|                          | -  |  |                     |  | FORM APPROVED                         |
|--------------------------|--|--|---------------------|--|---------------------------------------|
|                          |  | MEDICAID SERVICES  | (X2) MULTIPI        |  | OMB NO: 0938-0391<br>(X3) DATE SURVEY |
|                          | CORRECTION   | IDENTIFICATION NUMBER:   |                     |  | COMPLETED                             |
|                          |  | 345307   | B. WING             |  | C<br>03/24/2022                       |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                                       |
|                          | T GASTONIA LLC   |  |                     | 4414 WILKINSON BLVD  |                                       |
|                          |  |  |                     | GASTONIA, NC 28056   |                                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)  | DATE                                  |
| F 000                    | INITIAL COMMENTS   | i  | F 00                | כ<br>כ   |                                       |
|                          | to conduct a complain<br>exited on 3/21/22. An<br>obtained on 3/24/22.<br>changed to 3/24/22.<br>investigated and all c  | ered the facility on 3/21/22<br>nt investigation survey and<br>dditional information was<br>Therefore, the exit date was<br>A total of 4 allegations were<br>f them were<br>00186376 and NC00186349. |                     |  |                                       |
| F 684<br>SS=D            | Quality of Care  |  | F 68                | 4  | 4/20/22                               |
|                          | applies to all treatme<br>facility residents. Bas<br>assessment of a residents receive<br>accordance with prof<br>practice, the compre-<br>care plan, and the resident | ndamental principle that<br>nt and care provided to<br>ed on the comprehensive<br>dent, the facility must ensure<br>e treatment and care in<br>essional standards of<br>nensive person-centered      |                     |  |                                       |
|                          | Based on record rev<br>interviews with staff a<br>facility failed to provid  | iew, observation and<br>and the wound doctor, the<br>de wound care to a venous<br>rders for 1 of 3 residents<br>ed for wound care.   |                     | Resident #4 dressing change was<br>completed immediately<br>All residents receiving treatments have<br>the potential to be affected.   |                                       |
|                          | The findings included  | :  |                     | The Director of Nursing (DON) complete   | ed                                    |
|                          | 2/3/22 with diagnoses<br>venous hypertension<br>extremity.   | admitted to the facility on<br>s that included chronic<br>with ulcer of left lower   |                     | a 100% audit was completed on<br>3/22/2022 of all residents who had<br>treatment orders to validate that the<br>wound care was provided as well as the<br>treatment was signed for completed. No<br>discrepancies were identified. |                                       |
|                          | The quarterly Minimu assessment dated 2/   | m Data Set (MDS)<br>7/22 indicated Resident #4   |                     | By 3/22/2022, the DON re-educated the  |                                       |
| ABORATORY                | <br>DIRECTOR'S OR PROVIDER/  | SUPPLIER REPRESENTATIVE'S SIGNATUR   | E I                 | TITLE  | (X6) DATE                             |
|                          | cally Signed   |  |                     |  | 04/13/2022                            |

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.

PRINTED: 08/15/2023

|               |                        | MEDICAID SERVICES  | a   |                                  |  | OMB NO. 093                 |      |  |
|---------------|------------------------|--|---|----------------------------------|--|-----------------------------|------|--|
|               | OF DEFICIENCIES        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:      | · · ·                                     | LE CONSTRUCTI                    |  | (X3) DATE SURV<br>COMPLETED |      |  |
|               |                        |  | A. BUILDING                               |                                  |  | С                           |      |  |
|               |                        | 345307   | B. WING                                   |                                  |  |                             |      |  |
|               | ROVIDER OR SUPPLIER    | 545507   |   |                                  | ESS, CITY, STATE, ZIP CODE   | 03/24/20                    | )22  |  |
| NAME OF F     | ROVIDER OR SUFFLIER    |  |   |                                  |  |                             |      |  |
| THE IVY A     | T GASTONIA LLC         |  | 4414 WILKINSON BLVD<br>GASTONIA, NC 28056 |                                  |  |                             |      |  |
| (X4) ID       | SUMMARY ST             | ATEMENT OF DEFICIENCIES                                    | ID  |                                  | PROVIDER'S PLAN OF CORRECTION  |                             | (X5) |  |
| PREFIX<br>TAG |                        | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG                             |                                  | ACH CORRECTIVE ACTION SHOULD BE<br>DSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) |                             | DATE |  |
| F 684         | Continued From page    | e 1  | F 68                                      | 4                                |  |                             |      |  |
|               |                        | vely impaired and was totally                              | 1.00                                      |                                  | nurses on regulation 483.25  |                             |      |  |
|               |                        | ssistance with bed mobility.                               |   |                                  | g quality of care and ensuring   |                             |      |  |
|               | · ·                    | cated Resident #4 had a                                    |   |                                  | s receive treatment and care   |                             |      |  |
|               | total of three venous  |  |   |                                  | g to professional standards and  | 4                           |      |  |
