 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING					C 23/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD BASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	with the interdisciplina residents' weight loss abnormal labs., acute issues with morning re determine if any trend interventions put in play wound measurements process or issues with issues noted in mornin DON Designee. If into of achieving desired r Provider will be notified re-addressed and pot and replace interventi achieve wound healin and acute charting bo The alleged date of IJ The credible allegatio jeopardy removal was removal date of 6/18/2 A review of the in-serv 6/14/22 to 6/16/22 ind aides were educated integrity issues, labora	s. act weekly Focus meetings ary team to discuss any es, skin integrity issues, any charting boards, or any eviews of lab. book to Is and will discuss the ace; skin assessments, s with wound healing n wound healing; and lab. ng reviews by the DON or erventions are not reflective esults, the Primary Care ed, and interventions will be ential to add or eliminate ons as appropriate to g goals, notification of labs., ards. I removal is 6/18/2022. In for the immediate s validated on 6/23/22 with a 22. vice education records from licated the nurses and nurse on identification of skin atory results not addressed, nd deterioration of pressure es were educated on	F	684	DE	EFICIENCY)		
	integrity and signs of resident. The nurses	sepsis if observed on a were educated on reporting rovider any new pressure						

If continuation sheet Page 49 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/26/2022 1 APPROVED 2: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(//: 06/:	; 23/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	of changes in skin into being addressed, cha deterioration of press the Primary Care Pro The nurses also expla of utilizing acute char Path tools workbook a up on laboratory tests A review of an audit of Director of Nursing in- were checked to deter laboratory results hav there were any identifi integrity issues that hav identified and if there significant change that The results of the audo Physician Assistant of needed. A review of a sample skin issues indicated conduct weekly skin a measurements to be on the Treatment Adm	e interviewed and ad been trained on the topics egrity, laboratory results nge in condition, ure ulcers and notification of vider of the above changes. ained about the new system ting boards, Interact Care and laboratory book to follow a that were ordered. ompleted on 6/15/22 by the dicated all resident charts rmine if any outstanding re not been addressed, if fied residents with skin ave not been previously were any resident with at have not been addressed. lit were reported to the n 6/16/22 for follow-up as of residents with current an order was initiated to assessments and documented by the nurses ninistrator Record. oards, Interact Care Path Rs and the laboratory book	F 684				
	A weekly focus meeti which included the Ac Nursing, and the Infec	ng was held on 6/17/22 Iministrator, the Director of ction Preventionist. They ng areas: skin observations, atory audit					

Facility ID: 923314

If continuation sheet Page 50 of 133

	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO	E SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED		
						С		
		345307			06	/23/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
	T GASTONIA LLC			4414 WILKINSON BLVD				
				GASTONIA, NC 28056				
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 684	Continued From page	• 50	F 684	1				
	conditions and acute	charting boards.						
F 686 SS=K		event/Heal Pressure Ulcer ˈi)(ii)	F 686	5		7/16/22		
	resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indivi- demonstrates that the (ii) A resident with pre- necessary treatment a with professional stan promote healing, prev- new ulcers from deve This REQUIREMENT by: Based on observation interviews with staff, N Assistant, and Medica to complete skin asse effectively assess, an and ensure treatment implemented and mor resident's response (f who was at high risk f hospitalized on 4/5/22 pressure ulcer (full-the loss) with tunneling (p destruction under the the facility failed to up resident's Treatment / to match the wound d	hensive assessment of a nust ensure that- is care, consistent with is of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent idards of practice, to vent infection and prevent loping. is not met as evidenced ms, record reviews, and Nound Physician, Physician al Director, the facility failed essments as ordered, d monitor a pressure ulcer, s/interventions were dified/adjusted according to Resident #9). Resident #9 for pressure ulcers was 2 with an infected stage 4 ickness skin and tissue bassageway of tissue skin surface). In addition, date physician orders on a Administration Record (TAR) ressing orders in the es for wound dressings		 (1) Address how corrective action accomplished for those residents f have been affected by the deficien practice; Resident (#9) was identified a longer a resident of the facility. Resident (#6) was identified. T physician orders were verified and validated in the electronic medical on 7/14/2022 by wound nurse (2) Address how the facility will id other residents having the potentia affected by the same deficient prace Current residents received a head-to-toe skin evaluation completion 	ound to t nd is no The record entify I to be ctice;			

Facility ID: 923314

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 686 Continued From page 51 F 686 residents reviewed for pressure ulcers (Resident 7/12/2022, by the Administrative Nursing #9 and Resident #6). Team. Newly identified skin condition will be Immediate jeopardy began on 3/30/22 when the assessed by In-house Wound Care Nurse facility failed to provide the necessary care and certified in wound care, and Wound care services for a pressure ulcer that deteriorated in Doctor notified for new treatment, and condition. The facility failed to modify the PCP updated. treatment, implement interventions, Current residents with active wounds monitor/evaluate the impact of the interventions, reviewed by Wound care Doctor on and adjust accordingly. This led to a high-risk 7/14/2002 and orders updated as resident (Resident #9) being hospitalized on needed. 4/5/22 for sepsis due to an infected stage 4 Current resident records were sacral pressure ulcer. On 4/19/22, Resident #9's reviewed to ensure an order was in place family decided on comfort-guided care with on the TAR for weekly skin evaluations. hospice. Resident #9 was transferred to the Review will be completed by 7/15/2022, hospice house on 4/21/22 and died on 4/23/22 by Administrative Nursing Team. due to cerebral infarction. The Immediate Jeopardy was removed on 6/17/22 when the (3) Address what measures will be put into place or systemic changes made to facility implemented an acceptable credible ensure that the deficient practice will not allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower recur: scope and severity level of E (no actual harm with the potential for more than minimal harm that is Re-education was provided to not immediate jeopardy) to ensure education and Licensed Nursing staff by the Director of monitoring systems put into place are effective. Nursing/ Designee related to the following: Example #2 was cited at a scope and severity Performing and documenting weekly о level of E. wound evaluation along with weekly skin checks/evaluations for residents with The findings included: identified wounds/pressure wounds on a weekly and as needed basis. Resident #9 was admitted to the facility on Performing and documenting weekly 1. 0 skin evaluation as scheduled and as 3/4/19 with diagnoses that included hypertension, atrial fibrillation, peripheral vascular disease, needed. peripheral artery disease, obesity, nicotine 0 Physician notification related to new dependence, paraplegia and wheelchair bound area of skin impairment, deterioration of a since 2012. wound, or signs and symptoms of wound infection. A review of the Physician's Orders in Resident o Physician notification related to newly #9's medical record indicated an order for the admitted resident with identified skin

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 52 of 133

PRINTED: 07/26/2022

						<u>D. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		. ,	E SURVEY PLETED
			A. BUILDIN	G		
		345307	B. WING		06	C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		/23/2022
				4414 WILKINSON BLVD		
THE IVY A	T GASTONIA LLC			GASTONIA, NC 28056		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG	1 Y	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	O THE APPROPRIATE	COMPLETIO DATE
F 686	Continued From page	e 52	F 68	86		
	following:	5 02		impairment.		
		n check/skin observation tool		o Physician and resid	ent responsible	
	•	d Saturday on the evening		party notification related		
	shift.	d balanday on the evening		refusal of physician pres		
		kide diaper relief cream with		treatment or care plan in		
		re barrier ointment and apply		o Following physician		
	,	ocks, groin, and upper		dressing changes as or		
		a day and as needed.		o Nurse to nurse com		
				to residents' health conc		
	Resident #9's care pl	an initiated on 8/26/21		completed shift to shift		
	-	had a pressure area to the		Education to be complet	ed by 7/15/2022	
		one forming the base of			,	
		s). He refused to be put				
	back to bed due to hi	m being a smoker and he		Re-education was p	provided to	
	only wanted to lie dow	wn once a day for		Certified Nursing staff by	/ Director of	
	incontinence care and	d then wanted right back up		Nursing/Designee relate	d to the following:	
	to smoke. He refused	d to see the wound doctor.		o New observed skin	area is to be	
	Interventions included	d to administer treatments		reported promptly to cha	arge	
	as ordered and monit	tor for effectiveness,		nurse/Director of Nursing		
	encourage the reside	nt to lie down during the		o Incontinence care is	-	
	-	fuses treatment, confer with		routinely minimum of ev	ery 2 hours and	
		ciplinary team, and family to		PRN		
		y alternative methods to gain		o Turning and reposit	•	
	compliance and docu	ment alternative methods.		residents' plan of care o tolerates.	r as residents	
		uation and Management		o Report resident refu		
		by the wound physician on		assigned Nurse/ Charge		
		sident #9 had a shear, full		of Nursing as appropriat		
	thickness wound to th			o Residents are to rec	ceive showers as	
		ntimeters) in length, 1.3 cm		scheduled.		
		n depth. He also had a		o Report any changes		
		wound to the right buttock		color or smell to assigne	-	
		cm in length, 2 cm in width		Nurse or Director of Nur	sing as	
		Both wounds had a light		appropriate.		
		wound physician applied a		o Report any changes		
	hydrocolloid dressing	to each buttock.		assigned Nurse/ Charge		
				of Nursing as appropriat		
		h the Wound Physician on		o Nurse to (assigned)		
	6/8/22 at 11:30 AM re	evealed he had not seen		communication via verba	al communication	

Facility ID: 923314

If continuation sheet Page 53 of 133

CENTER	S FUR MEDICARE &	MEDICAID SERVICES					3 NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	· · · ·	DATE SURVEY COMPLETED
							С
		345307	B. WING				06/23/2022
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				4 WILKINSON BLVD STONIA, NC 28056		
(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) COMPLETIOI DATE
F 686	Continued From page	e 53	F 6	86			
	Resident #9 for the p Resident #9 had decl	ast 6 months because lined assessment at times. mily involvement or team			related to residents' health conditio completed shift to shift	n to be	
	meeting to address n	on-compliance and Resident om his service on 9/30/21			Education will be completed by 7/1	5/2022	
	after his last visit. Th	e facility had not informed had required his services			Education will be included with new Licensed Nurse and Certified Nursi Aide hire orientation by Director of Nursing/Designee		
	order for hydrocolloid Wednesday, and Fric and left buttocks (she The quarterly Minimu assessment dated 1/				 (4) Indicate how the facility plans i monitor its performance to make su solutions are sustained; Director of Nursing/Designee v conduct 10 skin observation review completion weekly for 4 weeks, the 	ure that vill vs for	
	behaviors, required e with bed mobility and totally dependent on use and bathing. He sides of his lower ext	extensive physical assistance personal hygiene, and was staff assistance with toilet had impairment to both			 skin observation reviews weekly fo weeks, then 1 skin observation rev weekly for 4 weeks. Results of the reviews will be discussed during the monthly Qual Assurance meeting for tracking, tree 	r 4 iew ity	
	#9 was always incont bowel. Resident #9 v pressure ulcers/injuri unhealed pressure ul	tinent of both urine and was at risk of developing es, but he didn't have any cers/injuries. He had a wice for bed and received			 DON and/or Designee will be responsible for bringing/discussing reviews in monthly Quality Assuran Meeting for 3 months or until subst compliance is maintained. 	team.	
	Pressure Ulcer Risk,' Resident #9 was at h pressure ulcer due to perception, very mois limited mobility. He a friction and shear due	"Braden Scale for Predicting ' dated 2/14/22 indicated igh risk for developing a overy limited sensory st skin, chairfast and very also had a problem with to him requiring moderate ince in moving and complete			Date of compliance: 7/16/2022		

Facility ID: 923314

If continuation sheet Page 54 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page impossible.	9 54	F	686				
	were documented by 3/23/22. On 3/9/22, N Resident #9 had redn groin area. On 3/23/2 Resident #9 had a ras Resident #9 's care pla indicated Resident #9 coccyx. He had been refused to be turned of included to administe monitor for effectivent treatment, confer with interdisciplinary team why, and try alternativ compliance and docu A review of Resident 5 indicated there was n weekly skin check/ski completed after 3/28/2	A sident #9's medical record Nurse #1 on 3/9/22 and Nurse #1 documented ess to his buttocks and 22, Nurse #1 documented sh to his bottom. An last revised on 3/28/22 had a pressure ulcer to the in bed due to decline and off his back. Interventions r treatments as ordered and ess. If the resident refused in the resident, , and family to determine ve methods to gain ment alternative methods. #9's medical record o evidence of any other n observation tool 22. The progress notes 2 indicated no documented #9 with wound						
	6:43 PM revealed she Resident #9 on 3/9/22 areas on his buttocks #9's bottom had alwa note any open wound barrier cream to his b #1 stated she couldn'	h Nurse #1 on 6/12/22 at completed a skin check on 2 and observed no open . Nurse #1 stated Resident ys been red, but she did not or ulcer. She applied uttocks as ordered. Nurse t remember if Resident #9's colloid dressing on when						

Facility ID: 923314

If continuation sheet Page 55 of 133

	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 23/2022
NAME OF F	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			4	414 WILKINSON BLVD			
	AT GASTONIA LLC		0	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	she did his skin check completed another sk and she observed ras applied his prescribed further stated she also was a hydrocolloid dr buttocks when she ch A phone interview wit 11:06 AM revealed sh a skin check on 3/19// couldn't remember wh day, and she failed to skin evaluation becau shift. Further intervie she took care of Resi noted a tremendous of buttocks when she wa hydrocolloid dressing she observed an oper measured approximation in width with a 1-2 cm	 c. On 3/23/22, Nurse #1 c. On 3/23/22, Nurse #1 c. in check on Resident #9 shes to his bottom, so she d barrier cream. Nurse #1 o couldn't remember if there essing on Resident #9's necked his skin on 3/23/22. h Nurse #5 on 6/13/22 at ne was assigned to complete 22 on Resident #9 but she nat his skin looked like that o completely document his use of interruption during the w with Nurse #5 revealed dent #9 on 4/4/22 and she change on Resident #9's as about to change his on 4/4/22. Nurse #5 stated n decubitus ulcer which tely 8 cm in length and 8 cm a depth. The ulcer had a lot 	F 686		DEFICIENCY)		
	of drainage, and she wasn't sure if all the of because she had to of had contaminated the feces would often get and she had to chang Nurse #5 stated she Resident #9's pressur and she knew he nee wound doctor or the fi- think he needed to be that time. When the fi- (DON) came in the nee from the medication of the former DON that fi- the wound doctor. The	noticed a foul odor, but she odors came from the wound lean up urine and stool that wound. Nurse #5 said on Resident #9's dressing ge it a few times on her shift. was shocked at how much re ulcer had deteriorated, ded to be referred to a acility physician but didn't e sent out to the hospital at former Director of Nursing ext day to relieve Nurse #5 eart, Nurse #5 recalled telling Resident #9 needed to see he former DON assured her wound and do whatever					

Facility ID: 923314

If continuation sheet Page 56 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page was necessary.	56	F	686				
	12:18 PM revealed sh on 3/24/22 and 3/25/2 hydrocolloid dressing stated she first saw R sacrum on 3/24/22. N observed a quarter-si: #9's bottom that looked drainage and no foul of report this observation this was normal for hit complete a wound as: didn't think she had to An interview with Nurs at 4:38 PM revealed s shift and often provide #9. NA #1 stated whe Resident #9 in Novem one dressing to each gave him a bed bath of a big wound on his bo NA #4 stated she was Resident #9's pressur to remember or even like. NA #4 stated she ended up placing at le #9's pressure ulcer. A phone interview witt 11:03 AM revealed sh #9's hydrocolloid dress several scattered ope shaped on his buttock the hip bone) areas. I having to apply 4 hydrocentice the several scattered ope shaped on apply 4 hydrocentice the several scattered ope shaped on placentice the several scattered ope shaped on placentice the several scattered ope	zed open area on Resident ed clean, pink and had no odor. Nurse #7 did not n to anyone as she thought m. She also did not sessment because she						

Facility ID: 923314

If continuation sheet Page 57 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		345307	B. WING _			_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				44	414 WILKINSON BLVD			
THEIVTA	T GASTONIA LLC			G	ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION DTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	and she recalled that of the wounds. They odor, but she didn't the the doctor or complete Nurse #8 couldn't give measurements of the ulcer on the right butto one on the left. She w as well because they and remove urine and #8 stated the area wh were easily contamina Nurse #8 also stated the wounds looked bas bleeding and had a lo A phone interview with 2:12 PM revealed she #9's hydrocolloid dress noticed that the open gotten worse, but she when it started to get remembered Residen smaller than the size of started working with h had changed his hydr noticed that the woun size of a baseball, and Nurse #2 did not notif worsening of Residen because she thought by the wound doctor. didn't think about com assessment and didn' severe that she neede hospital at that time.	he wounds as red and beefy, she didn't have to pack any drained a lot and had some ink she had to report it to e a wound assessment. e approximate wounds but stated that the ock was smaller than the wasn't sure about the odor had to clean up Resident #9 d stool off the wound. Nurse ere his ulcers were located ated with stool and urine. that NA #4 probably thought ad because they were t more drainage than usual. h Nurse #2 on 6/13/22 at e had done most of Resident using in March 2022 and she wound on his buttocks had didn't remember exactly worse. Nurse #2 stated she t #9's wound being slightly of a quarter when she im but on 3/30/22 when she ocolloid dressing, she d had gotten bigger to the d it was draining more. y the doctor of the t #9's pressure ulcer he was already being seen Nurse #2 also stated she upleting a wound 't think his wound was that	F	586				

Facility ID: 923314

If continuation sheet Page 58 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING _			_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER		- I	ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Sodium solution - inje for UTI (urinary tract in separate sites. Ceftria antibiotic used to treat infections. It works by preventing their growth An interview with the 16/14/22 at 9:20 AM re prescribed antibiotic in 3/31/22 but could not Resident #9 had a dre coccyx or buttocks at The UM stated that sh Resident #9 the shot abnormalities or open reported there was no caused any concern, a odor. An interview with Nurs AM revealed she was take care of Resident wound dressing befor to her that he was have nurses to change his she went ahead and co couldn't remember wh at that time. Nurse #8 March 2022 and had in DON. A phone interview with AM revealed she work 7:00 PM to 7:00 AM at in the bed whenever st	ted an order for Ceftriaxone ct 1 gram intramuscularly infection) x 2 doses in axone is a cephalosporin t a wide variety of bacterial y killing bacteria or h. Unit Manager (UM) on vealed she injected a nto Resident #9's buttock on recall whether or not essing that covered his the time of the injection. Ne was focused on giving that she didn't notice any areas to his buttocks. She othing that alarmed her or and she did not notice any se #9 on 6/14/22 at 11:05 not usually assigned to #9 but had changed his e whenever he complained <i>v</i> ing a hard time getting the dressings. Nurse #9 stated did his dressing, but she hat his buttocks looked like 9 stated this happened in reported this to the former	F	586				

Facility ID: 923314

If continuation sheet Page 59 of 133

		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 07/26/2022 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			SURVEY LETED
		345307	B. WING		_		23/2022
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	he was always compl let her provide inconti stated Resident #9's I slashed areas whene him. NA #5 noticed F to break down and that putting a dressing to the would usually put one She couldn't tell for sub buttocks started to we been open for at least sent to the hospital. If from the wound increa- odor coming from it. when his dressing hat #7 about it, and she w would have to wait be was not scheduled to could not remember w A progress note dated Nurse #3 indicated Re unstageable ulcer on very large, approximation cm unstageable. Clei- wound cleanser and (A phone interview witt 10:20 AM revealed sh from 7:00 AM to 7:00 Nurse #3 recalled see buttocks on 4/3/22 wh hydrocolloid dressing surprised to see how stated it was the wors had ever seen. Nurse	something. NA #5 stated iant with her, and he always nence care to him. NA #5 pottom always had small, ver she started working with tesident #9's bottom starting at was when they started the open areas and they e dressing to each buttock. ure when Resident #9's orsen but she said it had t a month before he was NA #5 stated the drainage ased and she noticed a foul She remembered one time d come off, she told Nurse vas told by Nurse #7 that he ecause the dressing change be done on her shift. NA #5 when this had happened. d 4/3/22 and written by esident #9 had a huge the buttocks. Ulcer was ttely 8 centimeters (cm) by 8 aned ulcer on coccyx with antiseptic) dressing applied. h Nurse #3 on 6/13/22 at he took care of Resident #9 PM on 4/2/22 and 4/3/22.	F 686				

Facility ID: 923314

If continuation sheet Page 60 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/26/2022 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(06/2	C 23/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			4	414 WILKINSON BLVD			
THEIVTA	T GASTONIA LLC		G	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Nurse #3 saw the wor Director of Nursing (D former DON placed a wound. Nurse #3 ass had notified the docto ulcer and received an dressing. Nurse #3 s doctor of the pressure the former DON know going to take care of i A phone interview witt PM revealed she took night shift and someti PM. At first, Resident would open and to wh ointment. The open a re-open whenever he the day. NA #6 could Resident #9's bottom stated that she report #5. NA #6 stated Res to worsen and had a f to worse in a short pe in color and the draina also stated she thoug Resident #9's pressur giving the nurses orde the wound. A phone interview wa 12:01 PM, 6/14/22 at 10:19 AM with the for A nurse practitioner (f indicated Resident #9 wound to his buttocks one-fourth area of the	und, she called the former ION) into the room and the in antiseptic dressing on the sumed that the former DON r of Resident #9's pressure order for the antiseptic tated she did not notify the e ulcer because she had let r and she thought she was t. h NA #6 on 6/14/22 at 7:15 c care of Resident #9 on the mes she came in at 7:00 t #9 had a red area that nich they applied cream and area would heal and then refused to lie down during n't remember when first looked bad, but she ed it to Nurse #2 and Nurse sident #9's ulcer continued foul odor. It went from bad riod of time, it became dark age was horrible. NA #6 ht the doctor was aware of re ulcer and that he was ers about the treatment for s attempted on 6/13/22 at 12:00 PM and 6/15/22 at mer DON with no return call.	F 686				

Facility ID: 923314

If continuation sheet Page 61 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345307	B. WING) 06/2	C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				4414 WILKINSON BLVD			
THEIVYA	T GASTONIA LLC			GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	after an injury) preser was also a 2 cm by 2 heel. Unable to stage sent to the hospital fo Multiple attempts were but they were unsucce worked with the Media An interview on 6/14/2 Physician Assistant cu facility revealed Reside been assessed each nurse for the size, dra signs, and symptoms debridement. With es would have debrided #9 out for evaluation. A phone interview with on 6/14/22 at 4:22 PM open areas on Reside recurred due to his no offloading and inconti sure about the pressu- before he was sent ou stated Resident #9 ha and he felt this was lik MD stated he wasn't s developed fast, but he to what extent the pre- deteriorated. The MD expected to be notifie deterioration/decline i though they had expe- get worse due to his re also stated that with the	to the buttocks and there cm necrotic area to the right a wound, recommend he be r wound evaluation. e made to contact the NP, essful. The NP no longer cal Director's team. 22 at 12:25 PM with the urrently working at the lent #9's wound should have week by medical staff or a linage, type of tissues, of infection, and need for schar tissue present, the ecome infected, and she the wound or sent Resident the Wedical Director (MD) A revealed he was aware of ent #9's buttocks that on-compliance with nence care, but he wasn't ure ulcer that developed right at to the hospital. The MD ad so many co-morbidities kely a terminal ulcer. The surprised the ulcer e couldn't say how fast and issure ulcer had o further stated he had	F 68	36			

Facility ID: 923314

If continuation sheet Page 62 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/26/2022 APPROVED 0: 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		345307	B. WING		_	06/:	; 23/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	pretty readily. He said #9's pressure ulcer pr based on his past hist co-morbidities. Resident #9's hospita 4/5/22 indicated Resid Emergency Departme Resident #9 was foun sepsis/septic shock w an infected decubitus injury of buttock stage cells indicating an infe encephalopathy, acut superimposed on chro intravascular volume low sodium. The surg sacral ulcer determine necrotic, and malodor erythema. Plan was f diverting colostomy. I ulcer was contaminate was critically ill and at resulting in end-organ fevers were up to 103 infected sacral pressu tomography) scan of t revealed extensive su (deep seeded infectio organisms) and tunne gluteal and above the #9 also had a stage 4 plantar foot and a soft stump. Resident #9's death of	d he didn't feel Resident ogression was avoidable tory, behaviors, and I admission notes dated dent #9 was seen in the ent for altered mental status. d to have severe ith acute organ dysfunction, ulcer stage IV, a pressure e IV, elevated white blood ection, metabolic e renal failure onic kidney disease stage 3, depletion (dehydration), and gical consult for decubitus ed the ulcer was large, rous ulcer with only minimal for surgical debridement and it was suspected the sacral ed with stool. Resident #9 e risk for decompensation of dysfunction. The resident's e Fahrenheit due to an tre ulcer. A CT (computed the sacral pressure ulcer ubcutaneous gas formation	F 686					

If continuation sheet Page 63 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			1414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	on 6/13/22 at 5:34 PM supposed to complete each resident but if the ulcer, the nurses were doctor's attention. An ulcer should be referr proper treatment and The Administrator was Jeopardy on 6/14/22 at The facility provided to Plan with the correction 1. Identify those recip are likely to suffer, a se a result of the noncom The identified residen a resident of the facility wound that increased facility allegedly failed Resident #9 who was pressure sores and he ulcers. The resident of hospital and was note IV pressure ulcer. All other residents has affected by the deficite * An immediate skin audit of all residents is 14, 2022, by the licen completed by June 15 * The skin assessme	Director of Nursing (DON) A revealed the nurses were a weekly skin checks on the resident had a pressure a supposed to bring it to the my resident with a pressure ed to the wound doctor for evaluation. as notified of Immediate at 12:57 PM. the following IJ Removal on date of 6/17/22. tients who have suffered, or serious adverse outcome as npliance: at (Resident #9) is no longer ty. Resident #9 had a in size and severity and the d to identify changes for assessed as a high risk for ad a history of pressure was later discharged to the ed to have an infected stage we the potential to be ent practice. assessment/total body s being initiated today, June ised nursing staff and will be	F 686				

Facility ID: 923314

If continuation sheet Page 64 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345307	B. WING			_		C 23/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD ASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	resident's skin integrit documented skin asse and will be documente sheet. * Any resident/s with will be measured and RN certified wound nu * Any resident with a or worsening wounds inform the DON or DO Provider will be notifie or DON Designee. * Any resident that re assessment, will be a assigned licensed nur to see if they can assi allow us to conduct sk * If the resident cont BIMS score of 12 or g information by the DO regarding the risks of or wound care and wi The DON or DON Des plan during the weekkl updated on the care p notification. * The Primary Care I the DON or DON Des as well and will be do After 3 separate atten resident to allow, the notify the Primary Care	ey and compare to the last essment for the resident ed on the skin assessment in newly developed wounds staged by facility employed urse. In y newly developed wounds , the resident's nurse will DN Designee. Primary Care ed immediately by the DON efuses to have skin sked again by their rse, and will contact family ist in encouraging them to kin assessment. inues to refuse and has a greater, will be provided with DN or DON Designee refusing skin assessment II be care planned as such. signee will update the care y Focus meeting if not blan at the time of Provider will be notified by signee regarding the refusal cumented in the Care Plan.	F	686					

If continuation sheet Page 65 of 133

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/26/2022 MAPPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345307	B. WING			_		C 23/2022	
NAME OF P	ROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE	-		
THE IVY A	T GASTONIA LLC				4414 WILKINSON BLVD GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page	÷ 65	F	686	;				
	notification on the TAI assessments by 6/15, Designee will ensure TAR. The current res wounds/pressure sore assessment and/or m documented in Reside The DON and/or the I nurse and/or DON de will reflect the docume assessment and/or m order for the wound c resident on weekly ba 2. Actions taken to all failure to prevent advo occurring or recurring Immediate in-service Director of Nursing (D wound nurse and/or D conducted to the nurs and nurse aides. * The in-service will telephone, or text. Th were unable to be con have in person in-service an assignment and w in-service sign in sheat that were not availabl text of highlighted info in-service will have to when they report to w residents. Also, signa	/2022. The DON or DON the order is placed on the sidents with es that need weekly reasurements will be ent/s chart by 6/15/2022. RN certified wound care esignee will ensure the TAR entation of weekly reasurements along with the are for the individual asis. ter the process or system erse outcome from tr initiated 6/14/2022 by the DON) and/or RN certified DON Designee will be sing staff to include nurses be conducted in person, nose staff members that ntacted other than text, will vice training prior to taking ill have evidence of the h their signature on the et. Those staff members e in person that received a prmation presented in the be provided 1:1 in-service							

Facility ID: 923314

If continuation sheet Page 66 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING _			_	() 06/2	C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				14 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	(EACH CORREC CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	residents. All staff will in-service communication and will have the in-per- working shift with sign prior to them working staff (nurses and nurse agency staff will recein in the in-service prior The DON and/or RN of DON Designee will be which staff need in per- day and shift they are will be notified that thi beginning on 6/14/202 A. The in-service will Director of Nursing (D wound nurse and/or D staff regarding perform weekly wound assess weekly skin checks/ew identified wounds/pres and as needed basis. be posted/available at the nurse assigned to number when the indi assessment, and doct wound/pressure sores This will be posted as B. Director of Nursin wound nurse and/or D responsible for creatin residents in addition to new admissions or re- integrity. This list will TAR. If any resident r	ee prior to taking care of the I have evidence of tion initiated by 6/14/2022 erson in-service prior to their natures on the sign-in sheet their shift. All newly hired the aides) along with any ve the information contained to working with residents. certified wound nurse and/or e responsible for tracking trson education and what scheduled to work. They s is effective immediately 22. I be presented by the ON Designee to all nursing ming and documenting treents along with the valuations for residents with ssure wounds on a weekly An assignment sheet will t the nurse's station to alert a particular resident/room vidual resident's weekly skin umentation of s measurements are due. of 6/17/2022. g (DON) and/or RN certified DON Designee will be	F 6	86				

Facility ID: 923314

If continuation sheet Page 67 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING		_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				4414 WILKINSON BLVD			
	T GASTONIA LLC			GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	reflected on the TAR a record regarding the r notification of Primary will also notify the DO refusal of any assess All weekly skin assess sore assessments and the individual resident C. Any resident that assessment or wound their assigned license family to see if they ca them to allow us to co D. If the resident cor BIMS score of 12 or g information by the DC regarding the risks of or wound care and wi Staff will be educated Designee for refusals assessments, wound care. E. The Primary Care the DON or DON Des as well and will be do F. Although contract assessments, the lice be expected to condu and measurements re service providers. G. Licensed nursing notify the Primary Care new pressure wound	and a note in the resident efusal along with the Care Provider. The nurse N or DON designee for ment and/or wound care. sments and wound/pressure d measurements will be on 's TAR. refuses to have skin I care will be asked again by d nurse and will contact an assist in encouraging nduct skin assessment. tinues to refuse that has a reater, will be provided with N or DON Designee refusing skin assessment II be care planned as such. to notify the DON or DON	F 68	16			

Facility ID: 923314

If continuation sheet Page 68 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345307	B. WING				C /23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE IVY A	T GASTONIA LLC				4414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 686	 and/or RN certified we conducted to the nurse and nurse aides and y 6/16/2022. H. Licensed nursing notify the Primary Cat admitted resident is n wound/pressure sore. wound or open area weekly skin assessme TAR. I. Signs and sympton * Faster heart rate * Reduced urine outp * Fever and chills * Difficulty in breathing * Mental confusion * Hyperventilation J. The Nurse Aides y nurse with any chang immediately to the ind Such changes as red break, abrasions, or a observations that wer observations during p * The facility will con with the Interdisciplina any resident wounds interventions put in pl interventions are been DON designee will no Provider of the status additional wound treated to the status additing the status additing the status additi	ector of Nursing (DON) ound nurse will be sing staff to include nurses will be completed by staff will be educated to re Provider if a newly oted to have open . The new resident with will have orders to conduct ent and measurements on ms of sepsis to include: ut g will be educated to notify the es in skin integrity dividual resident's nurse. ness, rashes, any skin any unusual skin integrity te not noted with skin orior care provided. aduct weekly Focus meetings any team (IDT) to discuss and will discuss the ace and determine if the eficial and if not, the DON or	F	686			

Facility ID: 923314

If continuation sheet Page 69 of 133

PRINTED: 07/26/2022

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 07/26/2022 APPROVED 0: 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		345307	B. WING		_	C 06/23/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	responsible for ensuring meetings occur. * The IDT include dia registered dietician (w DON designee, Admin Director, Activity Direct aide that are involved The alleged date of IJ The credible allegation jeopardy removal was removal date of 6/17/2 On 6/23/22, the facility validated through rect interviews. The facility validated through rect interviews. The facility occumentation for all reporting a change in integrity. In addition, education sheets on t completing skin assess provided details on hor readmissions would h as needed skin assess nurse. Interviews con staff validated skin as to each resident and w Treatment Administration nurse to complete. The able to explain the neithe facility.	DON or DON Designee is ng the weekly Focus etary manager, the then available) DON or histrator, Social Service ctor, and nurse and/or nurse in the care of residents. removal is 6/17/2022. In for the immediate is validated on 6/23/22 with a 22. y's credible allegation was ord reviews and staff y provided education staff on identifying and condition especially in skin the facility provided signed he new system for sements. The education ow all new admissions, ave an initial, weekly, and sments completed by the iducted with the nursing sessments were assigned were flagged on the tion Record (TAR) for the he nurses interviewed were w system implemented by re interviewed and t signs of changes in skin	F 686					

Facility ID: 923314

If continuation sheet Page 70 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	06/2) 23/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
THE IVY A	AT GASTONIA LLC			414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	The Director of Nursir and described the wa ensure skin assessme reported all skin asses the electronic medica Treatment Administra completed by the nursi sheet set up by the D her designee were re- assessments daily to assessments daily to assessments had bee The DON explained s the sheets were comp "checked" as done. A weekly focus meetin which included the Ad Nursing, and the Infect discussed the followin wound reports, labora review/notification, we conditions and acute 2. Resident #6 was re- to the facility on 4/22/ diagnoses included m malnutrition, pressure pressure ulcer left hip and pressure ulcer rig Resident #6's most re- (MDS) was a quarter 4/8/2022. The MDS re- cognitively able to ma daily living. Resident a from one staff member MDS indicated Reside pressure ulcers. A star	ng (DON) was interviewed y the new system worked to ents were completed. She ssments were assigned in I record (EMR) on the tor Record (TAR) to be se based on an assignment ON. She explained she or sponsible for reviewing the ensure all skin en thoroughly completed. the or her designee verified bleted in detail and not just ng was held on 6/17/22 dministrator, the Director of ction Preventionist. They ng areas: skin observations, atory audit eight loss, change of charting boards. e-admitted from the hospital 2021. Her cumulative noderate protein-calorie e ulcer of right ankle, o, pressure ulcer left ankle, ght hip.	F 686				

Facility ID: 923314

If continuation sheet Page 71 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page or muscle.	÷71	F 686				
	last reviewed on 4/14 for pressure ulcers. In	#6's most recent care plan /2022 included a focus area nterventions included s as ordered and monitor for					
	a) Resident #6's pres	sure ulcer on right hip.					
	"cleanse right hip with collagenase ointment calcium alginate with superabsorbent dress	d 3/1/2022 read in part n wound cleanser, apply to wound bed and apply silver. Cover with sing and bordered gauze. daily, on the day shift."					
		d 5/10/2022 read in part ntment to the surface of the p on the day shift."					
	the dressing treatment indicated to discontine collagenase ointment part "wet to moist with hypochlorite solution	and gauze. Apply skin prep wound and then apply					
	care order for the righ was discontinued on (order noted the prima	orders showed the wound ht hip initiated on 3/1/2022 6/9/2022 at 12:52 P.M. The ary dressing was and calcium alginate with					
		orders showed the wound at hip initiated on 5/10/2022					