|               | application of nonsur  |  |   |                                  | Education included the   | •                           |      |  |
|               | ointments/medication   |  |   |                                  | ion of the licensed nurse to   |                             |      |  |
|               |                        |  |   |                                  | vound care as ordered by the   |                             |      |  |
|               | Resident #4's care pl  | an revised on 3/10/22                                      |   | · · ·                            | n, sign/initial and date dressing  |                             |      |  |
|               | -                      | 4 had a venous ulcer to the                                |   |                                  | n dressing change. Make sure   |                             |      |  |
|               | left lower medial leg, |  |   | atment administration record) is | 6  |                             |      |  |
|               | lower lateral leg and  |  | signed to                                 | only reflect completion of       |  |                             |      |  |
|               | lateral foot which was | s resolved on 3/10/22.                                     |   | dressing                         | changes.   |                             |      |  |
|               | Interventions include  | d treatments as ordered.                                   |   |                                  |  |                             |      |  |
|               |                        |  |   |                                  | l or Unit Manager will conduct   |                             |      |  |
|               |                        | ted 3/12/22 for Resident #4                                |   |                                  | of 3 residents TARs to ensure  |                             |      |  |
|               |                        | g treatment to the left lower                              |   |                                  | reatment orders are signed for   |                             |      |  |
|               |                        | er leg (medial and lateral)                                |   |                                  | ed and visually inspect residents  | s□                          |      |  |
|               |                        | olution, apply (antifungal)                                |   |                                  | s to ensure it was changed,  |                             |      |  |
|               |                        | emulsion dressings and                                     |   |                                  | and dated. At a frequency of 3   |                             |      |  |
|               | -                      | p site with a gauze bandage                                |   |                                  | 3 times a week for 4 weeks,  |                             |      |  |
|               | roll and change daily  | every day shift.   |   |                                  | time a week for 8 weeks and  |                             |      |  |
|               |                        | "" T · ·   |   |                                  | hthly. Schedule for QI monitorin   | ig                          |      |  |
|               | A review of Resident   |  |   | will be me                       | odified based on findings.   |                             |      |  |
|               |                        | d (TAR) for March 2022                                     |   | Doculto -                        | of OI monitoring will be recorde   | d                           |      |  |
|               |                        | nt order for Resident #4's                                 |   |                                  | of QI monitoring will be recorde   | u                           |      |  |
|               |                        | rked as completed by Nurse<br>18/22, Nurse #5 on 3/19/22   |   |                                  | ported to the QAPI (quality<br>ce performance improvement)                         |                             |      |  |
|               | and Nurse #4 on 3/20   |  |   |                                  | e monthly by the DON or  |                             |      |  |
|               | anu Nuise #4 011 3/20  | JIZZ.  |   |                                  | e. The QAPI committee will   |                             |      |  |
|               | During an observation  | n of wound care on Resident                                |   |                                  | the effectiveness of the   |                             |      |  |
|               |                        | 80 AM with Nurse #2, a                                     |   |                                  | ng / observation tools for making  | a                           |      |  |
|               |                        | #4's left lower leg was noted                              |   |                                  | to the correction action if  | 3                           |      |  |
|               | with a date of 3/16/22 | 0  |   |                                  | ry to maintain substantial   |                             |      |  |
|               |                        |  |   |                                  | ice. The QAPI committee  |                             |      |  |
|               | An interview with Nur  | rse #2 on 3/21/22 at 2:13 PM                               |   |                                  | s consists of but not limited to th  | he                          |      |  |
|               |                        | he did Resident #4's wound                                 |   |                                  | rator, DON, MD, and at least 3   |                             |      |  |
|               |                        | at the date on the old                                     |   | other me                         |  |                             |      |  |
|               | dressing and did not   | notice that it had been dated                              |   |                                  |  |                             |      |  |
|               | -                      | emoved it. Nurse #2 stated                                 |   | Completi                         | on date: 4/20/2022   |                             |      |  |

Facility ID: 923314

If continuation sheet Page 2 of 14

| INST_INING OF DEFICIENCIES<br>AND PLAN OF CORRECTION       (N) INDER SUPPLIER<br>INDER AND PLAN OF CORRECTION       (N) INTIFIE CONSTRUCTION<br>A BULDING<br>D VMIG       (N) INTIFIE CONSTRUCTION<br>A BULDING       (N) INTIFIE<br>CONSTRUCTION<br>INTIFIE CONSTRUCTION<br>A BULDING       (N) INTIFIE CONSTRUCTION<br>A BULDING       (N) INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION       (N) INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>INTIFIE<br>CONSTRUCTION<br>IN |             | -  | ID HUMAN SERVICES   |         |                               |                       | FORM              | ): 08/15/2023<br>MAPPROVED<br>). 0938-0391 |
|--|-------------|--|---|---------|-------------------------------|-----------------------|-------------------|--|
| 345307         B. WING         003/24/2022           INME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         311111111111111111111111111111111111   | STATEMENT C | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   | · · ·   |                               |                       | (X3) DATE<br>COMP | SURVEY<br>LETED                            |
| NMME OF PROVIDER OR SUPPLIER     THEET ADDRESS. CITS JOINT 2002       THE INV AT GASTONIA LLC     Mit MULKINSON BL/D<br>GASTONIA, NC 20056       MUD<br>PREEX<br>TAG     SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PERCEPED 0P VILL<br>RECULTORY OR LSC DENTIFYING INFORMATION)     PRODUCTORECTIC ADDRESS CITS JOINT SHOULD DE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY     Image: Comparison of the appropriate<br>DEFICIENCY     Image: Comparison of the appropriate<br>DEFICIENCY       F 684     Continued From page 2<br>that she was focused on the procedure and was<br>thinking about what she needed to do while<br>changing Resident #4's treatment to her left leg<br>should have been done daily and she was not<br>sure why it had not been change daince 3/16/22.<br>Nurse #2 stated that she did notice that Resident<br>#4's left leg wound looked drine than usual.     F 684       A phone interview with Nurse #3 on 3/21/22 at<br>2:10 PM revealed she worked with Resident #4<br>on 3/17/22 and 3/18/22 but she<br>didn't to it because the<br>wound doctor was scheduled to come to the<br>facility on either 3/17/22 or 3/18/22 but she<br>couldn't remember which day he was supposed<br>to come. Nurse #3 also stated that she worked<br>with Resident #4 or 3/19/22 and 3/18/22 but she<br>couldn't remember which day he was supposed<br>to come. Nurse #3 also stated that she worked<br>with Resident #4 wound<br>care because she thought she was only<br>supposed to pass medications during the four<br>hours that she worked on 3/19/22 at<br>11:33 PM revealed she came in at 1:00 PM on<br>3/19/22 and worked with Resident #4 whill the<br>reported for work because Nurse #3 had already<br>left at 11:30 AM. Nurse #5 stated she didn't do<br>Resident #4 storement to her left leg because<br>she thought Nurse #3 had already<br>left at 11:30 AM. Nurse #3 stated she didn't do<br>Resident #4 storement hore left leg because<br>she thought Nurse #3 had already<br>left at 11:30 AM. Nu  |             |  | 345307  | B. WING |                               | _                     |                   |  |
| 411 WILKINSON BLVD<br>GASTONIA, NC 2805       OWI ID<br>PRETX<br>TVG     SUMMARY STREMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MILST BE PRECEDED BY FULL<br>RECULTORY OR LSC DETIFYING INFORMATION)     DP       F 684     Continued From page 2<br>that she was focused on the procedure and was<br>thinking about what she needed to do while<br>changing Resident #4's treatment to her left leg<br>should have been done daily and she was not<br>sure why it had not been changed since 31/6/22.     F 684       A phone interview with Nurse #3 on 3/21/22 at<br>2:10 PM revealed she worked with Resident #4's treatment to<br>her left lower leg but she didn't do it because the<br>wound locked drier than usual.     F 684       A phone interview with Nurse #3 an 3/21/22 at<br>2:10 PM revealed she worked with Resident #4 so wound<br>core. Nurse #3 stated was hit from 7:00<br>AM to 7:00 PM. Nurse #3 stated she knew she<br>was supposed to do Resident #4's wound<br>care because she thought she was only<br>supposed to pass medications during the four<br>hours that she worked on 3/19/22 at<br>12:35 PM revealed she core to the<br>facility on either 3/19/22 to 3/19/22 but she<br>couldn't remember which day he was supposed<br>to come. Nurse #3 also stated that she worked<br>with Resident #4 on 3/19/22 from 7:00 AM to<br>11:30 AM but she didn't do Resident #4 swound<br>care because she thought she was only<br>supposed to pass medications during the four<br>hours that she worked on 3/19/22.       A phone interview with Nurse #5 on 3/21/22 at<br>12:35 PM revealed she care in at 1:00 PM on<br>3/19/22 and worked with Resident #4 with 10 the<br>reported for work because Nurse #3 stated the locked or<br>Nursing (DON) had the keys to her car when she<br>reported for work #3 stated she didn't do<br>Resident #4's treatment to her left leg because<br>she thought Nurse #3 stated she didn't do<br>Resident #4's treatment to her left leg because<br>she thought Nurse #3 stated the to her l   | NAME OF P   | ROVIDER OR SUPPLIER  |   | s       | TREET ADDRESS, CITY, ST       | ATE, ZIP CODE         |                   |  |
| WILD<br>PRETX<br>TVG         SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY WUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)         D<br>PRETX<br>TVG         D<br>PRETX<br>TVG         D<br>PRETX<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY         CONFIRM<br>(CONFERT<br>DEFICIENCY)           F 684         Continued From page 2<br>that she was focused on the procedure and was<br>thinking about what she needed to do while<br>changing Resident #4's treatment to her left leg<br>should have been done daily and she was not<br>sure why it had not been changed since 3/16/22.<br>Nurse #2 stated that she din dotice that Resident<br>#4's left leg wound looked drier than usual.         F 684           A phone interview with Nurse #3 on 3/21/22 at<br>2:10 PM revealed she worked with Resident #4<br>on 3/17/22 and 3/18/22 on the day shift from 7:00<br>AM to 7:00 PM. Nurse #3 stated that she din to be to the<br>facility on either 3/17/22 or 3/17/22 or 3/17/22 bit she<br>couldn't remember which day he was supposed<br>to come. Nurse #3 also stated that she worked<br>with Resident #4 on 3/19/22 from 7:00 AM to<br>11:30 AM but she didn't do it because the<br>wound doctor was scheduled to come to the<br>facility on either 3/17/22 or 3/17/22 or 3/17/22 bit she<br>couldn't remember which day he was supposed<br>to come. Nurse #3 also stated that she worked<br>with Resident #4 on 3/19/22 from 7:00 AM to<br>11:30 AM but she didn't do Resident #4 swound<br>care because she thought she was only<br>supposed to pass medications during the four<br>hours that she worked on 3/19/22 at<br>12:35 PM revealed she came in at 1:00 PM on<br>3/19/22 and worked with Resident #4 unit the<br>night shift. Nurse #5 stated the Director of<br>Nursing (DON) had the keys to her cart when she<br>reported for work because. Nurse #5 stated she didn't do<br>Resident #4 treatment to her left leg because<br>she thought Nurse #5 stated she didn't do need the on her   |             |  |   | 4       | 414 WILKINSON BLVD            |                       |                   |  |