If continuation sheet Page 72 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			_		C 23/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
	T GASTONIA LLC			44	414 WILKINSON BLVD			
				G	ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	order noted the prima collagenase ointment A physician order data read: Cleanse with 0. then apply wet to moi hypochlorite saturated cover with superabso dressing and change An observation was c 3:48 PM of a wound t on the right hip. The V present in the facility. removed Resident #6 placed a wet gauze of the end of his evaluat collected and prepare treatment for Residen washed her hands wit clean gloves, and rem right hip. The Unit Ma and cleansed each we with 0.125% sodium h Unit Manager used a around the wound, ap 0.125% sodium hypor superabsorbent dress to the right hip. The b with the current date a	5/9/2022 at 12:51 P.M. The ry dressing was ed 6/9/2022 for the right hip 125% sodium hypochlorite st 0.125% sodium d gauze to wound bed and rbent pad. Wrap with border daily on day shift. onducted on 6/9/2022 at reatment dressing change Vound Physician was The Wound Physician 's existing dressing and ver right hip wound site at ion. The Unit Manager d supplies to provide wound t #6. The Unit Manager th soap and water, applied noved the gauze from the nager applied clean gloves bund with gauze soaked hypochlorite solution. The skin prep on the skin uplied a gauze saturated with chlorite sodium, a ing, and a bordered gauze ordered gauze was dated and Unit Managers initials.	F	586				
	Physician order dated	3/1/2022 showed the						

If continuation sheet Page 73 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345307	B. WING _			-		C 23/2022	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	-		
	T GASTONIA LLC			44	414 WILKINSON BLVD				
	I GASTONIA LEC			G	ASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 686	"cleanse with 0.125% solution, apply wet to hypochlorite saturated cover with superabso gauze change daily o wound." A Wound Physician net the dressing treatment indicated to discontine collagenase ointment part "wet to moist with hypochlorite solution a to the skin around the superabsorbent silico An observation was c 3:48 PM of a wound t on the left hip. The Wo Resident #6's existing gauze over the left hip his evaluation. The Up prepared supplies to p Resident #6. The Unit hands with soap and and removed the gau Manager applied clea wound with gauze so hypochlorite solution. skin prep on the skin gauze saturated with sodium, a superabsor bordered gauze to the	for the left hip read in part sodium hypochlorite moist 0.125% sodium d gauze to wound bed and rbent pad. Wrap with rolled in day shift for pressure ote dated 5/12/2022 under it plan for the left hip ue the alginate calcium and . The new dressing read in a 0.125% sodium and gauze. Apply skin prep wound. Apply ne bordered dressing." onducted on 6/9/2022 at reatment dressing change ound Physician was present und Physician removed g dressing and placed a wet o wound site at the end of nit Manager collected and provide wound treatment for t Manager washed her water, applied clean gloves, ze from the left hip. The Unit n gloves and cleansed each aked with 0.125% sodium The Unit Manager used a around the wound, applied a 0.125% sodium hypochlorite	F 6	86		JEFICIENCY)			
	A review of physician	orders showed the wound							

Facility ID: 923314

If continuation sheet Page 74 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	06/2) 23/2022
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
			4	414 WILKINSON BLVD			
THE IVY A	T GASTONIA LLC		G	ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	 was discontinued on 0 The follow order for the 6/9/2022 read in part sodium hypochlorite to 0.125% sodium hypochorite to 0.125% sodium hypochor	hip initiated on 3/1/2022 6/9/2022 at 7:54 P.M. The left hip was started on "Cleanse with 0.125% then apply wet to moist chlorite saturated gauze to r with superabsorbent pad. essing and change daily on sure ulcer on the buttocks. The dated 5/26/2022 under th plan noted an initial id on the buttocks. The papply hydrocolloid sheet to	F 686		DEFICIENCY)		
	each wound with gau	l clean gloves and cleansed ze soaked with 0.125% solution. The Unit Manager					

Facility ID: 923314

If continuation sheet Page 75 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345307	B. WING		_		C 23/2022	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
THE IVY A	T GASTONIA LLC			1414 WILKINSON BLVD GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page applied a hydrocolloid the date and the Unit	I sheet over the wound, with	F 686					
	Physician order dated ankle read in to apply ointment 100,000-0.1 skin around the woun	sure ulcer on the right ankle 12/17/2021 for the right nystatin and triamcinolone unit/gram percent to the ds on the right and left ankle Tuesday, Thursday, and						
	ankle read in part "wa	l 5/30/2022 for the right ash skin, apply skin prep ssing three times a week on d Thursday."						
	the dressing treatment evaluation for a wound dressing ordered und plan indicated for the use "wet to moist with hypochlorite solution at triamcinolone and ½ r	d on the right ankle. The er the dressing treatment wound on the right ankle to n 0.125% sodium and gauze. Apply ½ nystatin cream (premixed in bund the wound. Apply						
	care order for the righ	orders showed the wound at ankle initiated on atinued on 6/9/2022 at 12:50						
	3:48 PM of a wound t on the right ankle. The present in the facility.	onducted on 6/9/2022 at reatment dressing change e Wound Physician was The Wound Physician 's existing dressing and						

Facility ID: 923314

If continuation sheet Page 76 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/26/2022 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		345307	B. WING			06/2	C 23/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	placed a wet gauze o' the end of his evaluat collected and prepare treatment for Residen washed her hands wit clean gloves, and rem ankle. The Unit Mana and cleansed each we with 0.125% sodium h Unit Manager applied cream and ½ nystatin wound, applied a gau sodium hypochlorite s dressing, and a borde The bordered gauze w date and Unit Manage The Physician order s wounds on bilateral la cleanse wound with s apply ½ triamcinolone cream to the skin arou moist with sodium hyp gauze, apply superab gauze. An interview was com P.M. with the Unit Ma the Unit Manager stat entering new wound t resident's electronic m Wound Physician com update the physician com updated the orders as interview the Unit Man discontinued some wo	ver the right ankle wound at ion. The Unit Manager ed supplies to provide wound at #6. The Unit Manager th soap and water, applied noved the gauze from the ger applied clean gloves ound with gauze soaked hypochlorite solution. The a cream of ½ triamcinolone to the skin around the ze saturated with 0.125% sodium, a superabsorbent ered gauze to the right ankle. was dated with the current ers initials. Started on 6/9/2022 for ateral ankles read in part odium hypochlorite solution, e cream and ½ nystatin und the wound, apply wet to pochlorite sodium saturated usorbent pad and border ducted on 6/9/2022 at 4:45 nager. During the interview, ted she was responsible for rreatment orders in the nedical record after the npleted rounds at the facility. ot always have time to	F 686				

Facility ID: 923314

If continuation sheet Page 77 of 133

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING _			-	06/	23/2022
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				14 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 686	locations to simplify d Resident #6. An interview was com P.M. with the Director the interview the DON orders should be enter electronic medical rec evaluated by the Wou stated staff should fol treatment plan and if in the wound dressing Physician needed to b A telephone interview 6/13/2022 at 8:53 A.M During the interview, when a wound dressin new dressing should supplies were availab were ordered, the new implemented within 4 Physician stated the of wound notes under D his orders for the dress wounds. He further st orders entered onto the follow should match the wound notes. During stated when there was should reach out to his discussed when he co orders entered for the changes.	order for multiple wound ressing changes on ducted on 6/10/2022 at 4:40 of Nursing (DON). During V stated wound dressing ered into the resident's cord within 24 hours of being and Physician. She further low the physician's there are any discrepancies g orders, the Wound be contacted for clarification. Was conducted on A. with the Wound Physician. the Wound Physician stated ing order was changed, the be effective that day if the le at the facility. If supplies w dressing should be -5 days. The Wound dressings listed on his ressing Treatment Plan, are ssing to be applied to the ated the wound dressing ne TAR for the nurses to he dressings written on his the interview the physician s a discrepancy, the nurses in to make sure what was ompleted rounds are the aresident's wound dressing		586				7/16/22
F 692 SS=K	Nutrition/Hydration St CFR(s): 483.25(g)(1)-		F 6	92				//16/22

Facility ID: 923314

If continuation sheet Page 78 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I		1			FORM	D: 07/26/2022 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				SURVEY PLETED
		345307	B. WING				23/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	§483.25(g) Assisted r (Includes naso-gastric both percutaneous endosc enteral fluids). Based comprehensive assess ensure that a resident §483.25(g)(1) Maintai of nutritional status, se desirable body weight balance, unless the re- demonstrates that this preferences indicate of §483.25(g)(2) Is offeren- maintain proper hydra §483.25(g)(2) Is offeren- there is a nutritional p- provider orders a ther This REQUIREMENT by: Based on staff intervi- facility failed to monitor weekly basis as order a severe unintended of implement/adjust inter- sent to the hospital or feeding tube placed in resident (Resident #1) nutritional status. The a physician ordered n of 2 sample residents Resident #2). Immediate Jeopardy B	autrition and hydration. and gastrostomy tubes, doscopic gastrostomy and opic jejunostomy, and on a resident's asment, the facility must asment, the facility must asment, the facility must as acceptable parameters uch as usual body weight or a range and electrolyte esident's clinical condition as is not possible or resident otherwise; ed sufficient fluid intake to ation and health; ed a therapeutic diet when roblem and the health care apeutic diet. is not met as evidenced ews and record reviews, the or a resident's weight on a red by the physician, identify decline in his weight, and rventions. The resident was a 4/7/2022 and had a the stomach for 1 of 1 0) reviewed for maintain facility also failed to provide utritional supplement for 2	F	692	 (1) Address how corrective action w accomplished for those residents fou have been affected by the deficient practice; Resident (#10) was identified an no longer a resident of the facility. Resident (#11) was identified an no longer a resident of the facility. Resident (#2) was identified, and supplements were put into place. (2) Address how the facility will iden other resident having the potential to affected by the same deficient practice 	nd to d is d is tify be	

Facility ID: 923314

If continuation sheet Page 79 of 133

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 692 Continued From page 79 F 692 to lose weight and had a cumulative weight loss Facility scale was re-calibrated on of 24.4% since 1/19/2022. Immediate Jeopardy 6/11/2022, by Maintenance Director to was removed as of 6/14/2022 when the facility ensure accuracy, and placed on a routine implemented an acceptable allegation of calibration schedule Immediate Jeopardy removal. The facility All Residents were re-weighed by remains out of compliance at a scope and 7/13/2022 severity level "E" (No actual harm with potential Residents with weight discrepancy for more than minimal harm that is not immediate were communicated to the resident's jeopardy) for the facility to continue staff respective physician and resident education, ensure monitoring systems put into representative. New physician orders place are effective. The jeopardy tag is left out of were obtained, and care plans were compliance at a scope and severity E also for updated as appropriate Resident #11 and #2. Registered Dietician evaluated current residents with weight discrepancy by The findings included: 7/13/2022. Recommendations were reviewed with the resident's respective 1. Resident #10 was admitted to the facility on physician. New physician orders were 3/21/2019 with diagnosis of cerebral palsy and obtained, and care plans updated as intellectual disorders. Resident #10 was 52 years appropriate Residents with current weight loss will old. be reviewed at the routine weekly risk Resident #10's care plan last updated on included meetina meal satisfaction and by mouth intake. Weekly Risk meeting will consist of Interventions included add Resident #10 to the the Interdisciplinary Team (IDT) to include meal list of residents needing additional Registered Dietician. assistance with feeding and weigh/monitor results Director of Nursing/Designee will weekly. present information at the weekly risk meeting, Information will consist of Physician diet order initiated on 5/11/2020 read in Residents with Weight changes, general part "No Added Salt diet, dysphagia mechanically change in conditions, abnormal labs, altered diet, thin consistency related to cerebral wound report, care plan updates, and any palsy." The order was active on resident's other issues identified during review of discharge date of 4/8/2022. residents ADHOC IDT meeting was held on Physician order initiated on 4/21/2021 read in part 7/15/2022 to review current residents with "weekly weights every day shift every Wednesday weight loss to include areas such as RD for weight monitoring." The order was active on recommendations, physician orders and resident's discharge date of 4/8/2022. the person-centered care plan updates Residents with an oral nutritional

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 80 of 133

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 692 Continued From page 80 F 692 Physician order initiated on 9/8/21 read in part supplement had the physician orders and "add magic cup frozen nutritional treat every care plans updated to reflect current lunch for nutritional support". The order was nutritional treatment/supplement active on resident's discharge date of 4/8/2022. (3) Address what measures will be put Resident #10's guarterly MDS dated 12/5/2021 into place or systemic changes made to indicated resident was not cognitively intact for ensure that the deficient practice will not daily decision making. Resident #10's height was recur; 61 inches and he weighed 124 pounds. Resident diet included therapeutic and mechanically Re-education was provided to IDT altered diet. The MDS indicated Resident #10 and Nursing staff by the Director of was assessed for total dependence on one staff Nursing/Designee related to the following: member for assistance with eating. Resident #10 о Accuracy of weights had no weight loss or gain since the previous Timeliness of obtaining weights 0 review. The MDS further indicated Resident #10 Accuracy and timeliness of 0 had limited range of motion on both sides of his documentation upper and lower extremities. Obtaining routine weights 0 Re-weights as appropriate 0 Nurse's progress note dated 1/5/2022 showed Following physician orders for 0 Resident #10 was diagnosed with COVID-19. obtaining weights Resident #10 remained in the facility. 0 Communication expectations when a change is noted from the previous weight Resident #10's electronic medical record, on the vital sign tab which included weights showed his Education will be given to new Licensed weight documented as 125.7 pounds on and Certified nursing staff orientation and 1/19/2022, weight collected by mechanical lift. be given by Director of Nursing/Designee Re-education was provided to Food Review of January 2022 Medication and Nutrition staff by the Director of Administration Record (MAR) revealed no Nursing/Designee related to the following: documentation of weights on 1/26/2022. Communication expectations when a 0 change in meal consumption is noted A review was conducted of Resident #10's meal intake records for January 2022 revealed his Education will be given to new hire food intake as resident refused on 11 occasions (15% and Nutrition staff orientation and be given of the meals documented), 0-25% of the meal by Director of Nursing/Designee was consumed on 31 occasions (44% of the meals documented), 26-50% of the meal was Re-education was provided to consumed on 13 occasions (18% of the meals interdisciplinary team and Registered documented), 51-75% of the meal was consumed Dietician by the Administrator/Designee

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923314

If continuation sheet Page 81 of 133

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 692 Continued From page 81 F 692 on 12 occasions (17% of the meals documented), related to the following: and 76-100% of the meal was consumed on 4 o Routine risk meeting that includes occasions (6% of the meals documented). reviewing the medical record of residents with active weight loss, or have a weight Review of February 2022 MAR revealed no loss arrested but require continued information of weekly weights was recorded for monitoring, and residents' who receive the month. enteral nutrition Education will be given to new hire A review was conducted of Resident #10's meal Department head and Registered intake records for February 2022 revealed his Dietician Orientation by Director of intake as resident refused on 7 occasions (9% of Nursing/ Designee the meals documented), 0-25% of the meal was consumed on 16 occasions (21% of the meals Re-education was provided to the documented), 26-50% of the meal was consumed staff related to the components of on 15 occasions 20(% of the meals documented), regulation F692 related to weight 51-75% of the meal was consumed on 24 management occasions (32% of the meals documented), and Education will be added to new hire 76-100% of the meal was consumed on 13 orientation and be given by Director of occasions (17% of the meals documented). Nursing/ Designee Education will be completed by 7/15/2022 Resident #10's care plan was updated on 3/3/2022 included an area of focus for difficulty swallowing related to dysphagia, cerebral palsy, and mental disorder. On review of the care plan history updates, there was no update completed (4) Indicate how the facility plans to on 3/3/2022, unable to identify staff who made the monitor its performance to make sure that solutions are sustained; update to the care plan. Dietician note dated 3/3/2022 showed Resident Director of Nursing/Designee will #10 was stable with weight for greater than 6 complete 10 resident record reviews for months, he was fed by staff, and received a nutritional supplements, weight loss, RD magic cup with lunch daily. The Dietician's and physician notification, interventions, documentation stated no acute nutrition concerns physician orders, responsible party at this time. Will continue current diet/supplement notification, interdisciplinary risk meeting regimen and will follow up as needed. review and care plan updates weekly for 4 weeks, then 5 resident record reviews A telephone interview was conducted on 6/8/2022 weekly for 4 weeks, then 1 resident record at 4:15PM with the facility's Consultant review weekly for 4 weeks. Registered Dietician (RD). During the interview,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 82 of 133

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ____ С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 692 Continued From page 82 F 692 RD stated Resident #10 had a significant weight Director of Nursing/Designee will change from 1/19/2022 to 3/9/2022. The RD complete 10 resident observation reviews indicated she started working at the facility in for validation of obtaining weights, January 2022 and at that time, she was contacted supplement usage and meal consumption by facility staff through email, telephone, or text weekly for 4 weeks, then 5 resident when a resident had a significant weight change. observation review x 4 weeks, then every The RD further stated she had not received 2 weeks x4 weeks, then monthly x1 notifications from staff about Resident #10's month. weight change. During the interview the RD stated when she completed the dietary Results of the reviews will be assessment in March, there was no discussed during the monthly Quality documentation in Resident #10's medical record Assurance meeting for tracking, trending, that stated he had a weight decrease. The RD and recommendations from the IDT team further stated she ran a weight report at the beginning of each month and stated Resident #10 weight change would have showed on the report Date of compliance: 7/16/2022 she ran when she returned to the facility on 4/8/2022. Resident #10 had been discharged on 4/7/2022. Resident #10's annual MDS dated 3/5/2022 indicated Resident #10 had a weight of 126 pounds and was on a mechanical altered and therapeutic diet. The MDS further stated Resident #10 had not had a weight loss of 5% in the last month or a weight loss of 10% in the last 6 months. A follow up interview conducted on 6/13/2022 at 10:28 A.M. with the RD revealed she was responsible to complete the weight section on the MDS. During the interview she stated she used the last weight available in Resident #10's medical chart. The weight used for the March MDS was from January 2022 and was recorded as 125.7 pounds, which she rounded up to 126 pounds. Review of March 2022 MAR revealed no