| Precisiv<br>TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     PRETX<br>TAG     CREAL OR PROPRIATE     COMPLETM<br>DEFICIENCY       F 684     Continued From page 2<br>that she was focused on the procedure and was<br>thinking about what she needed to do while<br>changing Resident #4's treatment to her left leg<br>should have been done daily and she was not<br>sure why it had not been changed since 3/16/22.<br>Nurse #2 stated that she did notice that Resident<br>#4's left leg wound looked drier than usual.     F 684       A phone interview with Nurse #3 on 3/21/22 at<br>2:10 PM revealed she worked<br>was supposed to do Resident #4's treatment to<br>her left lower leg but she didn't do it because the<br>was supposed to do Resident #4's treatment to<br>her left lower leg but she didn't do it because the<br>doubt remember which day he was supposed<br>to come. Nurse #3 also stated that she worked<br>with Resident #4 on 3/19/22 or 3/18/22 but she<br>couldn't remember which day in be was supposed<br>to come. Nurse #3 also stated that she worked<br>with Resident #4 on 3/19/22.       A phone interview with Nurse #5 on 3/21/22 at<br>12:35 PM revealed she come in at 1:00 PM on<br>3/19/22.       A phone interview with Nurse #5 on 3/21/22 at<br>12:35 PM revealed she come in at 1:00 PM on<br>3/19/22.       A phone interview with Nurse #5 on 3/21/22 at<br>12:35 PM revealed she came in at 1:00 PM on<br>3/19/22.       A phone interview with Nurse #5 stated the Director of<br>Nursing (DON) had the keys to her cart when she<br>reported for work because. Nurse #5 stated she didn't do<br>Resident #4 to hereiment to her left leg bacause<br>she thought Nurse #5 stated she didn't do<br>Resident #4 sto reatment to her left leg bacause<br>she thought Nurse #5 stated she didn't do  | THE IVY A   | T GASTONIA LLC   |   | G       | GASTONIA, NC 28056            |                       |                   |  |
| <ul> <li>that she was focused on the procedure and was thinking about what she needed to do while changing Resident #4's dressing. Nurse #2 stated that Resident #4's treatment to her left leg should have been done daily and she was not surve why it had not been changed since 31/6/22. Nurse #2 stated that Resident and not been changed since 31/6/22. Nurse #2 stated that she did notice that Resident #4's left leg wound looked drier than usual.</li> <li>A phone interview with Nurse #3 on 3/21/22 at 2:10 PM revealed she worked with Resident #4's left leg wound looked drier than usual.</li> <li>A phone interview with Nurse #3 on 3/21/22 at 2:10 PM revealed she worked with Resident #4's reatment to her left lower leg but she didn't do it because the wound doctor was scheduled to come to the facility on either 3/17/22 or 31/8/22 but she couldn't remember which day he was supposed to come. Nurse #3 also stated that she worked with Resident #4's wound care because she thought she didn't do Resident #4's wound care because with Nurse #5 on 3/21/22 at 12:35 PM revealed she care in at 1:00 PM on 3/19/22.</li> <li>A phone interview with Nurse #5 stated she dim't do Resident #4 will the night shift. Nurse #5 stated she dim't do Resident #4's treatment to her greported for worke with Resident #4 will the night shift. Nurse #5 stated she dim't do Resident #4's treatment to here the full the night shift. Nurse #5 stated she dim't do Resident #4's treatment to here the fleg because she thought Nurse #3 taked she dim't do Resident #4's treatment to here the fleg because she thought Nurse #3 taked she dim't do Resident #4's treatment to here the to here the ge because she thought Nurse #3 taked she dim't do Resident #4's treatment to here the to here the ge because she thought Nurse #3 taked she dim't do Resident #4's treatment to here the to here the ge because she thought Nurse #3 taked she dim't do Resident #4's treatment to here the the ge because she thought Nurse #3 taked she dim't do Resident #4's treatment to here the the</li></ul>  | PREFIX      | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL  | PREFIX  | (EACH CORREC<br>CROSS-REFEREN | CTIVE ACTION SHOULD B |                   | COMPLETION                                 |
| shift and just forgot to mark it off on her TAR.<br>Nurse #5 also stated she didn't think to check<br>Resident #4's left leg dressing before she marked<br>it off as completed on Resident #4's TAR on<br>3/19/22 because she usually worked on the night  | F 684       | that she was focused<br>thinking about what si<br>changing Resident #4<br>stated that Resident #<br>should have been dor<br>sure why it had not be<br>Nurse #2 stated that si<br>#4's left leg wound loo<br>A phone interview witt<br>2:10 PM revealed she<br>on 3/17/22 and 3/18/2<br>AM to 7:00 PM. Nurs<br>was supposed to do F<br>her left lower leg but si<br>wound doctor was scl<br>facility on either 3/17/<br>couldn't remember wit<br>to come. Nurse #3 al<br>with Resident #4 on 3<br>11:30 AM but she did<br>care because she tho<br>supposed to pass me<br>hours that she worked<br>A phone interview witt<br>12:35 PM revealed sh<br>3/19/22 and worked w<br>night shift. Nurse #5<br>Nursing (DON) had th<br>reported for work becc<br>left at 11:30 AM. Nurs<br>Resident #4's treatments<br>she thought Nurse #3<br>shift and just forgot to<br>Nurse #5 also stated<br>Resident #4's left leg<br>it off as completed on | on the procedure and was<br>he needed to do while<br>I's dressing. Nurse #2<br>#4's treatment to her left leg<br>he daily and she was not<br>een changed since 3/16/22.<br>she did notice that Resident<br>oked drier than usual.<br>h Nurse #3 on 3/21/22 at<br>e worked with Resident #4<br>22 on the day shift from 7:00<br>we #3 stated she knew she<br>Resident #4's treatment to<br>she didn't do it because the<br>heduled to come to the<br>22 or 3/18/22 but she<br>hich day he was supposed<br>so stated that she worked<br>0/19/22 from 7:00 AM to<br>n't do Resident #4's wound<br>ought she was only<br>dications during the four<br>d on 3/19/22.<br>h Nurse #5 on 3/21/22 at<br>he came in at 1:00 PM on<br>with Resident #4 until the<br>stated the Director of<br>he keys to her cart when she<br>ause Nurse #3 had already<br>se #5 stated she didn't do<br>ent to her left leg because<br>i had already done it on her<br>o mark it off on her TAR.<br>she didn't think to check<br>dressing before she marked<br>Resident #4's TAR on | F 684   |                               |                       |                   |  |