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(06//) 23/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	documentation on 3/2 documented on 3/9/2 documented on 3/23/ Resident #10 refused 3/16/2022 and 3/30/2 Attempts were made entered the weights for and 3/23/2022, via tel A review was conduct intake records for Mai as resident refused of meals documented), 26-50% on 13 occasions (20% 51-75% of the meal wo occasions (23% of the 76-100% of the meal wo occasions (30% of the 76-100% of the meal occasions (30% of the Resident #10 weighed mechanical lift on 3/9, 11.5% weight loss sim Resident #10 weighed undocumented how th (representing a 24.4% 1/19/2022). An interview was com P.M. with the Unit Mai Resident #6 on 4/6/20 stated she started wo of March 2022 and has missing for residents, stated the resident's a	2/2022. The weight 022 was 111.2 pounds and 2022 as 112.3 pounds. to be weighed on 022. to interview Nurse #1 who or Resident #10 on 3/9/2022 lephone were unsuccessful. ted of Resident #10's meal rch 2022 revealed his intake n 7 occasions (11% of the 0-25% of the meal was asions (17% of the meals 6 of the meal was consumed 6 of the meals documented), vas consumed on 15 e meals documented), and was consumed on 20 e meals documented). d 111.2 pounds collected by /2022. (representing an ice 1/19/2022). d 95 pounds on 4/6/2022, ne weight was collected. 6 weight loss since ducted on 6/8/2022 at 3:11 nager, who weighed 022. The Unit Manager rking at the facility the end ad identified ordered weights The Unit Manager further	F 692				

Facility ID: 923314

If continuation sheet Page 84 of 133

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/26/2022 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345307	B. WING				C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
				4	4414 WILKINSON BLVD		
	T GASTONIA LLC			0	GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	days the resident weil revealed, the assigne either documenting the the information to the documented the resid resident's medical record the Unit Manager stat month to identify miss with the assigned nur weights were collecte #10's medical record, she was unsure why the weights for Resident a revealed maybe the w and not documented is unaware of any pap resident weights listed entered. During the in revealed with the vari next, Resident #10 sh She further stated she was completed on Ref medical record it appe completed and she w done. During the inter stated Resident #10 v was not familiar enou visually recognize he Lab test for Comprehe (CMP) was ordered a lab results were comp is a fax date stamp or that reads "Sat Mar 1. results revealed an al 6.1 millimoles per Lite 3.5-5.1 mmol/L) and a deciliter (g/dL) (normati-	ghts were ordered. She then d nurse was responsible for he resident's weight or giving Unit Manager and she lent's weight into the cord. During the interview ted she ran a report each sing weights and followed up se to ensure the resident d. After reviewing Resident the Unit Manager stated there were so many missing #10. The Unit Manager then weights had been collected in the system; however, she berwork at the facility with d that have not been neterview the Unit Manager ation from one weight to the nould have been reweighed. e was unsure if a reweigh esident #10 but based off the eared a reweigh was not as unsure why it was not rview the Unit Manager was "a little guy", but she gh with the resident to	F	692			

If continuation sheet Page 85 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/26/2022 APPROVED D: 0938-0391	
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345307	B. WING			_		C 23/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD BASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 692	indicated Resident #1 loss. Under "Assessm weight loss the note m agitation. Requires as (activities of daily livin consumption of meals included in progress m Attempts were made Practitioner via teleph An interview conducte with Nurse #10. Durin stated nurses provide beginning of the shift weights ordered for the the residents and gav the nurse to documen record. She further sta manager completed m weight alerts triggered stated the medical ch	bgress note dated 4/7/2022 0 had a 16-pound weight bent and Plan" for significant eads in part "Periods of sistance with ADL's g). Monitor weight. Monitor ". Lab results dated 3/11/22 note. to interview Nurse none were unsuccessful. ed on 6/8/2022 at 3:19 P.M. g the interview, Nurse #10 d NAs with a list at the with residents who had hat day. The NAs weighed e the information back to it in the resident's medical ated the former unit eweighs for residents with d by the medical chart. She art alerted the use of nges from the previous	F	692		DEFICIENCY)			
	informed the former L Manager completed a change had occurred. were made aware of through the medical re when the reweigh cor Nurse #10 stated she resident and had not weight loss. When she chart, she stated Res	Init Manager. The Unit reweigh to verify a weight . The Physician and RD weight changes alerted ecord computerized system ifirmed a weight change.							

Facility ID: 923314

If continuation sheet Page 86 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>				(X3) DATE SURVEY COMPLETED	
		345307	B. WING			_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				4	414 WILKINSON BLVD			
	T GASTONIA LLC			Ģ	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	An interview was cond A.M. with Nurse #5. D #5 stated she had pro- in the months prior to the facility. She stated change in his eating p weight. An interview was cond A.M. with Nurse Aide interview, NA #7 state Resident #10. She state to hold his food and fe included cakes, half of cans. An interview was cond A.M. with NA #6. Duri stated she stayed in t Resident #10 with eat something in his hand item and feed himself wanted a snack offere from staff and ate it. V the snack, he threw th revealed Resident #11 provided to him. Durir stated she had not ob Resident #10. An interview was cond A.M. with Nurse#2. D #2 stated Resident #1 appeared to have had discharge to the hosp stated she was unsur- ate for mealtime, how on third shift. During t	ducted on 6/10/2022 at 9:32 buring the interview Nurse ovided care to Resident #10 him being discharged from d she had not noticed any battern or any change in his ducted on 6/11/2022 at 6:57 (NA) #7. During the ed she was familiar with ated Resident #10 was able eed himself finger foods that of a sandwich, and soda ducted on 6/11/2022 at 7:19 ng the interview NA #6 he room and assisted ting. When he was given d, he was able to hold the 5. She stated if Resident #10 ed to him, he took the snack When Resident #10 refused he snack on the floor. NA #6	F	692				

Facility ID: 923314

If continuation sheet Page 87 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 APPROVED). 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345307	B. WING			_		C 23/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
	T GASTONIA LLC			4	414 WILKINSON BLVD				
				G	ASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 692	and told him "Hello". S spoke to Resident #10 greeting. Nurse #2 sta Resident #10 and she assess him. Nurse #2 of vital signs which we normal range. During stated due to Resider response, she felt sor Resident #10 sent to for evaluation. Resident #10 was add 4/7/2022 with a chief status. The physician the emergency depar P.M. revealed Reside A nutrition consultatio #10 was admitted to t a primary diagnosis o sodium level). The me showed Resident #10 through his nose to hi	e 87 red Resident #10's room She revealed when she D, he did not respond to her ated this was not normal for e went to his bedside to stated she completed a set ere within Resident #10's the interview, Nurse #2 at #10's lack of a verbal mething was wrong and had the emergency department mitted to the Hospital on complaint of altered mental examination completed in tment on 4/7/2022 at 8:50 nt #10 weighed 95 pounds. In was ordered. Resident he hospital on 4/7/2022 with f hypernatremia (elevated edical records reviewed had a feeding tube inserted s stomach (nasogastric an x-ray was ordered and	F	692					
	completed for a "tube of the nasogastric tub revealed a small bow Resident #10's stoma course indicated the r successful PEG tube placed directly into the The resident was disc another skilled nursin a discharge weight of	check ["] to verify placement e. The x-ray findings el feeding tube ended in ch. A review of the hospital esident underwent a placement (feeding tube e stomach) on 4/18/2022. sharged on 4/19/2022 to g facility. Resident #10 had 104 pounds.							
		ducted on 6/11/2022 at onal Nurse Consultant s would be to monitor							

Facility ID: 923314

If continuation sheet Page 88 of 133

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD BASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	notify responsible par Responsible Party. On 6/11/2022 at 5:55 Nurse Consultant and informed of the imme The facility provided a allegation of Immedia 6/14/2022. The allega removal indicated: Credible Allegation of Removal for F692 1. Identify those recip are likely to suffer, a s a result of the noncor The identified residen longer a resident of th a 24.4 % weight loss identification or asses time of his loss of wei avoidability. All other residents ha affected by the deficie question as to accura scale has now been r will be weighed today in identifying resident and any discrepancie weight will be address representative being residents were identif weight loss. We have	ventions for weight loss and ties to include the MD and P.M., the facility's Regional I Director of Nursing were diate jeopardy. an acceptable credible te Jeopardy removal on ation of immediate jeopardy Immediate Jeopardy ients who have suffered, or serious adverse outcome as npliance: t (Resident #10) is no ne facility. Resident #10 had from January to April with no issment of weight loss during ght to determine ve the potential to be ent practice. There is cy of weights, therefore the ecalibrated and all residents 6.12.2022. This will assist s that have any weight loss s from last weight to today's sed with MD and resident	F 692				

Facility ID: 923314

If continuation sheet Page 89 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
				4	414 WILKINSON BLVD			
	T GASTONIA LLC			G	SASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	and will contact family encouraging them to responsible represent notified. The Registered Dietic today and will be revier resident to determine and the MD will be mar- recommendation and appropriate. The IDT tomorrow, 6.13.2022 interventions. 2. Actions taken to all failure to prevent advo occurring or recurring Immediate inservice in Director of Nursing (D Nurse Consultant to the nurses and nurse aid residents are weighed basis. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents. The inservice wand the interdisciplina registered dietician, con- therapists that are invo residents are weighted the interdisciplina registered dietician, con- therapistered dieticia	y to see if they can assist in be weighed. Their tatives and MD are being cian was on the IDT call ewing each individual appropriate interventions ade aware of the MD will determine if team will meet again to review all the ter the process or system erse outcome from propriate the Corporate he nursing staff to include es to ensure that all d on an at least monthly will also include dietary staff ary team, including the ertified dietary manager and volved in the care of the ice will be conducted in mail or text. Those staff ve inservice that was not in person, will be sign in sheet inservice	F	692				

Facility ID: 923314

If continuation sheet Page 90 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/26/2022 APPROVED 0: 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345307	B. WING		_	06/:	_ 23/2022	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 692	receive the informatio prior to working with r Any resident that has intervention to weigh weighed at the interva- resident. If there is a pounds greater or less obtained, the staff me inform the charge nur- will inform the Unit Ma DON designee of the The Unit Manager and DON designee will no party of any weight los immediate interventio loss and to attain optii the Registered Dietici recommendations. The be contacted by phon or DON designee with changes to address a interventions and reso Audit of all residents' 6/11/2022 by the (DO Manager, and/or the Q and completed 6/12/2 residents have had ar weight obtained. The of documented weigh determine if any weigh identified. The weight evening 6.11.2022 by ensure the accuracy of weights to be obtained.	n contained in the inservice esidents. a physician order or more frequently, will be als specific to the individual weight discrepancy of 5 s than the previous weight ember will reweigh and se. The charge nurse in turn anager or the DON or the weight discrepancy. d/or the DON and/or the tify the MD and responsible ss and will put in place an n to prevent further weight mum weight gain based on an and/or MD ne Registered Dietician will e and or email by the DON n any identified weight nd assist with the olution. weights will be initiated N) and/or Certified Dietary Corporate Nurse Consultant 022 to determine if any ny weight loss since last audit will consist of review ts from the last 2 months to	F 692					

If continuation sheet Page 91 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
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THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	order for more freque updated an placed at nurses and nurse aide DON designee will no or the next business of identified weight loss. interventions and reco gain goals. If any residents are id 5 pound weight loss of responsible party will DON and/or DON Desi interventions will be p weight loss. Any resident with ider weighed weekly until based on their usual b individual desired wei input are attained and consecutive days. The the individual resident based on their prefere their usual body weigh with input from RD. If any resident is iden weight loss, the MD w by the Unit Manager a designee to determine underlying pathology continued weight losses The facility will condu- with the Interdisciplina resident weight losses interventions put in pl	nt weights. A list will be the nurse's station for the es reference. The DON or tify the RD within 24 hours day of any resident with The RD will assist with ommendations for weight entified to have greater than or greater, the MD and be notified by the UM and/or signee and immediate ut in place to prevent further htified weight loss will be they meet their weight goal body weight or their ght with the RD and/or MD i maintained for 90 e determination of utilizing t weight gain goals will be ence of desired weight goal, ht based on their preference tified to have continued vill be immediately notified and/or the DON and/or DON e if there were any that would contribute to c. ct weekly Focus meetings ary team to discuss any	F 692				

Facility ID: 923314

If continuation sheet Page 92 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	
		345307	B. WING		_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	T GASTONIA LLC			4414 WILKINSON BLVD			
	IT GASTONIA LEO			GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	meets their or desired interventions are not r desired results, the in- re-addressed and pot and replace interventi achieve weight gain g Date of corrective action Immediate Jeopardy R 6/14/2022 The facility's credible Jeopardy removal was The validation was ever record reviews and re- attendance sheets to provided to staff that a identifying and treation interventions included platform scales were re- weight accuracy, resider residents with a signiff reweighed to ensure w Dietician will consult to recommendations (mos supplements and ther Director and Respons residents medical reco- ensure interventions free weekly weight meeting discuss weight loss. The Administrator not allegation for the remo- for the removal date of 06/16/22. The Administrator not	I body weight. If reflective of achieving terventions will be ential to add or eliminate ons as appropriate to toals. ion completion Removal date will be allegation of Immediate s validated on 6/16/2022. idenced by staff interviews, view of inservice verify education had been addressed a new system of g weight loss. The I the weight scales and recalculated to ensure dents were weighed and icant weight loss were weight loss, the Registered he weight loss and offer ore frequent weights, rapy screens) the Medical bible Parties will be notified, ords were reviewed to had been put in place, gs will be held by the IDT to	F 69				

Facility ID: 923314

If continuation sheet Page 93 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STA	ATE, ZIP CODE		
				441	4 WILKINSON BLVD			
	T GASTONIA LLC			GA	STONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	93	F 6	92				
	11/18/21 from a hospidiagnoses included memiplegia (severe or on one side of the body partial weakness or loo of the body) following affecting her left non-orintracranial hemorrhat the skull, which can lead the skull, which ca	A standard consistence of the standard constandard consistence of the standard constan						

If continuation sheet Page 94 of 133

DEPARTMENT OF HE CENTERS FOR MEDI		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 23/2022
NAME OF PROVIDER OR SUP	PLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY AT GASTONIA L	LC.				414 WILKINSON BLVD GASTONIA, NC 28056			
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692 Continued F	rom page	94	F	692				
area of focus potential nut and medicat care plan int provide her of intake for ev as ordered. A verbal orde on 1/7/22 to to no meal ir which read, meal time." Resident #11 (MDS) was a 4/10/22. The intact cogniti independent inches tall ar The resident 119.0# on 5/ recent weigh A review was intake record intake as: 0-25% of tt occasions (4 26-50% of occasions (4 76-100% o	s indicatin ritional pri ion use (erventior diet as or ery meal er was ag provide I take. Th "Please of a quarter resident ve skills with eatind 117#. : weights 1/22 and at). s conduc ds from the the meal % of the the meal 8% of the the meal 8% of the	#11's care plan included an ng the resident had a roblem related to dementia initiated on 12/19/21). The is indicated the facility would dered, monitor and record and provide supplements gain received by the provider Ensure with meals for poor the order included a notation ensure patient receives at recent Minimum Data Set y assessment dated twas assessed to have and was reported to be ng. She was noted to be 68 also included, in part: 121.0# on 6/6/22 (her most ted of Resident #11's meal he past 30 days revealed her was consumed on 3 meals documented); was consumed on 36 e meals documented); al was consumed on 30 e meals documented); al was consumed on 30 e meals documented);						

Facility ID: 923314

If continuation sheet Page 95 of 133

	MENT OF HEALTH AN					FORM	2: 07/26/2022 APPROVED 0: 0938-0391	
STATEMENT (CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345307	B. WING		_	06/:	C 23/2022	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD BASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 692	An observation was c AM of Resident #11 a room with her breakfa tray table beside her. read, "add house shal There was no House nutritional supplement inquiry, the resident c a nutritional supplement An observation was c PM as Resident #11 v eating a sub sandwick facility. No House Sh supplement was seen observation. When as nutritional supplement her room nor offered t An observation was c AM as Resident #11 v her breakfast meal trat tray table beside her. read, "add house shal There was no House nutritional supplement inquiry, the resident re nutritional supplement over the last 3 days. An observation was c PM as Resident #11's her. There was no House nutritional supplement over the last 3 days. An observation was c PM as Resident #11's her. There was no House nutritional supplement over the last 3 days. An observation Resident a Administration Record 6/9/22. The MAR indi	onducted on 6/8/22 at 8:40 s she was sitting in her st meal tray placed on the The top of her meal ticket ke with all meal trays." Shake nor any other t on her meal tray. Upon onfirmed she did not receive ent with the meal. onducted on 6/8/22 at 12:35 vas sitting in her wheelchair n brought from outside the ake or nutritional at the time of the sked, the resident stated a t was neither brought into to her. onducted on 6/9/22 at 8:37 vas sitting in her room with by placed on the bedside The top of her meal ticket ke with all meal trays." Shake nor any other t on her meal tray. Upon	F 692					

Facility ID: 923314

If continuation sheet Page 96 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 // APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				4414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S (EACH CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA		(X5) COMPLETION DATE
						DEFICIENCY)		
F 692	Continued From page		F	692				
	showed Ensure was r	6/7/22. The documentation not provided with the last 7						
	consecutive meals se on 6/7/22 and through	rved (beginning with lunch 1 lunch on 6/9/22).						
		ducted on 6/9/22 at 2:20 PM ager. During the interview,						
	the Dietary Manager							
	ordered for residents.							
		ig for them (including a						
		:#11)they do not get						
		e." Upon inquiry, the Dietary						
	Manager indicated co							
		Ensure were provided from						
		ent. When asked what the I be, the Dietary Manager						
		sure and stated Resident						
	· ·	not correct because the						
	physician's order was							
	An interview was con with the facility's Unit	ducted on 6/9/22 at 5:11 PM Manager, During the						
	-	inager was asked who was						
		ng Resident #11 received a						
	nutritional supplemen	t such as Ensure. She						
		was responsible for this and						
		lent refused the supplement,						
		be documented in the						
		cord and the physician						
		the Unit Manager was on Resident #11's June						
		cated Resident #11 had last						
	received Ensure on th							
	Accompanied by the	Unit Manager on 6/9/22 at						
	5:15 PM, an observat							
		g station refrigerator. The						
		d Ensure was typically						

Facility ID: 923314

If continuation sheet Page 97 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	stored in the refrigera was found stored in the reported there was not facility. The Unit Man Resident #11 loved the and was not even par received. When aske at this point, the Unit provider and consultat Ensure was out of store appropriate alternative Resident #11 until the An interview was com- interim Administrator of During the interview, or regarding failure of Re- nutritional supplement daily. The interim Addie expect a nutritional sup available in-house or contacted for an acce supplement to be sele 3. Resident #2 was a 7/25/20. His cumulant diabetes, dysphagia (hemiplegia (severe or on one side of the body partial weakness or lo of the body) following (stroke) affecting his I vascular dementia with A Nutrition Note dated the facility's Registered the resident received supplement. His most	tor. However, no Ensure he refrigerator; she then b Ensure in stock at the ager stated she knew is nutritional supplement ticular about the flavor she d what needed to be done Manager reported the nt RD needed to be notified ock to see if there was an that could be offered to that could be offer	F 692				

Facility ID: 923314

If continuation sheet Page 98 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345307	B. WING				C 23/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CI	TY, STATE, ZIP CODE	•	
	T GASTONIA LLC			4414 WILKINSON BL	VD		
				GASTONIA, NC 28	8056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page		F 6	92			
	resident's current wei remained stable over	RD on 4/8/22 reported the ght was 144# and had the past 6 months. This esident #2 received Magic upplement.					
	(MDS) was a quarter 4/12/22. The resident cognitive skills for dai assessment reported extensive assistance physical assistance.	t had moderately impaired ly decision making. The Resident #2 required from staff with one person He was 69 inches tall and ceived a therapeutic and					
	area of focus which in risk related to the diag status post removal o surgically placed tube	nt's care plan included an idicated he was at nutrition gnosis of dysphagia and f a percutaneous tube (a used to deliver nutrition), aspiration (initiated on					
	5/22/22 with re-entry f Resident #2 ' s re-adr 5/26/22) included a C with mechanical soft t thick consistency liqui breakfast to aid in me physician orders also frozen nutritional cup for nutritional support on 9/13/21).	onsistent Carbohydrate diet extures and nectar/mildly ids; add large portions at eting needs. His current included an order for a / treat once daily with lunch supplementation (initiated					

If continuation sheet Page 99 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 07/26/2022 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(06/:	23/2022
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	An observation was c PM as Resident #2 w of bed raised and a lu bedside tray table in f meal ticket included a nutritional treat every nutritional cup/treat w An interview was con- with the Dietary Manager Department's list of mo ordered for residents. I do not have anything reference to Resident supplements from me reported the only nutr came from the Dietary Cup. Magic Cup is a ice cream when froze thawed. Magic Cup is a ice cream when froze thawed. Magic Cup is a ice serving. An observation was c 12:15 PM of meal ser Resident #2's hallway (NA) #1 recognized R meal tray on the cart his lunch; she returne The meal tray was pla front of the resident a she began to assist h included a cheese qu mashed potatoes, a c meal ticket had a nota which read in part: "	onducted on 6/9/22 at 12:16 as lying in bed with his head nch meal tray placed on the ront of him. The resident's notation to send a frozen day with lunch. No frozen as on his meal tray. ducted on 6/9/22 at 2:20 PM ger. During the interview, reviewed the Dietary utritional supplements She stated, g for them (including a #2)they do not get ." The Dietary Manager itional supplement that / Department was Magic frozen dessert that is like n but like pudding when s a nutritional supplement alories with 9 grams protein	F 692				

Facility ID: 923314

If continuation sheet Page 100 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/26/2022 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY PLETED
		345307	B. WING		_		C /23/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD			
				GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	100	F 69	92			
	Dietary Manager on 6 Dietary Manager was observation which rew treat was not sent out Department on Resid Dietary Manager repo Magic Cup was put or sent out with the othe questioned what had originally intended for Manager also express the Dietary Departme Confirmation slip from resident was new, ret a change in his/her di orders put into a resid record (EMR) were no the Dietary Departme	ent #2's lunch tray. The orted she was certain a in his tray and that tray was r residents' meal trays. She happened to the meal tray Resident #2. The Dietary sed concern about failure of int to receive a Diet Order in nursing whenever a urned to the building, or had et order. She reported the lent's electronic medical of always communicated to int.					
F 693 SS=D	PM with the Regional presence of the facilit (DON). During the int regarding the facility's supplements as order discussed. The Regio DON concurred there communication "disco and Dietary Departme Tube Feeding Mgmt/F CFR(s): 483.25(g)(4)(§483.25(g)(4)-(5) Entr (Includes naso-gastric both percutaneous en	a failure to provide nutritional red by the physician were conal Nurse Consultant and was apparently a connect" between the Nursing ents. Restore Eating Skills (5)	F 65	93			7/16/22

Facility ID: 923314

If continuation sheet Page 101 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		345307	B. WING		Of	C 5/23/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 693	enteral fluids). Based comprehensive assess ensure that a residen §483.25(g)(4) A resid eat enough alone or v enteral methods unlead condition demonstrate clinically indicated an resident; and §483.25(g)(5) A resid means receives the a services to restore, if and to prevent compli- including but not limite diarrhea, vomiting, de- abnormalities, and na This REQUIREMENT by: Based on observatio- interviews, and Woun- facility failed to follow maintenance of a PEC tube (feeding tube pla- 1 sampled resident (F The findings included Resident #6 was adm 4/22/2021 as a reentr cumulative diagnoses protein-calorie malnut failure to thrive. A review of Resident initiated on 3/1/2022 if which indicated the re-	on a resident's asment, the facility must t- ent who has been able to with assistance is not fed by ass the resident's clinical es that enteral feeding was d consented to by the ent who is fed by enteral ppropriate treatment and possible, oral eating skills ications of enteral feeding ed to aspiration pneumonia, ehydration, metabolic isal-pharyngeal ulcers. is not met as evidenced ns, record review, staff id Physician interview, the the physician's order for the G (percutaneous epigastric) aced in the stomach) for 1 of Resident #6). : itted to the facility on y from the hospital. Her	F 69	 (1) Address how corrective action accomplished for those residents for have been affected by the deficient practice; " Resident (#6) was identified, a new treatment was provided to the insertion site per physician order of 6/10/2022 (2) Address how the facility will ide other residents having the potentia affected by the same deficient practice; " No other resident receives ent feeding (3) Address what measures will be into place or systemic changes ma 	ound to t and a peg n entify I to be stice; eral e put	

Facility ID: 923314

If continuation sheet Page 102 of 133

OLIVILI		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	ATE SURVEY OMPLETED
			A. BUILDING		-	
		345307	B. WING			C 06/23/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		00/23/2022
				4414 WILKINSON BLVD		
THE IVY A	T GASTONIA LLC			GASTONIA, NC 28056		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 693	Continued From page	102	Гсо			
1 035			F 69		ation will mat	
		ar diet. The interventions ordered to PEG tube site.		ensure that the deficient pra	ictice will not	
		ordered to T LG tube site.		" Re-education was prov	ided to	
	A review of physician	orders dated 3/2/2022		Licensed nursing staff by the		
		G tube insertion site with		Nursing (DON) / Designee r		
	-	ochlorite solution (antiseptic		following:		
	solution), apply silver	alginate and split gauze and		o Following physician trea	atment orders	
	change daily every sh	nift.		" Re-education was prov		
				staff related to the compone		
		conducted on 6/9/2022 3:48		regulation F693 related to tu	ube feeding	
		nent dressing change. The		management.		
	-	noved Resident #6's existing			Lb. 7/45/0000	
		a wet gauze over the PEG the end of the evaluation.		Education will be completed	1 by 7/15/2022	
	The Unit Manager co			Education will be included w	vith new hire	
	-	ound treatment for Resident		Licensed Nursing staff orien		
		r washed her hands with		Director of Nursing/Designe		
	soap and water, appli					
		om the PEG tube insertion		(4) Indicate how the facility	plans to	
	site. The Unit Manage	er applied clean gloves and		monitor its performance to r	nake sure that	
		ound the PEG tube with a		solutions are sustained;		
		125% sodium hypochlorite				
		nager applied a split 4x4		" Director of Nursing/Des	-	
	-	G tube and used tape to		conduct 10 treatment obser		
	and Unit Mangers init	s dated with the current date		to ensure treatments provid facility standards and is carr		
	and Onit Mangers init	lais.		physician orders weekly for		
	An interview was con	ducted on 6/10/2022 at 8:46		5 treatment observation rev		
		inager. During the interview		for 4 weeks, then 1 treatment	•	
		ted yesterday (6/9/2022),		weekly for 4 weeks.		
		4 gauze around Resident		" Results of the reviews		
		on site. The physician order		discussed during the month		
		e Unit Manager. She stated		Assurance meeting for track		
	-	EG tube insertion site was		and recommendations from	the IDT team	
	-	silver and split gauze.		Data of compliances 7/40/00	222	
	-	he Unit Manager stated she		Date of compliance: 7/16/20)22	
		ght dressing to the PEG ne stated she thought the				
	physician had ordered					

Facility ID: 923314

If continuation sheet Page 103 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/26/2022 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345307	B. WING		_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 693	Continued From page	9 103	F 693				
F 803 SS=E	with the Director of Nu interview, the DON re- responsible to review order prior to each res- she expected staff to treatment orders. The unsure why the Unit M that was different than An interview conducted with the Wound Physician with silver was used w Resident #6's PEG tu with the collection of w site. The Wound Physician with silver was used w Resident #6's PEG tu with the collection of w site. The Wound Physician alginate with silver ap insertion site. Menus Meet Resident CFR(s): 483.60(c)(1)- §483.60(c)(1) Meet the residents in accordan guidelines.; §483.60(c)(2) Be prep §483.60(c)(3) Be folloo §483.60(c)(4) Reflect reasonable efforts, the	each wound treatment sident wound treatment and follow the physician wound o DON stated she was Manager applied a dressing in the physician's order. ed on 6/13/2022 at 8:53 A.M. ician. During the interview, stated the calcium alginate with a 4x4 gauze on be insertion site to assist wound drainage from the sician stated there was no by not having the calcium plied around the PEG tube t Nds/Prep in Adv/Followed (7) d nutritional adequacy. e nutritional needs of ce with established national pared in advance; wed;	F 803				7/16/22

Facility ID: 923314

If continuation sheet Page 104 of 133

		D HUMAN SERVICES			F	FORM APPROVED B NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345307	B. WING _			C 06/23/2022
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	·•	
THE IVY AT GASTONIA LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				4414 WILKINSON BLVD GASTONIA, NC 28056		
(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) COMPLETION DATE
F 803	input received from re groups; §483.60(c)(5) Be upd §483.60(c)(6) Be revi dietitian or other clinic professional for nutriti §483.60(c)(7) Nothing construed to limit the personal dietary choid This REQUIREMENT by: Based on observatio interviews, and record to provide all of the for planned menu for 3 o Resident #11 and Re- observations conduct The findings included 1. Resident #12 was 5/2/22 from a hospita The resident's admiss (MDS) dated 5/9/22 in impaired cognitive ski Resident #12's currer was a Regular diet wi An observation was of AM as Resident #12 s	esidents and resident ated periodically; ewed by the facility's cally qualified nutrition ional adequacy; and g in this paragraph should be resident's right to make ces. is not met as evidenced ins, resident and staff d reviews, the facility failed iod items as specified by the f 7 residents (Resident #12, sident #2) during 4 of 4 meal ed. : admitted to the facility on l. sion Minimum Data Set indicated he had moderately ills for daily decision making. it diet order (dated 5/13/22) th regular textures. onducted on 6/8/22 at 8:35 sat in his room with his d on the bedside tray table. cket on his tray indicated	F 8	 1. What corrective action(s) was accomplished for those residen have been affected by the defice practice; " Resident (#12) has been resonand unfulfilled food requests. R preferences will be completed be Dietary Manager/Designee by 7" Resident (#11) has been id and no longer resides at the face " Resident (#2) has been reson the grievance process to incevents such as missing meal trand unfulfilled food requests. R preferences will be completed be Dietary Manager/Designee by 7" Resident (#11) has been id and no longer resides at the face " Resident (#2) has been reson the grievance process to incevents such as missing meal trand unfulfilled food requests. R preferences will be completed Dietary Manager by 7/15/2022 2. How you will identify other having potential to be affected be same practice and what correct 	ts found to ient e-educated lude ay items esident by the 7/15/2022 lentified cility. educated lude ay items esident by the Residents by the	
	breakfast meal placed The resident's meal ti	d on the bedside tray table. cket on his tray indicated the following: orange juice;		having potential to be affected b	by the	

Facility ID: 923314

If continuation sheet Page 105 of 133

		MEDICAID SERVICES				0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SI COMPLE	
					с	
		345307	B. WING			3/2022
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4414 WILKINSON BLVD		
	T GASTONIA LLC			GASTONIA, NC 28056		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 803	Continued From page	105	F 80;	2		
1 003			F 80.	-		
		whole milk; coffee; and fruit				
		ported he did not receive		has been re-educated on the gri		
		t. The observation of his		process to include events such a	-	
		nilk was not sent in a carton ent reported he would like to		meal tray items and unfulfilled for requests.		
	have received milk wi	-		" Resident preferences will be	-	
				completed on all Residents by th		
	A mealtime observation	on was conducted on 6/8/22		Manager/Designee by 7/15/2022	•	
		ent #12 in his room after he			-	
		h meal tray. The resident's				
		his tray indicated his meal		3. What measures will be put i	nto place	
		Dijon pork loin; buttered red		or what systematic changes you		
	-	occoli florets; dinner roll;		to ensure that the practice does		
	· ·	pudding; whole milk; and			,	
		ion revealed Resident #12		" Dietary Manager was re-ed	lucated by	
	did not receive milk w	ith his meal. Upon inquiry,		Administrator and/or Designee of	-	
	the resident stated he	would have liked to have		completing and communicating	resident	
	milk with his meal.			food/drink preferences. Education	on was	
				completed on 7/11/2022		
	An observation was c	onducted on 6/9/22 at 8:47		" Licensed Nursing staff, Cer	tified	
	AM at 8:47 AM of Res	sident #12 after his		Nursing staff ,Therapy Staff and		
		as delivered to his room.		staff were re-educated by Direct		
		cket on his tray indicated		Nursing/Designee on validating		
		the following: orange juice;		ticket preferences match the foo		
		muffin; margarine; grits;		items provided on the resident tr	-	
		nd fruit jelly. No milk was		Education to be completed by 7/	15/2022	
		ay. Resident #12 stated he				
		eceive milk with his breakfast		Education will be added to new		
	meal.			licensed nursing staff, certified n		
	A lunch time cheer of	tion was conducted on		staff, therapy staff and Dietary s	all	
		s Resident #12 ' s meal tray		orientation by Director of Nursing/Designee		
		oom. The resident's meal				
	ticket placed on his tra			4. How the corrective action(s) will be	
		uttered Italian green beans;		monitored to ensure the practice		
	-	strawberry shortcake; whole		recur, i.e., what quality assurance		
		e resident was observed as		program will be put in place;		
		al ticket to the items on his				
		#12 reported he was again		" Administrator/Designee to c		

Facility ID: 923314

If continuation sheet Page 106 of 133

CENTER STATEMENT (AND PLAN OF NAME OF PI		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345307	· /	NG	CONSTRUCTION		FORM OMB NC (X3) DATE COMF	D: 07/26/2022 MAPPROVED D: 0938-0391 SURVEY PLETED C 23/2022
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIZ		(EACH CORRECTIV	N OF CORRECTION		(X5) COMPLETION DATE
	(EACH DEFICIENC' REGULATORY OR L Missing milk from his also missing the straw resident stated, "Som my strawberry shortca An interview was con- with the Dietary Mana concerns regarding th were discussed. The of the residents to rec planned for their mea meal ticket on the ress Manager reported sho receive milk as well a indicated by their mea with the facility's inter inquiry, the interim Ac expect the meal ticket	A MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) a 106 meal and confirmed he was vberry shortcake. The eone else must have gotten ake." ducted on 6/9/22 at 2:20 PM ager. During the interview, ne mealtime observations se concerns included failure weive the food items as I and as indicated by the ident's tray. The Dietary e would expect a resident to s the other food items as al ticket. ducted on 6/9/22 at 5:45 PM im Administrator. Upon Iministrator stated, "I would t to reflect what the meal is." admitted to the facility on ital. t diet order (initiated	PREFI TAG	x 803	(EACH CORRECTIV CROSS-REFERENCE	E ACTION SHOULD BI D TO THE APPROPRIA CIENCY) Insure all items list and weekly to inclu nd for 4 weeks, weekly for 4 ay review weekly iews will be nonthly Quality tracking, trendir from the IDT tea	ated ude for	
	(MDS) was a quarterl 4/10/22. The resident intact cognitive skills to An observation was c AM of Resident #11 a room with her breakfa table beside her. The her tray indicated the	recent Minimum Data Set y assessment dated was assessed to have for daily decision making. onducted on 6/8/22 at 8:40 is she was sitting in her ast tray placed on the tray e resident's meal ticket on meal consisted of the ; scrambled egg; biscuit;						