Facility ID: 923314

If continuation sheet Page 3 of 14

|                          | -  | D HUMAN SERVICES<br>MEDICAID SERVICES  |                     |                               |  | FORM              | ): 08/15/2023<br>MAPPROVED<br>). 0938-0391 |
|--------------------------|--|--|---------------------|-------------------------------|--|-------------------|--|
| STATEMENT C              | DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · · ·               | E CONSTRUCTION                |  | (X3) DATE<br>COMP | SURVEY<br>LETED                            |
|                          |  | 345307   | B. WING             |                               | _  |                   | C<br>24/2022                               |
| NAME OF PR               | ROVIDER OR SUPPLIER  |  | s                   | TREET ADDRESS, CITY, ST       | ATE, ZIP CODE  |                   | -  |
|                          | T GASTONIA LLC   |  | 4                   | 414 WILKINSON BLVD            |  |                   |  |
|                          | I GASTONIA LLC   |  | 0                   | GASTONIA, NC 28056            |  |                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORREC<br>CROSS-REFEREN | PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BE<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                 |
| F 684                    | Continued From page<br>shift and treatments w<br>done on the day shift.<br>A phone interview with<br>12:41 PM revealed sh<br>on 3/20/22 from 7:00<br>never got around to d<br>treatment to her left left<br>she got ready to do it,<br>for her to come back left<br>she had gathered the<br>Resident #4's wound<br>already gotten up in h<br>difficult for her to do it<br>wheelchair. Nurse #4<br>the oncoming shift, but<br>the name of the nurse<br>A phone interview with<br>3/21/22 at 3:53 PM re<br>the facility on Thursda<br>on 3/17/22 so the last<br>was on 3/10/22. The<br>requested for the nurse<br>dressing changes to F<br>venous ulcer to her le<br>difficult wound to heal<br>he prescribed an antifi<br>to the wound to decre<br>decrease the fungal left<br>medicated cream lose<br>Resident #4's dressin | A 3<br>vere usually scheduled to be<br>a Nurse #4 on 3/21/22 at<br>the worked with Resident #4<br>AM to 3:00 PM but she<br>oing Resident #4's<br>teg. Nurse #4 stated when<br>Resident #4 had requested<br>ater in the shift. But when<br>supplies she needed to do<br>care, Resident #4 had<br>er wheelchair and it was<br>while she was in her<br>to stated she reported this to<br>at she could not remember<br>the wound doctor on<br>vealed he usually came to<br>ay, but he did not do rounds<br>time he saw Resident #4<br>wound doctor stated he had<br>sing staff to do daily<br>Resident #4 who had a<br>ft leg which had been a<br>. The wound doctor stated<br>ungal cream to be applied<br>ase inflammation and | F 684               |                               |  |                   |  |
|                          | eliminating the proble<br>new batch of antifung<br>dressing should be ap<br>venous ulcer to her le   | m. He also stated that a<br>al cream and a new<br>pplied daily to Resident #4's  |                     |                               |  |                   |  |

Facility ID: 923314

If continuation sheet Page 4 of 14

|                          | MENT OF HEALTH AN<br>S FOR MEDICARE & I  | D HUMAN SERVICES   |                     |  |   | FORM              | ): 08/15/2023<br>APPROVED<br>0: 0938-0391 |
|--------------------------|--|--|---------------------|--|---|-------------------|---|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 |  |   | (X3) DATE<br>COMP | SURVEY<br>LETED                           |
|                          |  | 345307   | B. WING             |  | _   |                   | C<br>24/2022                              |
| NAME OF PI               | ROVIDER OR SUPPLIER  |  | s                   | TREET ADDRESS, CITY, STA                 | ATE, ZIP CODE   |                   |   |
| THE IVY A                | T GASTONIA LLC   |  |                     | 414 WILKINSON BLVD<br>GASTONIA, NC 28056 |   |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORREC<br>CROSS-REFEREN            | PLAN OF CORRECTION<br>TIVE ACTION SHOULD BE<br>ICED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                |
| F 684<br>F 842<br>SS=D   | telling the nursing stat<br>not coming to the faci<br>not sure why Nurse #<br>DON also came in to<br>Nurse #3 when she le<br>not tell her that Reside<br>had not been complet<br>#3 told her that she had<br>the DON had to do wa<br>in at 1:00 PM. The Do<br>poor communication to<br>led to Resident #4 not<br>treatment for several of<br>Resident Records - Id<br>CFR(s): 483.20(f)(5),<br>\$483.20(f)(5) Residen<br>(i) A facility may not re<br>resident-identifiable to<br>accordance with a con<br>agrees not to use or of<br>except to the extent th<br>to do so.<br>\$483.70(i) Medical red<br>\$483.70(i)(1) In accor<br>professional standard<br>must maintain medicat<br>that are-<br>(i) Complete;<br>(ii) Readily accessible<br>(iv) Systematically org | A revealed she remembered<br>if that the wound doctor was<br>ity on 3/17/22 so she was<br>3 did not know about it. The<br>work on 3/19/22 to relieve<br>ift at 11:30 AM but she did<br>ent #4's treatment to her leg<br>ed. The DON stated Nurse<br>ad everything done and all<br>as wait for Nurse #5 to come<br>ON stated there had been<br>between the nurses which<br>t receiving her wound<br>days.<br>lentifiable Information<br>483.70(i)(1)-(5)<br>At-identifiable information that is<br>to the public.<br>lease information that is<br>to an agent only in<br>ntract under which the agent<br>lisclose the information<br>he facility itself is permitted<br>cords.<br>dance with accepted<br>s and practices, the facility<br>al records on each resident<br>ented;<br>e; and | F 684               |  |   |                   | 4/20/22                                   |

|                          | -  | D HUMAN SERVICES<br>MEDICAID SERVICES   |                     |                              |  | FORM              | ): 08/15/2023<br>APPROVED<br>0. 0938-0391 |
|--------------------------|--|---|---------------------|------------------------------|--|-------------------|---|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | E CONSTRUCTION               |  | (X3) DATE<br>COMP | SURVEY<br>LETED                           |
|                          |  | 345307  | B. WING             |                              | _  | (<br>03//         | C<br>24/2022                              |
| NAME OF PI               | ROVIDER OR SUPPLIER  |   | 1                   | STREET ADDRESS, CITY, ST     | ATE, ZIP CODE  |                   | -   |
|                          |  |   |                     | 4414 WILKINSON BLVD          |  |                   |   |
| THE IVY A                | T GASTONIA LLC   |   |                     | GASTONIA, NC 28056           |  |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORREC<br>CROSS-REFERE | PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BI<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                |
| F 842                    | all information contain<br>regardless of the form<br>records, except when<br>(i) To the individual, or<br>representative where<br>(ii) Required by Law;<br>(iii) For treatment, pay<br>operations, as permitt<br>with 45 CFR 164.506;<br>(iv) For public health a<br>neglect, or domestic w<br>activities, judicial and<br>law enforcement purp<br>purposes, research pur<br>medical examiners, fu<br>a serious threat to hea<br>by and in compliance<br>§483.70(i)(3) The faci<br>record information agai<br>unauthorized use.<br>§483.70(i)(4) Medical<br>for-<br>(i) The period of time<br>(ii) Five years from the<br>there is no requirement<br>(iii) For a minor, 3 yea<br>legal age under State<br>§483.70(i)(5) The med<br>(i) Sufficient information<br>(ii) A record of the res<br>(iii) The comprehensiv<br>provided; | and in the resident's records,<br>in or storage method of the<br>release is-<br>r their resident<br>permitted by applicable law;<br>yment, or health care<br>red by and in compliance<br>activities, reporting of abuse,<br>violence, health oversight<br>administrative proceedings,<br>oses, organ donation<br>urposes, or to coroners,<br>ineral directors, and to avert<br>alth or safety as permitted<br>with 45 CFR 164.512.<br>lity must safeguard medical<br>ainst loss, destruction, or<br>records must be retained<br>required by State law; or<br>e date of discharge when<br>int in State law; or<br>urs after a resident reaches<br>law.<br>dical record must contain-<br>on to identify the resident;<br>ident's assessments;<br>ye plan of care and services | F 842               |                              |  |                   |   |

|                          | MENT OF HEALTH AN<br>S FOR MEDICARE & I   |  |                   |     |   | FORM                                      | ): 08/15/2023<br>APPROVED<br>0. 0938-0391 |
|--------------------------|---|--|-------------------|-----|---|---|---|
| STATEMENT (              | DF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,               |     | CONSTRUCTION  | (X3) DATE<br>COMP                         | SURVEY<br>LETED                           |
|                          |   | 345307   | B. WING           |     |   |   | C<br>24/2022                              |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                   | ST  | IREET ADDRESS, CITY, STATE, ZIP CODE  |   |   |
|                          |   |  |                   | 44  | 14 WILKINSON BLVD   |   |   |
| THEIVYA                  | T GASTONIA LLC  |  |                   | G   | ASTONIA, NC 28056   |   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  |   | (X5)<br>COMPLETION<br>DATE                |
| F 842                    | <ul> <li>(v) Physician's, nurse</li> <li>professional's progres</li> <li>(vi) Laboratory, radiology</li> </ul>  | 's, and other licensed<br>ss notes; and<br>ogy and other diagnostic  | F                 | 842 |   |   |   |
|                          | This REQUIREMENT<br>by:<br>Based on record revi<br>facility failed to mainta<br>Administration Record<br>venous ulcer for 1 of 3<br>reviewed for wound ca<br>The findings included  | dmitted to the facility on<br>that included chronic  |                   |     | Resident #4 dressing change was<br>completed immediately<br>All residents receiving treatments have<br>the potential to be affected.<br>The Director of Nursing (DON) complet<br>a 100% audit was completed on<br>3/22/2022 of all residents who had<br>treatment orders to validate that the<br>wound care was provided as well as th<br>treatment was signed for completed. N   | ited                                      |   |
|                          | extremity.<br>The quarterly Minimum<br>assessment dated 2/7<br>was severely cognitive<br>dependent on staff as<br>The MDS further indic<br>total of three venous of<br>application of nonsurg<br>ointments/medications<br>A physician order date<br>indicated the following<br>leg: cleanse left lowe<br>with ¼ (antiseptic) sol<br>cream, cover with oil of<br>abdominal pads, wrap<br>roll and change daily of<br>A review of Resident a<br>Administration Record | m Data Set (MDS)<br>7/22 indicated Resident #4<br>ely impaired and was totally<br>sistance with bed mobility.<br>cated Resident #4 had a<br>ulcers and received<br>gical dressings and<br>s other than to feet.<br>ed 3/12/22 for Resident #4<br>g treatment to the left lower<br>r leg (medial and lateral)<br>ution, apply (antifungal)<br>emulsion dressings and<br>o site with a gauze bandage<br>every day shift. |                   |     | discrepancies were identified.<br>By 3/22/2022, the DON re-educated the<br>licensed nurses on regulation 483.25<br>regarding quality of care and ensuring<br>residents receive treatment and care<br>according to professional standards and<br>practice. Education included the<br>expectation of the licensed nurse to<br>provide wound care as ordered by the<br>physician, sign/initial and date dressing<br>with each dressing change. Make sure<br>TAR (treatment administration record)<br>signed to only reflect completion of<br>dressing changes.<br>The DON or Unit Manager will conduct<br>reviews of 3 residents TARs to ensure<br>that the treatment orders are signed for<br>completed and visually inspect resider<br>dressings to ensure it was changed,<br>signed, and dated. At a frequency of 3 | ne<br>nd<br>g<br>s<br>is<br>t<br>r<br>ts⊡ |   |

Facility ID: 923314

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## 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 03/24/2022 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 7 F 842 left lower leg was marked as completed by Nurse residents 3 times a week for 4 weeks. #3 on 3/17/22 and 3/18/22, Nurse #5 on 3/19/22 then one time a week for 8 weeks and and Nurse #4 on 3/20/22. then monthly. Schedule for QI monitoring will be modified based on findings. A phone interview with Nurse #3 on 3/21/22 at 2:10 PM revealed she worked with Resident #4 Results of QI monitoring will be recorded on 3/17/22 and 3/18/22 on the day shift from 7:00 will be reported to the QAPI (quality AM to 7:00 PM. Nurse #3 stated she knew she assurance performance improvement) was supposed to do Resident #4's treatment to committee monthly by the DON or her left lower leg but she didn't do it because the designee. The QAPI committee will wound doctor was scheduled to come to the evaluate the effectiveness of the facility on either 3/17/22 or 3/18/22 but she monitoring / observation tools for making couldn't remember which day he was supposed changes to the correction action if to come. Nurse #3 stated she couldn't remember necessary to maintain substantial signing off Resident #4's TAR on 3/17/22 and compliance. The QAPI committee 3/18/22 as completed even though she didn't do members consists of but not limited to the her treatment to her left leg. Administrator, DON, MD, and at least 3 other members. A phone interview with Nurse #5 on 3/23/22 at 5:11 PM revealed she came in at 1:00 PM on Completion date: 4/20/2022 3/19/22 and worked with Resident #4 until the night shift. Nurse #5 stated the Director of Nursing (DON) had the keys to her cart when she reported for work because Nurse #3 had already left at 11:30 AM. Nurse #5 stated she didn't do Resident #4's treatment to her left leg because she thought Nurse #3 had already done it on her shift and just forgot to mark it off on her TAR. Nurse #5 also stated she went ahead and marked it off as completed so that it won't be flagged as incomplete and extremely late. Nurse #5 stated it was difficult to follow up on tasks that needed to be done that day because there had been three nurses who had worked on the cart for one shift but normally, she would check the dressing first and make sure it was completed before she would mark it off as complete on the TAR.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 08/15/2023