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 07/26/2022 MAPPROVED). 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345307	B. WING			_		C 23/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
	T GASTONIA LLC			44	414 WILKINSON BLVD			
				G	ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 803	Continued From page		F	803				
	coffee; and fruit jelly.	cold cereal; whole milk; An observation of Resident						
	#11's meal tray revea juice, scrambled egg	led she received a glass of						
	sausage (sausage, eg	•						
	biscuit, margarine, oa	tmeal, coffee and jelly.						
		om of Resident #11's meal o oatmeal." Upon inquiry,						
		e did not receive milk or						
		reakfast (confirmed by the						
		eal tray). She reported she eceive milk and expressed						
		ving oatmeal with her meal						
	stating, "They know I							
	An interview was con	ducted on 6/9/22 at 2:20 PM						
	-	ager. During the interview,						
		e mealtime observations se concerns included failure						
		eive the food items as						
		l and as indicated by the						
		ident's tray. The Dietary e would expect a resident to						
	-	other food items as indicated						
	by their meal ticket.							
	An interview was cone	ducted on 6/9/22 at 5:45 PM						
	-	im Administrator. Concerns						
	-	neal observations were ed missing menu items from						
	the meal tray (specific	-						
		honored. Upon inquiry, the						
		stated, "I would expect the vhat the meal is." He also						
	reported he would exp							
	preferences to be hor							
		dmitted to the facility on ive diagnoses included						

		D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
THE IVY A	T GASTONIA LLC						
				GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 803	Continued From page diabetes, dysphagia (hemiplegia (severe or on one side of the bod partial weakness or lo of the body) following (stroke) affecting his I vascular dementia wit The resident's most re (MDS) was a quarter 4/12/22. The residen cognitive skills for dai Resident #2's physicia included a Consistent mechanical soft textur consistency liquids; a breakfast to aid in me An observation was c attempted with Reside as the resident was ly bed raised and a bed front of him. An 8-our orange-appearing liqu was observed to be o breakfast meal tray w placed outside of his in Resident #2's meal tray milk carton or glass for	e 108 difficulty swallowing), complete loss of strength dy) / hemiparesis (mild or oss of strength on one side a cerebral infarction eft non-dominant side; and h behavioral disturbance. ecent Minimum Data Set y assessment dated t had moderately impaired by decision making. an orders dated 5/26/22 Carbohydrate diet with res and nectar/mildly thick dd large portions at eting needs. onducted and an interview ent #2 on 6/9/22 at 8:43 AM ing in bed with his head of side tray table placed in nece empty glass with an iid at the bottom of the glass	F 803	[
	slice of bread (approx scrambled eggs (0% of consumed). Residen he should have been items: orange juice (r scrambled egg, butter crust), margarine, grit	imately 25% consumed), consumed), and grits (0% t #2's meal ticket indicated sent the following food nectar-thickened), red wheat toast (no hard					

Facility ID: 923314

If continuation sheet Page 109 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/26/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345307	B. WING		_		C /23/2022
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 803 F 809 SS=F	#2's breakfast. An interview was con- with the Dietary Mana concerns regarding the were discussed. The of the residents to reco- planned for their meal meal ticket on the ress Manager reported shar receive milk and the of by their meal ticket. An interview was con- with the facility's inter- inquiry, the interim Ad expect the meal ticket Frequency of Meals/S CFR(s): 483.60(f)(1)-(§483.60(f) Frequency §483.60(f)(1) Each re facility must provide a regular times compara the community or in a needs, preferences, re §483.60(f)(2)There m hours between a subs breakfast the following nourishing snack is se hours may elapse bet meal and breakfast the group agrees to this n	had been sent for Resident ducted on 6/9/22 at 2:20 PM ger. During the interview, he mealtime observations se concerns included failure rever the food items as and as indicated by the ident's tray. The Dietary e would expect a resident to other food items as indicated ducted on 6/9/22 at 5:45 PM im Administrator. Upon liministrator stated, "I would to reflect what the meal is." Gnacks at Bedtime (3) of Meals sident must receive and the t least three meals daily, at able to normal mealtimes in ccordance with resident equests, and plan of care. ust be no more than 14 stantial evening meal and g day, except when a erved at bedtime, up to 16 ween a substantial evening e following day if a resident meal span.	F 803				7/16/22
		e, nourishing alternative ist be provided to residents					

Facility ID: 923314

If continuation sheet Page 110 of 133

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		E SURVEY IPLETED
		345307	B. WING			06	C 5/23/2022
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	T GASTONIA LLC			44	414 WILKINSON BLVD		
	I GASTONIA LLC			G	ASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 809	Continued From page	e 110	F	809			
		on-traditional times or outside		000			
		ervice times, consistent with					
	the resident plan of c						
	•	Γ is not met as evidenced					
	by:						
	Based on observatio	ons, staff and consultant			(1) Address how corrective action wil	l be	
		RD) interviews and record			accomplished for those residents foun	id to	
		led to serve a nourishing			have been affected by the deficient		
	evening snack and ol				practice;		
	· · · •	han 14 hours to elapse					
		n of a substantial evening			" Mealtimes adjusted on 6/9/2022 t		
		ne following day for residents			meet the regulatory guidance. Change		
	Hall and 100 Hall).	ident hallways (300 Hall, 200			mealtimes were communicated throug resident council. Resident council	In	
	riali anu 100 riali).				members agreed with mealtime		
	The findings included	l:			adjustments on 6/9/2022.		
		y's "Tray Cart Delivery			(2) Address how the facility will identi		
		the meal cart delivery times			other residents having the potential to		
	were scheduled as for				affected by the same deficient practice	€;	
		e 300 Hall was scheduled to					
		PM for Dinner and at 8:00			" Mealtime deliveries were changed		
	span between the two	licative of a 15 hour time			meet the regulatory guidance, and pos in the facility on 6/9/2022	sied	
	•	e 200 Hall was scheduled to			" Snack times were reviewed on		
		PM for Dinner and at 8:20			6/9/2022		
		licative of a 15 hour and 10			" Snack items were re-evaluated ar	nd	
	•	ween the two meals);			provided for residents at designated ti		
		e 100 Hall was scheduled to			on 6/9/2022 by the Director of		
		PM for Dinner and at 8:10			Nursing/Designee		
	•	licative of a 14 hour and 50					
	minute time span bet	ween the two meals).			(3) Address what measures will be p		
					into place or systemic changes made		
		iducted on 6/8/22 at 3:17 PM			ensure that the deficient practice will r	not	
	-	vities Director (AD). During			recur;		
		reported she worked in the			" Re-education was provided to Nu	roina	
		at the facility for 2-3 months,			 Re-education was provided to Nu and Dietary staff by the Director of 	ising	
	beginning in October	2021. She has worked as			and Dietary stall by the Director of		

Facility ID: 923314

If continuation sheet Page 111 of 133

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		10. 0938-039 FE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	VG	CON	MPLETED
						С
		345307	B. WING			6/23/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE	
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD GASTONIA, NC 28056		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN (()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIOI DATE
F 809	Continued From page	e 111	F8	309		
		ssisting Resident Council		following:		
		etings. When asked, the		o New meal delivery ti	mes	
		not aware of any meal		o Ensuring snacks are		
		ade or discussed in Resident		nursing station for reside		
	-	ce she had worked at the		times		
	facility.			Education to be complete	ed by 7/15/2022	
	An interview was con	ducted on 6/8/22 at 3:25 PM		" Re-education was pr	rovided to	
	with the facility's Diet	ary Manager. During the		Licensed and Certified n		
	interview, the Dietary	Manager was asked if she		Director of Nursing (DON	I) / Designee	
		al schedule since she came		related to the following:		
		ember 2021. The Dietary		o Snacks are to be offe		
	Manager stated she h			at designated times, and	most specifically	
	scheduled meal cart	greater than 14 hours) noted		at HS Education to be complete	nd by 7/15/2022	
		meal and breakfast meal of			eu by 1/15/2022	
		then discussed. When		Education will be include	d with new hire	
		I times, the Dietary Manager		Nursing and Dietary orier		
	stated she noticed the			Director of Nursing/Desig	jnee	
	between the resident	s' Dinner and Breakfast				
		came to work at the facility				
		how it had always been.		(4) Indicate how the faci		
		reported snacks were sent		monitor its performance t	to make sure that	
		e Nursing station each		solutions are sustained;		
		cks included fudge rounds cookies, peanut butter		" Administrator/Desigr	nee will conduct	
		kers, graham crackers, and		10 meal tray observation		
	a total of 7 sandwiche	-		are delivered on time to t	•	
				weekly to include a week		
	A telephone interview	/ was conducted on 6/8/22 at		weeks, then 5 meal tray of	observations	
		lity's consultant Registered		weekly for 4 weeks then		
		RD reported she began		observation weekly for 4	weeks	
		ity in January of 2022.		" Results of the review	wa will be	
		e facility's meal schedule		" Results of the review discussed during the more		
		14 hours to elapse between ostantial evening meal and		Assurance meeting for tra		
		ig day, the RD stated, "It's all		and recommendations fro		
		ger." When asked if she was				
		me span between Dinner				

Facility ID: 923314

IATEMENT OF DEFICIENT NAME OF PROVIDER O THE IVY AT GASTO (X4) ID PREFIX TAG (I) PREFIX TAG (I) F 809 Continu and Bre was not short-st January transitio worked An inter with the interview meals w regulatid Adminis accepta was an residenti followiny reported 14 hour Breakfa F 810 Assistiv CFR(s): SS=D S483.60 The fac and ute appropricant F 810 Ssitiv SS=D SS=D S483.60 The fac and ute appropricant This RE by: Based	RTMENT OF HEALTH AN ERS FOR MEDICARE & I				PRINTED: 07/26/202 FORM APPROVE OMB NO. 0938-039
THE IVY AT GASTO(X4) ID PREFIX TAG(I) RF 809Continu and Bre was not short-st January transitio workedF 809Continu and Bre was not short-st January transitio workedAn inter with the interview meals w regulatid Adminis accepta was an resident followin, reported 14 hour BreakfaF 810Assistiv SS=DF 810Ssistiv CFR(s): S483.60 The fac and ute appropr can use meals a This RE by: Based		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
THE IVY AT GASTO(X4) ID PREFIX TAG(I) RF 809Continu and Bre was not short-st 		345307	B. WING		C 06/23/2022
(X4) ID PREFIX TAG((I) RPREFIX 	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
(X4) ID PREFIX TAG((I RPREFIX TAG((I RF 809Continue and Brewas not short-st January transitio workedA ninter with the interview meals w regulation Adminis accepta was an resident following reported 14 hour Breakfa F 810 SS=DF 810 SS=DF 810 SS=DSS=DS483.60 The fac and ute appropri can use meals a This RE by: Based				4414 WILKINSON BLVD	
PRÉFIX TAG(I) RF 809Continu and Bre was not short-st January transitio workedAn inter with the interview meals w regulatid Adminis accepta was an resident followiny reported 14 hour BreakfaF 810Assistiv CFR(s): SS=DF 810Ssitiv CFR(s): and ute appropri can use meals a This RE by: Based	AT GASTONIA LLC			GASTONIA, NC 28056	
 and Brewas not short-st January transitio worked An interwith the interview meals w regulation Administ accepta was an resident followiny reported 14 hour Breakfa F 810 SS=D CFR(s): §483.60 The fac and ute approprican use meals a This RE by: Based 	(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)	D BE COMPLETION
 and Brewas not short-st January transitio worked An interwith the interview meals w regulation Administ accepta was an resident followiny reported 14 hour Breakfa F 810 SS=D CFR(s): §483.60 The fac and ute approprican use meals a This RE by: Based 	9 Continued From page	112	F 80	A	
§483.60 The fac and ute appropr can use meals a This RE by: Based	 and Breakfast the new was not. She reporte short-staffed when sh January 2022 and ha transitions ever since worked in a strictly cli An interview was conwith the facility's interinterview, the failure of meals within a time spregulations was discurded and the strict of the structure of the str	At day, the RD stated she d the facility was e started at the facility in s had a lot of staff . The RD stressed she nical role at the facility. ducted on 6/8/22 at 4:45 PM im Administrator. During the of the facility to provide ban specified by the ssed. At that time, the	F 8	Date of compliance: 7/16/2022	7/16/22
physicia requirin	D CFR(s): 483.60(g) §483.60(g) Assistive of The facility must prov and utensils for reside appropriate assistance can use the assistive meals and snacks. This REQUIREMENT by:	devices ide special eating equipment ents who need them and e to ensure that the resident devices when consuming is not met as evidenced ns, staff interviews and illity failed to provide ils as ordered by the sident (Resident #2) uipment at mealtime.		 (1) Address how corrective action w accomplished for those residents four have been affected by the deficient practice; Resident (#2) and is no longer a facility. 	ind to

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 113 of 133

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 810 Continued From page 113 F 810 Resident #2 was admitted to the facility on (2) Address how the facility will identify 7/25/20. His cumulative diagnoses included other residents having the potential to be diabetes, dysphagia (difficulty swallowing), affected by the same deficient practice; rheumatoid arthritis, and hemiplegia (severe or complete loss of strength on one side of the All Residents care plans were body) / hemiparesis (mild or partial weakness or reviewed by Administrative Nursing Team loss of strength on one side of the body) following on 7/14/2022 for adaptive equipment and a cerebral infarction (stroke) affecting his left specifics validated on the food ticket non-dominant side; and vascular dementia with provided to staff on the meal tray. behavioral disturbance. (3) Address what measures will be put The resident's physician orders dated 3/19/21 into place or systemic changes made to included an order for built up curved utensils for ensure that the deficient practice will not all meals (initiated on 3/19/21 and continued as recur; an active order). Re-education was provided to Dietary Resident #2's most recent Minimum Data Set staff by the Director of Nursing/Designee (MDS) was a quarterly assessment dated related to the following: 4/12/22. The resident had moderately impaired Providing Adaptive Equipment to 0 cognitive skills for daily decision making. The Residents with meal tray according to tray assessment reported Resident #2 required ticket order. Education will be completed by 7/15/2022 extensive assistance from staff with one person physical assistance. He was 69 inches tall and weighed 144 pounds (#). He received a Re-education was provided to therapeutic and mechanically altered diet. Licensed and Certified Nursing staff by the Director of Nursing/ Designee related An Occupational Therapy (OT) Evaluation and to the following: Plan of Treatment was completed on 5/6/22. The о What to do in the event the adaptive resident was referred to OT due to exacerbation equipment is not on the meal tray. of falls/fall risk, decrease in strength, decrease in Education will be completed by 7/15/2022 functional mobility, reduced ADL participation, Education will be included with new hire decreased neuromotor control and decreased coordination. An OT note dated 5/9/22 reported Licensed Nursing Staff, Certified Nursing the resident completed self-feeding requiring Staff, and Dietary Staff orientation by the minimum assistance and verbal cues. The note **Director of Nursing/Designee** reported various adaptive equipment was tried to assist in promoting an increase in independence (4) Indicate how the facility plans to with self-feeding monitor its performance to make sure that

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923314

If continuation sheet Page 114 of 133

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 07/26/2022 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345307	B. WING			C /23/2022
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COL		
			4	414 WILKINSON BLVD		
	T GASTONIA LLC		G	GASTONIA, NC 28056		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 810	Continued From page		F 810	solutions are sustained;		
	again completed on 6 reported Resident #2 decline with Activities indicated he would be improve range of mot and feeding tasks to o caregiver. An OT Treatment End reported the resident task during breakfast moderate assist with reported as able to as foods with stand by a An observation was of AM and a resident int #2 was observed lying the bed raised and his in front of him. An 8-c orange liquid appearin was observed to be o him. His breakfast me from the room and pla the hallway outside of meal tray was observ utensils on it with his the insulated dome. I were on Resident #2 included 1 slice breac eaten), grits (none ea ticket on the tray inclu in part, "Adaptive Equ Weighted Spoon, We Weighted Utensils."	had presented with further of Daily Living (ADLs) and enefit from OT services to ion (ROM), sitting balance decrease assistance from counter Note dated 6/3/22 completed a self-feeding requiring minimum to verbal cues. He was asist with feeding of finger ssistance. onducted on 6/9/22 at 8:43 erview attempted. Resident g in his bed with the head of s bedside tray table placed ounce empty glass with an ing at the bottom of the glass n his tray table in front of eal tray had been removed aced on the high boy cart in f his room. Resident #2's		 The Administrator/Desig conduct 10 meal observation ensure adaptive equipment is indicated on the meal ticket v include a meal on the weekel weeks, then 5 meal observat weekly for 4 weeks, then 1 m observation review weekly fo Results of the reviews w discussed during the monthly Assurance meeting for tracki and recommendations from t Date of compliance: 7/16/202 	reviews to s available as veekly to nd for 4 ion reviews heal r 4 weeks. ill be / Quality ng, trending, he IDT team	