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE       | CONSTRUCTION  | (X3) DAT     | O. 0938-039               |
|--------------------------|---|---|---------------------|---|--------------|---------------------------|
| ND PLAN OF               | FCORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING         | CON   | IPLETED<br>C |                           |
|                          |   | 345307  | B. WING             |   | 03           | 3/24/2022                 |
| NAME OF P                | ROVIDER OR SUPPLIER   |   | s                   | TREET ADDRESS, CITY, STATE, ZIP CODE  | •            |                           |
| THE IVY A                | AT GASTONIA LLC   |   |                     | 414 WILKINSON BLVD<br>GASTONIA, NC 28056  |              |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | OULD BE      | (X5)<br>COMPLETIO<br>DATE |
| F 842<br>F 888<br>SS=D   | A phone interview with<br>12:41 PM revealed sl<br>on 3/20/22 from 7:00<br>never got around to of<br>treatment to her left leg<br>went ahead and mark<br>care to her left leg as<br>when she got ready to<br>requested for her to of<br>she did, Resident #4<br>the bed. Nurse #4 st<br>oncoming shift, but sl<br>name of the nurse.<br>An interview with the<br>on 3/24/22 at 9:05 AN<br>should have document<br>on her left leg on the<br>completed it and if the<br>their shift, they should<br>had not been comple<br>communicated that it<br>the oncoming shift nu<br>COVID-19 Vaccination<br>CFR(s): 483.80(i)<br>COVID-19 Vaccination<br>must develop and imp<br>procedures to ensure<br>vaccinated for COVID<br>section, staff are cons<br>has been 2 weeks or<br>a primary vaccination<br>completion of a primar<br>COVID-19 is defined | th Nurse #4 on 3/21/22 at<br>he worked with Resident #4<br>AM to 3:00 PM but she<br>doing Resident #4's<br>eg. Nurse #4 stated she<br>ked Resident #4's wound<br>completed on the TAR<br>o do it but Resident #4 had<br>come back later and when<br>had already gotten up out of<br>ated she reported this to the<br>he could not remember the<br>Director of Nursing (DON)<br>M revealed the nurses<br>nted Resident #4's treatment<br>TAR after they had<br>ey weren't able to do it on<br>d have documented that it<br>ted and verbally<br>still needed to be done to<br>urse.<br>on of Facility Staff<br>(3)(i)-(x) | F 842               |   |              | 4/20/22                   |

Facility ID: 923314

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|                          | -   | D HUMAN SERVICES<br>MEDICAID SERVICES   |                   |     |  |  | FORM              | ): 08/15/2023<br>APPROVED<br>0. 0938-0391 |
|--------------------------|---|---|-------------------|-----|--|--|-------------------|---|
| STATEMENT (              | DF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,               |     | CONSTRUCTION                             |  | (X3) DATE<br>COMP | SURVEY<br>LETED                           |
|                          |   | 345307  | B. WING           |     |  | _  |                   | C<br>24/2022                              |
| NAME OF P                | ROVIDER OR SUPPLIER   |   |                   | S   | TREET ADDRESS, CITY, ST                  | ATE, ZIP CODE  | -                 |   |
| THE IVY A                | T GASTONIA LLC  |   |                   |     | 414 WILKINSON BLVD<br>GASTONIA, NC 28056 |  |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | (EACH CORRE)<br>CROSS-REFEREI            | PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BINCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                |
| F 888                    | Continued From page   | 9   | F                 | 888 |  |  |                   |   |
|                          | or resident contact, the<br>must apply to the follo<br>provide any care, treat<br>the facility and/or its m<br>(i) Facility employees<br>(ii) Licensed practitio<br>(iii) Students, trainees<br>(iv) Individuals who p<br>other services for the<br>under contract or by c<br>§483.80(i)(2) The pol<br>section do not apply to<br>(i) Staff who exclusive<br>telemedicine services<br>and who do not have<br>residents and other st<br>(1) of this section; and<br>(ii) Staff who provide<br>facility that are perform<br>the facility setting and<br>contact with residents<br>paragraph (i)(1) of this<br>staff who have pendir<br>been granted, exemp<br>requirements of this s<br>whom COVID-19 vacid<br>delayed, as recomme<br>clinical precautions an | s;<br>ners;<br>a, and volunteers; and<br>rovide care, treatment, or<br>facility and/or its residents,<br>other arrangement.<br>licies and procedures of this<br>o the following facility staff:<br>ely provide telehealth or<br>outside of the facility setting<br>any direct contact with<br>taff specified in paragraph (i)<br>d<br>support services for the<br>med exclusively outside of<br>who do not have any direct<br>and other staff specified in<br>s section.<br>licies and procedures must<br>n, the following components:<br>uring all staff specified in<br>s section (except for those<br>ng requests for, or who have<br>tions to the vaccination<br>ection, or those staff for<br>cination must be temporarily<br>nded by the CDC, due to<br>and considerations) have<br>m, a single-dose COVID-19 |                   |     |  |  |                   |   |