Facility ID: 923314

If continuation sheet Page 115 of 133

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	: 07/26/2022 APPROVED . 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
	345307	B. WING		_	06/2	; 23/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY AT GASTONIA LLC			4414 WILKINSON BLVD			
			GASTONIA, NC 28056			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
the Dietary Manager was observation of Residen missing his built-up uter Manager stated the ada on the meal ticket was the meal tray for the resi- questioned whether the helpful for the resident. An interview was condu AM with the facility's Di- Director of Rehab was Occupational Therapy A familiar with Resident # him. The Director repo- resident required built u along with supervision f When asked, she repor "fairly well" with self-fee utensils he had. Howev utensil, he would not be Upon further inquiry, the reported it would be oka eating on his own witho continually in the room; member would need to see if he needed help a An observation was con 12:20 PM of Resident # with his head of the bea	er. During the interview, as informed of the t #2's breakfast meal tray nsils. The Dietary aptive equipment printed what should be sent on sident. However, she e built-up utensils would be ucted on 6/13/22 at 9:55 rector of Rehab. The also a Certified Assistant (COTA) who was 22 and had worked with rted at this time, the up utensils for self-feeding, throughout the meal. rted the resident could do eding using the built-up ver, if he dropped the e able to pick it back up. e Director of Rehab ay for the resident to be out a staff member ; however, the staff o check back with him to and/or to be fed the meal. nducted on 6/13/22 at 22 as he was lying in bed d raised and his lunch e bedside tray table in front up spoon and fork on the to be using the built-up mself with his left hand.	F 810				

Facility ID: 923314

If continuation sheet Page 116 of 133

			()(0) 10 11 77-1		OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345307	B. WING		C 06/23/2022
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD GASTONIA, NC 28056	
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE
F 810	During the interview, regarding failure of R utensils available dur The interim Administr	concerns were expressed esident #11 to have built-up ing a mealtime observation. rator stated he would expect o be on his meal tray for	F 81	0	
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration A facility must be administration	ninistered in a manner that esources effectively and	F 83	5	7/16/22
	practicable physical, well-being of each re- This REQUIREMENT by: Based on record rev staff, family member, Medical Director, the effective leadership a systems to manage u change in condition, p pressure ulcers. This residents reviewed for #2, Resident #6, Res Resident #11). Immediate Jeopardy when effective system	mental, and psychosocial		 (1) Address how corrective action will accomplished for those residents found have been affected by the deficient practice; Resident (#2) was identified and is still a resident at the facility. Resident (#6) was identified and is still a resident at the facility. Resident (#9) was identified and is longer a resident at the facility. Resident (#10) was identified and no longer a resident at the facility. Resident (#11) was identified and no longer a resident at the facility. 	d to s s s no is
	services. Immediate of 6/18/2022 when th acceptable allegation removal. The facility a scope and severity	Jeopardy was removed as e facility implemented an of Immediate Jeopardy remains out of compliance at level "E" (No actual harm e than minimal harm that is		 (2) Address how the facility will identify other residents having the potential to affected by the same deficient practice All Residents were weighted on 	be

Facility ID: 923314

		MEDICAID SERVICES				D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · /	E SURVEY PLETED
		345307	B. WING			C / 23/2022
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD		
				GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 835	Continued From page	e 117	F 83	5		
F 033	not immediate jeopari staff education and er put into place are effer The findings included This tag is cross refer F-580: Based on reco with staff, and Medica to notify the Primary (changes in a resident when he developed a pressure ulcer, when deteriorated and whe hypotension (low bloc receiving intravenous failed to report results culture resulting in a c (Resident #9) for UTI Resident #9 was hosp sepsis/septic shock d pressure ulcer to the facility failed to notify when a resident had a loss (Resident #10). cumulative weight los through 4/6/22, was a 4/7/22 and had a feet	dy) for the facility to continue neure monitoring systems ective.	F 83	 7/13/2022. All Residents had a complete toe skin audit completed on 7/12. Administrative Nursing Team. Lab audit completed on 7/13. Administrative Nursing Team to emissed labs. All Residents assessed for a conditions not reported to Medica Provider by Administrative Nursir Review completed on 7/13/2022. Nurse staff re-educated on SB/ reporting change in condition on 07/11/2022 by Directory of Nursin (DON)/Designee Education will b completed by 7/15/2022. Administrative Nursing Team of Nursing, Infection Preventionis Manager) will be reviewing SBA clinical morning meeting Monday o DON and or designee will re MD any change in condition revis clinical morning meeting via SBA will present to Administrator for G (3) Address what measures will into place or systemic changes n ensure that the deficient practice recur; 	/22 by /2022 by ensure no hange of al ng Team. SBAR tification AR and MD on ng le n(Director st, Unit R in the -Friday. port to sed in R, and QA. be put hade to	
	with staff, family mem and Medical Director, the seriousness of sig resident's condition (F	ord reviews, and interviews aber, Physician Assistant the facility failed to identify gnificant changes in a Resident #9), complete and norough assessments and		 New Director of Nursing star June 7, 2022, and New Administr started on June 13, 2022. Nurse Consultant will be pro facility oversight to the administra to ensure that action plans are be followed. 	rator viding ative staff	

Facility ID: 923314

If continuation sheet Page 118 of 133

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MU		CONSTRUCTION		E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /				IPLETED
							С
		345307	B. WING			06/23/2022	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
	T 0 4 0 T 0 1 4 0			441	14 WILKINSON BLVD		
	T GASTONIA LLC			GA	STONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 835	Continued From page	e 118	E E	835			
		nedical attention when the			o Facility will be monitored remotel	v	
	resident's medical co				electronic data, and via conference ca		
		ulted in a delayed treatment			meeting.		
		infection) and hospitalization			 Nurse Consultant re-educated the 	е	
		nfected stage 4 pressure			Administrator and the Director of Nurs	sing	
	ulcer. This failure wa	u			on job descriptions with emphasis on		
	reviewed for quality o	of care (Resident #9).			role and responsibilities in the oversig	ht of	
					resident care and services on 6/17/20	22	
		servations, record reviews,			Nurse Consultant re-educated the		
		taff, Wound Physician,			Administrator and Director of Nursing		
		and Medical Director, the			Regulation F-835 with emphasis on th		
		lete skin assessments as			role and responsibilities in the oversig		
	ordered, effectively as pressure ulcer, and e				 resident care and services on 6/17/20 Nurse Consultant reviewed the ro 		
		ons were implemented and			and responsibilities related to Quality	JIC .	
	modified/adjusted acc				Assurance with the Nursing Home		
		(9). Resident #9 who was at			Administrator and Director of Nursing	on	
		ulcers was hospitalized on			6/17/2022.		
		d stage 4 pressure ulcer			Nurse Consultant re-educated the	е	
	(full-thickness skin ar	nd tissue loss) with tunneling			Administrator and Director of Nursing		
	(passageway of tissu	e destruction under the skin			related to the findings outlined in the		
	-	the facility failed to update			Immediate Jeopardy deficiencies to		
		a resident's Treatment			include corrective action and ongoing		
	dressing orders in the	d (TAR) to match the wound Wound Physician notes for			process evaluation and monitoring on 6/17/2022.		
	were for 2 or 3 reside	sident #6). These failures ents reviewed for pressure			Systemic changes put into place:		
	ulcers (Resident #9 a	inu Resident #0).			a Implemented routing aliginal mag	ting	
	F-692: Rased on stat	ff interviews and record			o Implemented routine clinical mee to discuss weights, labs, pressure ulco	-	
		alled to monitor a resident's			and change of conditions.	010	
	-	asis as ordered by the			o Implemented weekly resident risk	(
		severe unintended decline in			meeting to discuss areas such as wei		
		ment/adjust interventions.			loss, critical labs, pressure ulcers and		
		it to the hospital on 4/7/2022			weight loss.		
	-	pe placed in the stomach for			¿ Risk meeting will be composed o		
		lent #10) reviewed for			IDT, attendees Director of nursing, Ur		
		tatus. The facility also failed			Managers, Social Service Depart. Wo		
	to provide a physiciar	n ordered nutritional			care Nurse, Rehab. Director, MDS, IP		1

Facility ID: 923314

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 835 Continued From page 119 F 835 supplement for 2 of 2 sample residents (Resident and Dietary depart. Implemented on #11 and Resident #2). 06/17/2022. Implemented additional shift to shift о An interview conducted with the Administrator and communication on 6/17/2022 to discuss the Corporate Nurse Consultant on 6/15/22 at collateral related to acute changes in 2:09 PM revealed they were not aware of the condition, high-risk events, and labs. severity of the wounds and weight loss experienced by the affected residents, and the former Director of Nursing and the former (4) Indicate how the facility plans to Administrator played an enormous part in the monitor its performance to make sure that issue. They stated they needed to put effective solutions are sustained: systems in place, so the same issues don't happen again in the future. The Administrator will conduct 10 observations of clinical meeting The Administrator was notified of Immediate (conducted Mon-Fri.), weekly resident risk Jeopardy on 6/15/22 at 1:28 PM. meeting and shift to shift communication collateral is being utilized to discuss, and The facility provided the following IJ Removal respond to resident conditions weekly for Plan with the correction date of 6/18/22. 4 weeks, then 5 observations of clinical meeting weekly for 4 weeks and 1 All the following was covered with the New observation of clinical meeting weekly for Administrator and Director of Nursing. 4 weeks. Nurse Consultant will be providing facility Results of the reviews will be oversight to the administrative staff to ensure that discussed during the monthly Quality action plans are being followed. Assurance meeting for tracking, trending, * Nurse Consultant re-educated the and recommendations from the IDT team Administrator and Director of Nursing on job descriptions with emphasis on the role and Date of compliance: 7/16/2022 responsibilities in the oversight of resident care and services on 6/17/22. Nurse Consultant re-educated the Administrator and Director of Nursing on regulation F-835 with emphasis on the role and responsibilities in the oversight of resident care and services on 6/17/22. Nurse Consultant reviewed the role and responsibilities related to Quality Assurance with the Nursing Home Administrator and Director of Nursing.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/26/2022 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345307	B. WING			_		C 23/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD GASTONIA, NC 28056			
					-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page	9 120	F	835				
	* Nurse Consultant r	e-educated the						
		ector of Nursing related to						
	deficiencies to include	n the Immediate Jeopardy						
		uation and monitoring.						
	* Systematic change	es:						
		clinical meeting to discuss						
	conditions.	re ulcers and change of						
		ly resident risk meeting to						
	discuss areas such as	s weight loss, critical labs,						
	pressure ulcers and w	-						
	 Implemented addition collate 							
		high-risk events, and labs.						
	-	and Director of Nursing						
		to employees during the						
		related to the corrective						
	jeopardies.	acility on the immediate						
		e on June 17th, 2022, to						
		cil meeting to introduce the						
		nd expectations of care and						
	staff moving forward.							
	Quality Assurance/Pe On 6/17/22, an Ad ho	rformance Improvement						
		ement (QAPI) Meeting was						
		ne Credible Allegation of						
	Compliance as writter	٦.						
	All plans that have be	en put in place are effective						
	and we respectfully re							
	Immediate Jeopardy s 6/18/22.	status as of 12:00 AM on						
	* The Corporate Nur	se Consultant educated the						
	Administrator and DO	N on the components of the d. Additionally, the systems						

	-	D HUMAN SERVICES					FORM): 07/26/2022 MAPPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345307	B. WING _			_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				14 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	practices and were up to: *F580 Notify of Chang *F684 Quality of Care *F686 Treatment/Serv Pressure Ulcers *F692 Nutrition/Hydra The Administrator is re the Focus Meetings a Administrator was info on 6/15/22. * The facility will con with the Interdisciplina resident weight losses any abnormal labs. or reviews of lab. book to and will discuss the in skin assessments, wo wound healing progre healing; and lab. issue reviewed by the DON interventions are not r desired results, the Pr notified, and intervent and potential to add o interventions as appro- healing goals; weight labs. and change of c Date of alleged IJ rem The credible allegatio jeopardy removal was removal date of 6/18/2	eviewed for all deficient dated on 6/13/22 pertaining ges vices to Prevent/Heal tion Status esponsible for ensuring that re being held and the ormed of this responsibility duct weekly Focus meetings ary team to discuss any s, skin integrity issues, and any issues with morning o determine if any trends terventions put in place; bund measurements with ss or issues with wound es noted in morning or DON Designee. If eflective of achieving imary Care Provider will be ions will be re-addressed r eliminate and replace opriate to achieve wound gain goals; notification of onditions.	F	335				

Facility ID: 923314

If continuation sheet Page 122 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/26/2022 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD GASTONIA, NC 28056			
				-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	Continued From page	122	F 835				
	of the immediate jeop reviewed with the inte interventions put into						
	which included the Ad Nursing, and the Infe	eight loss, change of					
	dated 6/22/22 indicate and Director of Nursin	nt council meeting minute ed the new Administrator ig introduced themselves to ewed with them their care					
	status, laboratory resi reviewed. The medic	eted by the facility on skin ults and weights were al provider was notified of s for additional follow-up as					
	provided education w and Director of Nursin roles, and responsibil resident care and sen educated on identifyin jeopardy cited and dis components of the res F-686, F-692 and F-8	gulations for F-580, F-684, 35. The education also I responsibilities, correction					
		s and nurse aides revealed					

Facility ID: 923314

If continuation sheet Page 123 of 133

	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION	(V2) DA	<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
345307					С	
		B. WING		0	6/23/2022	
NAME OF PI	ROVIDER OR SUPPLIER	I	s	STREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2022
			4	414 WILKINSON BLVD		
THE IVY A	T GASTONIA LLC			GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 835	Continued From page	e 123	F 835			
	they received educati		1 000			
		ondition including skin				
	issues, weight loss, c	hanges in vital signs and				
		ting these changes to the				
	nurses and the medic					= 14 - 12 - 5
F 842 SS=D			F 842			7/16/22
	8483.20(f)(5) Resider	nt-identifiable information.				
	-	elease information that is				
	resident-identifiable to	•				
		lease information that is				
	resident-identifiable to	o an agent only in ntract under which the agent				
		disclose the information				
		he facility itself is permitted				
	§483.70(i) Medical re §483.70(i)(1) In accor					
		ls and practices, the facility				
		al records on each resident				
	that are-					
	(i) Complete;					
	(ii) Accurately docum					
	(iii) Readily accessible (iv) Systematically or					
		ility must keep confidential				
	all information contair	ned in the resident's records,				
		n or storage method of the				
	records, except when					
	(i) To the individual, o	permitted by applicable law;				
	(ii) Required by Law;	portration by applicable law,				
	(iii) For treatment, page	yment, or health care				
	operations, as permit	ted by and in compliance				
	with 45 CFR 164.506					

Facility ID: 923314

If continuation sheet Page 124 of 133

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345307	B. WING			C 06/23/2022		
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
	T GASTONIA LLC			4	4414 WILKINSON BLVD			
				•	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 842	 (iv) For public health a neglect, or domestic vactivities, judicial and law enforcement purp purposes, research predical examiners, fua serious threat to heaby and in compliance §483.70(i)(3) The factor record information agunauthorized use. §483.70(i)(3) The factor record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 year legal age under State §483.70(i)(5) The mere (ii) Sufficient information (iii) A record of the ress (iii) The comprehensive provided; (iv) The results of any and resident review e determinations condutional values of the services reports as rest this REQUIREMENT by: Based on record revia facility failed to maintain on the Treatment Adm 	activities, reporting of abuse, violence, health oversight administrative proceedings, voses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments; ve plan of care and services r preadmission screening valuations and cted by the State; 's, and other licensed	F	842	(1) Address how corrective action will accomplished for those residents found have been affected by the deficient practice;			

Facility ID: 923314

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	()	IO. 0938-03	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,	NG	CON	COMPLETED	
					С		
		345307	B. WING			6/23/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
THE IVY AT GASTONIA LLC				4414 WILKINSON BLVD			
				GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIO DATE	
F 842	Continued From page	e 125	F8	342			
-		2 residents (Resident #6)					
	reviewed for wound c	· · · · · · · · · · · · · · · · · · ·		" Resident (#6) was id	entified. The		
				physician orders were ve			
	The findings included	:		validated in the electronic			
	Resident #6's physici	an orders active on 6/1/2022		(2) Address how the fac	ilitv will identify		
		wound treatment orders:		other residents having the			
	-): Apply skin prep and foam		affected by the same defi	-		
	dressing to left lateral	ankle change every shower			•		
		ursday 7 A.M 7 P.M.).		" All current Resident			
		ed on 6/9/2022 at 12:54		records were reviewed fo			
	P.M.			documentation/treatment			
		?): Apply skin prep then bordered gauze on shower		by the Administrative Nur 7/14/2022. Physician was			
		Monday, Thursday and		additional orders carried			
		discontinued on 6/9/2022 at		appropriate on 7/14/2022			
		8): cleanse with 0.125 %		(3) Address what measu	ures will be put		
	Sodium Hypochlorite	solution. apply wet to moist ochlorite saturated gauze to		into place or systemic char ensure that the deficient			
	wound bed then cove	er with superabsorbent		recur;			
		th kerlix. Change daily on		" Re-education was pr			
	-	discontinued on 6/9/2022 at		Licensed nursing staff by			
	12:48 P.M.	ported into the stampsh		Nursing / Designee relate	ea to the		
		serted into the stomach) eanse with 0.125% sodium		following: o Ensuring no omission	nc in the		
		apply silver alginate, and		medication and treatment			
		daily on day shift. Order		shift.			
		6/9/2022 at 12:52 P.M.					
		d cleanser, then apply		" Re-education was pr	ovided to		
	collagenase ointment	to wound bed and apply		Licensed nursing staff by			
	calcium alginate with			Nursing/Designee related	-		
		sing and bordered gauze.		o Medication and treat			
		shift for pressure ulcer to		administration is docume	-		
		liscontinued on 6/9/2022 at		accurately in the electron			
	12:52 P.M. -Right Hin (2): cleans	e with wound cleanser then		o Documentation pract resident refusal			
		tment to wound bed and		Education will be complete	ted by 7/15/2022		
		e with silver. Cover with					

Facility ID: 923314

If continuation sheet Page 126 of 133

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 842 Continued From page 126 F 842 superabsorbent dressing and bordered gauze. Education will be included with new Change daily on day shift for pressure ulcer to hire Licensed Nursing Staff orientation by right hip. Order was discontinued on 6/9/2022 at the Director of Nursing or Designee 12:51 P.M. - Left Hip: cleanse with 0.125% sodium (4) Indicate how the facility plans to hypochlorite solution then apply wet to moist monitor its performance to make sure that 0.125% sodium hypochlorite solution saturated solutions are sustained; gauze to wound bed then cover with Director of Nursing/Designee will superabsorbent dressing and wrap with rolled conduct 10 medication and treatment gauze, change daily. Order was discontinued on record reviews for completion weekly for 4 6/9/2022 at 7:54 P.M. weeks, then 5 medication and treatment - Right Ankle: wash skin, skin prep daily; Apply record reviews for completion weekly for 4 foam dressing three times a week during day shift weeks, then 1 medication and treatment on Sunday, Tuesday, and Thursday: Order was record reviews for completion weekly for 4 discontinued on 6/9/2022 at 12:50 P.M weeks. - Sacrum (buttocks): Apply hydrocolloid dressing Results of the reviews will be change three times a week on Sunday, Tuesday discussed during the monthly Quality and Thursday during day shift. Assurance meeting for tracking, trending, and recommendations from the IDT team Resident #6's Treatment Administration Record (TAR) reviewed for 6/1/2022 through 6/9/2022 indicated the following treatments were not documented as completed or not completed: - Left Lateral Ankle (1): Not documented on Thursday, 6/2/2022 and Thursday, 6/9/2022 - Left Lateral Ankle (2): Not documented on Thursday, 6/2/2022; Saturday 6/4/2022, and Thursday, 6/9/2022 - Left Lateral Ankle (3): Not documented on Thursday, 6/2/2022; Saturday 6/4/2022, and Thursday, 6/9/2022 - Peg tube insertion site: Not documented on Thursday, 6/2/2022; Saturday 6/4/2022, and Thursday, 6/9/2022 - Right Hip (1): Not documented on Thursday, 6/2/2022; Saturday 6/4/2022, and Thursday, 6/9/2022 - Right Hip (2): Not documented on Thursday, 6/2/2022 and Thursday, 6/9/2022

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVE 10. 0938-03
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	(X3) DA	TE SURVEY MPLETED		
		345307	B. WING		a	C 6/23/2022
AME OF PR	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CC		0.20.2022
	T GASTONIA LLC		441	4 WILKINSON BLVD		
	I GASTONIA LLC		GA	STONIA, NC 28056		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
F 842	Continued From page	a 127	F 842			
	- Left Hip: Not docum					
	6/2/2022 and Thursd - Sacrum (Buttocks):	•				
	A telephone interview 6/13/2022 at 11:43 A	was conducted on .M. with the Unit Manager.				
	Resident #6's dressir 6/9/2022 after the wo	nfirmed she completed ng changes on 6/2/2022 and ound doctor evaluated s. During the interview, the				
	Unit Manager stated completed dressing of days she rounded wit	she had not documented changes on the TAR on the th the wound doctor. She asings changes should be				
	documented on the T completed.	AR when they were				
		v with Nurse #7 who was 5 on 6/4/2022 was attempted Jl.				
	the Director of Nursin Regional Nurse Cons changes should be d TAR when the dressi	sultant revealed all dressing ocumented correctly on the ngs were completed.				
F 880 SS=E	Infection Prevention a CFR(s): 483.80(a)(1)		F 880			7/16/22
	§483.80 Infection Co The facility must esta infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and				

Facility ID: 923314

If continuation sheet Page 128 of 133

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 07/26/2022 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345307	B. WING			-	() 06/2	C 23/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC				414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 880	diseases and infection §483.80(a) Infection p program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable dis staff, volunteers, visito providing services und arrangement based u conducted according accepted national star §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the in involved, and (B) A requirement tha	smission of communicable ns. prevention and control olish an infection prevention IPCP) that must include, at ring elements: m for preventing, identifying, g, and controlling infections seases for all residents, pors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other in possible incidents of e or infections should be smission-based precautions ent spread of infections; lation should be used for a t not limited to:	F	880				

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 129 of 133

SINTERNATION OF DERICENCIES AND PLAN. DO CORRECTION (XI) PROVIDER/SUPPLENCUA IDENTIFICATION NUMBER (XI) PROVIDER/SUPPLENCUA STRETADDRESS, CITY, STRE_ZP CODE (XI) PARSANCE INAME OF PROVIDER OR SUPPLENCE STRETADDRESS, CITY, STRE_ZP CODE STRETADDRESS, CITY, STRE_ZP CODE (XI) PROVIDER OR SUPPLENCE STRETADDRESS, CITY, STRE_ZP CODE (XI) PROVIDER OR SUPPLENCE STRETADDRESS, CITY, STRE_ZP CODE (XI) PROVIDER OR SUPPLENCE (XI) PROVIDER OR SUPP		-	ID HUMAN SERVICES			FOR	M APPROVED 0. 0938-0391	
345307 B. VING 06/23/2022 IMME OF PROVIDER OF SUPURER SIMMARY STITEMENT OF DEFICIENCES INTER IVY AT CASTONIA LLC SIMMARY STITEMENT OF DEFICIENCES INTER IVY OR LSC DERTIFYING INFORMATION SIMMARY STITEMENT OF DEFICIENCES INTER IVY OR LSC DERTIFYING INFORMATION CONTROM SIGURATION SIGURATION SIGURATION SIGURATION OF DEFICIENCY INTER IVY OR LSC DERTIFYING INFORMATION TO PROVIDER PUNCT OF DEFICIENCES INTER IVY OR LSC DERTIFYING INFORMATION TO PROVIDER PUNCT OF DEPROPRIATE IPACT DEPROVEMENT OF DEFICIENCES INTER INFORMATION SIGURATION SIGURATION SIGURATION SIGURATION OF DEPROPRIATE DEFICIENCY CONTRET INFORMATION SIGURATION SIGURATION SIGURATION SIGURATION SIGURATION OF DEPROPRIATE DEPROPRIATE DEFICIENCY F 880 Continued From page 129 (V) The difficument or for IFOD (I direct contact with residene for ondirect contact with residene procedures to be followed by staff involved in direct resident contact. F 880 F 880 F 880 F 880 F 880 Eddress how corrective action will be accomplished for those or so to prevent the spread of infection. F 880 Eddress how corrective action will be accomplished for those residents found to have been affected by the deficient practice; * Resident (#2) was identified and no regative outcomes noted * Resident (#2) was identified and no regative outcomes noted * Resident (#15) was identified and no regative outcomes noted * Resident (#16) was identified and no regative outcomes noted * Resid	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DAT	E SURVEY IPLETED	
HE EVY AT GASTONIA LLC Multicity Section Multity Section Multicity Section			345307	B. WING		_		
THE INVAT GASTONIA. IC 2005 (M) D PHETEX TAG ISJUMMAY STATEMENT OF DEFICIENCIES (EACH GENCERV MUST BE READED BY FULL REQUATIONY OR LSC DEVITI'NTIG INFORMATION) ID PRETEX TAG PROVIDER'S PLANOT CORRECTION (EACH GENCERV MUST BE READED BY FULL REQUATIONY OR LSC DEVITI'NTIG INFORMATION) ID PRETEX TAG PROVIDER'S PLANOT CORRECTION (EACH GENCERV MUST BE READED BY FULL REQUATIONY OR LSC DEVITI'NTIG INFORMATION) ID PRETEX TAG PROVIDER'S PLANOT CORRECTION (EACH GENCERV MUST BE READED BY FULL REQUATIONY OR LSC DEVITI'NTIG INFORMATION) ID PRETEX (F 880 F 880 Continued From page 129 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. F 880 F 880 Ş483.80(a) (A) A system for recording incidents identified under the facility. S483.80(a) Annual review. F Garess how corrective action will be accomplished for those so process, and transport linens so as to prevent the spread of infection. ddress how corrective action will be accomplished for those seriedents found to have been affected by the deficient practice; * Based on record reviews, observations, staff interviews and the high level of transmission for COVID-19 in the countly, the facility failed to implement their infection control policy and the Centers for Disease Contol and Prevention (CCCC) guidelines for the use of Personal Protective Equipment (PEP) when 3 of 3 staff members (Nursz #2, Nursz #6 and the Interim Director of Nurs	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·		
GASTONIA, NC 2005 OWID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL RECULTORY OR LSC IDENTIFYING NFORMATION) Image: Construction PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH OEFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC IDENTIFYING NFORMATION) Image: Construction PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH OEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) Construction PREFIX TAG F 880 Continued From page 129 (v) The circumstances under which the facility user prohibit engloyees with a communicable disease or infected skin leasions from direct contact will reasonit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. F 880 F 880 S483.80(a)(4) A system for recording incidents identified under the facility: S483.80(b) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. F 880 ddress how corrective action will be accomplished for those residents found to have been affected by the deficient practice; ddress how corrective action will be accomplished for those residents found to have been affected by the deficient practice; * Resident (#15) mis of the use of Personal Protective Right for the use of Personal Protective Right for bas as of a 3 3 staff members (Nurse R2). Nurse #6 and the Interim Director of Nursing (IDON) failed to wear eye protector while providing care to 3 of 3 residents (Resident #2, Resident #15 and Resident #16) on 3 of 3 general halls. These failures occurred during a COVID-19 pandemic. * Nursie (#2) was identified and no negative outcomes noted * Nurse (#2) wa					4414 WILKINSON BLVD			
Prefix TAG (EACH DEFICENCY AND BE PRECEDED BY FULL RECULTION SHOULD BE CORSS-REPERENCE OT TON SHOULD BE ORSS-REPERENCE OT TO SHOULD BE OR THE SHOULD SHOULD BE OR SHOULD SHOULD BE OR SHOULD SHOULD SHOULD BE OR SHOULD SHOULD SHOULD SHOULD BE OR SHOULD	THE IVY A	T GASTONIA LLC			GASTONIA, NC 28056			
 (i) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact with residents to the followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility. §483.80(a)(4) A system for recording incidents identified under the facility. §483.80(a) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff interviews and the high level of transmission for COVID-19 in the county, the facility failed to implement their infection control policy and the Centers for Disease Control and Prevention (ICCC) guidelines for the use of Personal Protective Equipment (PEP) when 3 of 3 staff members (Nurse #2, Nurse #6 and the Interim Director of Nursing (IDON) failed to wear eye protection while providing care to 3 of 3 residents (Resident #15) and Resident #16) an 3 of 3 general halls. These failures occurred during a COVID-19 pandemic. The findings include: The findings include: 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETION	
A review of the CDC COVID-19 Data Tracker on on 6/13/2022 by the Infection	F 880	 (v) The circumstance must prohibit employed disease or infected sk contact with residents contact will transmit ti (vi)The hand hygiene by staff involved in dia §483.80(a)(4) A syste identified under the fat corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update the This REQUIREMENT by: Based on record revision interviews and the hig COVID-19 in the court implement their infect Centers for Disease O (CDC) guidelines for Protective Equipment members (Nurse #2, Director of Nursing (II protection while provit (Resident #2, Reside 3 of 3 general halls. T during a COVID-19 p 	s under which the facility ees with a communicable (in lesions from direct a or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. le, store, process, and to prevent the spread of view. ct an annual review of its ir program, as necessary. ' is not met as evidenced fews, observations, staff gh level of transmission for nty, the facility failed to tion control policy and the Control and Prevention the use of Personal t (PPE) when 3 of 3 staff Nurse #6 and the Interim DON) failed to wear eye ding care to 3 of 3 residents in #15 and Resident #16) on 'hese failures occurred andemic.	F 8	ddress how corrective action w accomplished for those resident have been affected by the defice practice; "Resident (#2) was identified negative outcomes noted "Resident (#15) was identified negative outcomes noted "Resident (#16) was identified negative outcomes noted "Nurse (#2) was identified, r on 6/13/2022 by the Infection Preventionist/Designee, and pro appropriate PPE "Nurse (#6) was identified, r	ts found to ient d and no ed and no ed and no re-educated pvided		

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 130 of 133

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345307 B. WING 06/23/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD THE IVY AT GASTONIA LLC GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 880 Continued From page 130 F 880 06/13/22 indicated the county where the facility Preventionist/Designee, and provided was located had a high level of community appropriate PPE transmission for COVID-19. Interim DON no longer employed here A review of the facility's policy for the use of (2) Address how the facility will identify Masks. Face Shields/Eve Googles dated 06/2022 other residents having the potential to be revealed the use of masks, face shields/eye affected by the same deficient practice; goggles must be used by all staff only when the community transmission rate is high, or the facility Staff was provided the appropriate is the highest level of cases per 100,000 people PPE including face shields and goggles on 6/13/2022 in the last 7 days according to CDC. The CDC guidance entitled, "Interim Infection (3) Address what measures will be put Prevention and Control Recommendations for into place or systemic changes made to Healthcare Personnel During the Coronavirus ensure that the deficient practice will not Disease 2019 (COVID-19) Pandemic," updated recur: on 09/10/21 indicated the following information under the section "Implement Universal Use of A root cause analysis will be completed by the Director of Nursing Personal Protective Equipment for HCP (Healthcare Personnel): If SARS-CoV-2 infection (DON), Infection Preventionist Nurse (IP), and the QAPI (Quality Assurance is not suspected in a patient presenting for care (based on symptom and exposure history), HCP Performance Improvement) Committee working in facilities located in counties with and Governing Body by 7/15/2022. This substantial or high transmission should also use root cause analysis will be incorporated PPE (Personal Protective Equipment) as into the facilities intervention plan. described below including: Eye protection (i.e., Re-education was provided on goggles or a face shield that covers the front and 6/13/2022 to the Director of Nursing sides of the face should be worn during all patient (DON) and the Infection Preventionist by care encounters. Administrator / Designee related to the following: 1.a. On 06/13/22 at 2:51 PM through 3:02 PM a The CDC COVID-19 Data Tracker continuous observation was made of Nurse #4 and how to ensure level of community going into Resident #2's room to medicate him. transmissions and what PPE is required. The Nurse wore a face mask but did not don eye All Staff re-education provided by the protection before going into the Resident's room and encountering the Resident. Director of Nursing/Infection Preventionist/Designee related to the b. On 06/13/22 at 3:05 PM through 3:14 PM a following: continuous observation was made of Nurse #4 **Recommended Personnel Protective**

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: CWNE11

Facility ID: 923314

If continuation sheet Page 131 of 133

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION		E SURVEY PLETED	
		345307	B. WING _		06	C 6/23/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
				4414 WILKINSON BLVD		
THE IVY A	T GASTONIA LLC			GASTONIA, NC 28056		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	· · · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIZ TAG	C (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETION
F 880	Continued From page	131		380		
1 000			F			
		15's room to assess his		Equipment (PPE) for when		
		theter by releasing his brief		communities COVID-19 Tra	ansmission	
		ubic site. The Nurse wore a t don eye protection before		levels are high. " Components of regula	tion E880	
		nt's room and encountering		related to Infection Control		
	the Resident.	nie reem and encountering		Education to be completed	by 7/15/2022	
	An interview was con	ducted with Nurse #4 on		Education will be included	with new hire	
	06/13/22 at 3:14 PM	who explained that she had		orientation by Director of N	ursing/	
	only been employed a	at the facility for about 90		Designee		
	days and had receive	ed education on infection				
	control upon hire but	since that time there had not		" An attestation stateme		
		ership in the infection control		completed by the Infection		
		inued to explain that as far		to attest that education will		
	as she knew she did	-		" A communication boar	•	
		ney only had to wear eye		at the sign-in kiosk alerting		
	-	g care of residents with		community transmission ra		
	COVID and there was	s no COVID in the facility.		PPE will be required to weat shift. This will be completed	•	
	c. On 06/13/22 from 3	8:20 PM to 3:35 PM a		Administrator/Designee by		
		on was made of Nurse #6		/ animistrator/Designee by	1110/2022.	
		6's room to provide dressing		(4) Indicate how the facilit	v plans to	
		#16's feet. During the		monitor its performance to		
	-	I the Interim Director of		solutions are sustained;		
		ed the Resident's room to		" Administrator, Director	of Nursing,	
		the treatment. Neither the		and Infection Preventionist	will monitor	
	Nurse nor the IDON of	donned personal eye		staff knowledge of transmis	ssion-based	
	protection before eng	aging in the Resident care		precautions and recommer		
	encounter.			when community transmiss		
				high by performing 10 staff		
	On 06/13/22 at 3:35 F			reviews weekly for 4 weeks		
		he Interim Director of		observation reviews weekly		
	-	6 immediately after the		then 1 staff observation rev	lews weekly	
	encounter with Resid			for 4 weeks.	will be	
		as part time and did not work		" Results of the reviews		
		a consistent basis and		discussed during the month		
	-	nat today (06/13/22) was her ent at the facility. Both nurses		Assurance meeting for trac and recommendations fron		
		hat they were under the				

Facility ID: 923314

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/26/2022 APPROVED 0: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING		_		C 23/2022
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 880	positive. The nurses s of what the county tra had not been educate protection. An interview was com- Nursing (DON) #2 and (IP) on 06/13/22 at 4: they both were hired of explained that she pu CDC website that ind for the county was me facility did not have to resident encounters. DON that the transmis should be going by wi that personal eye pro- resident encounters. they were unaware of being the indicator and wearing the eye prote During an interview w and the Corporate Nu 06/15/22 at 2:10 PM to began her employme The CNC explained th community level whic aware of the transmis	did not have to wear esident was not COVID stated they were not aware nsmission level was and ed by the facility to wear eye ducted with Director of d the Infection Preventionist 20 PM. The DON stated that on 06/07/22. The DON lled information from the icated the community level edium which meant that the owear eye protection for The Surveyor informed the ssion level was what they hich was high and indicated tection should be worn for The DON and IP indicated the transmission level d would immediately initiate action. ith both the Administrator trse Consultant (CNC) on the Administrator stated she nt at the facility on 06/14/22. hat she went by the h was medium and was not sion level. The CNC hat the facility should be idelines for the use of	F 880	Date of compliance	: 7/16/2022		

Facility ID: 923314

If continuation sheet Page 133 of 133