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|                          | -  | D HUMAN SERVICES<br>MEDICAID SERVICES  |                     |                             |   | FORM              | ): 08/15/2023<br>APPROVED<br>0. 0938-0391 |
|--------------------------|--|--|---------------------|-----------------------------|---|-------------------|---|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · /                 | PLE CONSTRUCTION            | -   | (X3) DATE<br>COMP | SURVEY<br>LETED                           |
|                          |  | 345307   | B. WING             |                             |   |                   | C<br>24/2022                              |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, S     | TATE, ZIP CODE  |                   |   |
|                          | T GASTONIA LLC   |  |                     | 4414 WILKINSON BLVD         |   |                   |   |
|                          | IT GASTONIA LEC  |  |                     | GASTONIA, NC 28056          |   |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRE<br>CROSS-REFERE | S PLAN OF CORRECTION<br>ECTIVE ACTION SHOULD B<br>ENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                |
| F 888                    | vaccination series for<br>vaccine prior to staff p<br>treatment, or other ser-<br>its residents;<br>(iii) A process for ens-<br>additional precautions<br>transmission and spre-<br>who are not fully vacco<br>(iv) A process for track<br>documenting the COV<br>all staff specified in pa-<br>section;<br>(v) A process for track<br>documenting the COV<br>any staff who have of<br>as recommended by to<br>(vi) A process for track<br>documenting information<br>(vii) A process for track<br>documenting information<br>(viii) A process for track<br>documenting information<br>who have requested,<br>has granted, an exem<br>COVID-19 vaccination<br>(viii) A process for en-<br>documentation, which<br>clinical contraindication<br>and which supports si<br>exemptions from vacco<br>and dated by a licens-<br>the individual request<br>is acting within their re<br>as defined by, and in<br>applicable State and I<br>ensuring that such do<br>(A) All information spe<br>authorized COVID-19 | a multi-dose COVID-19<br>providing any care,<br>rvices for the facility and/or<br>auring the implementation of<br>s, intended to mitigate the<br>ead of COVID-19, for all staff<br>inated for COVID-19;<br>king and securely<br>/ID-19 vaccination status of<br>aragraph (i)(1) of this<br>king and securely<br>/ID-19 vaccination status of<br>otained any booster doses<br>the CDC;<br>th staff may request an<br>taff COVID-19 vaccination<br>on an applicable Federal law;<br>tking and securely<br>icon provided by those staff<br>and for whom the facility<br>option from the staff<br>n requirements;<br>suring that all<br>o confirms recognized<br>ons to COVID-19 vaccines<br>taff requests for medical<br>cination, has been signed<br>ed practitioner, who is not<br>ing the exemption, and who<br>espective scope of practice<br>accordance with, all<br>ocal laws, and for further<br>cumentation contains: | F 88                | 38                          |   |                   |   |

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|  |   | D HUMAN SERVICES   |                    |     |  | FORM            | APPROVED<br>0. 0938-0391   |
|--|---|--|--------------------|-----|--|-----------------|----------------------------|
| CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER: |   |  |                    |     | (X3) DATE<br>COMP  | SURVEY<br>LETED |                            |
|  |   | 345307   | B. WING            |     |  |                 | C<br>24/2022               |
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                    | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  |                 |                            |
|  |   |  |                    | 4   | 414 WILKINSON BLVD   |                 |                            |
| THE IVY A  | T GASTONIA LLC  |  |                    | G   | GASTONIA, NC 28056   |                 |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   |                 | (X5)<br>COMPLETION<br>DATE |
| F 888  | and the recognized cl<br>contraindications; and<br>(B) A statement by the<br>recommending that the<br>exempted from the fave<br>vaccination requirement<br>recognized clinical co<br>(ix) A process for ensist<br>secure documentation<br>staff for whom COVID<br>temporarily delayed, a<br>CDC, due to clinical p<br>considerations, including<br>individuals with acute<br>COVID-19, and individe<br>monoclonal antibodie<br>for COVID-19 treatment<br>(x) Contingency plans<br>vaccinated for COVID<br>Effective 60 Days Afte<br>§483.80(i)(3)(ii) A pro-<br>staff specified in para<br>are fully vaccinated for<br>those staff for whom C<br>be temporarily delaye<br>CDC, due to clinical p<br>considerations;<br>This REQUIREMENT<br>by:<br>Based on record revif<br>facility failed to impler<br>for tracking COVID-19<br>3 staff reviewed for C<br>(Nurse #1). The facility | inical reasons for the<br>a authenticating practitioner<br>be staff member be<br>cility's COVID-19<br>ents for staff based on the<br>ntraindications;<br>uring the tracking and<br>n of the vaccination status of<br>0-19 vaccination must be<br>as recommended by the<br>orecautions and<br>ling, but not limited to,<br>illness secondary to<br>duals who received<br>s or convalescent plasma<br>ent; and<br>a for staff who are not fully<br>0-19.<br>er Publication:<br>bcess for ensuring that all<br>graph (i)(1) of this section<br>or COVID-19, except for<br>been granted exemptions to<br>ements of this section, or<br>COVID-19 vaccination must<br>d, as recommended by the | F                  | 888 | The Director of Nursing reviewed the<br>listing on 3/21/2022 of the facility<br>employees, licensed practitioners,<br>students, trainees, and volunteers and<br>contract personnel to ensure completion<br>of a primary vaccination series for COV<br>and/or exemption waiver has been |                 |                            |

Facility ID: 923314

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PRINTED: 08/15/2023

|                          | -   | D HUMAN SERVICES   |                     |   | FOR   | D: 08/15/2023<br>M APPROVED        |
|--------------------------|---|--|---------------------|---|---|------------------------------------|
| STATEMENT C              | DF DEFICIENCIES<br>CORRECTION   | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | CONSTRUCTION  | (X3) DATE   | D. 0938-0391<br>E SURVEY<br>PLETED |
|                          |   | 345307   | B. WING             |   |   | C<br>/ <b>24/2022</b>              |
| NAME OF PF               | ROVIDER OR SUPPLIER   |  | S                   | TREET ADDRESS, CITY, STATE, ZIP CODE  | 1 00  |                                    |
|                          |   |  | 44                  | 414 WILKINSON BLVD  |   |                                    |
|                          | T GASTONIA LLC  |  | G                   | ASTONIA, NC 28056   |   |                                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY)  | IOULD BE  | (X5)<br>COMPLETION<br>DATE         |
| F 888                    | Continued From page   | 12   | F 888               | submitted.  |   |                                    |
|                          | The findings included:  | :  |                     | Submitted.  |   |                                    |
|                          | A review of the facility<br>Vaccination, undated<br>vaccinations will be of<br>Disease Control (CDC<br>Administration (FDA))<br>immunization is medic<br>individual has already<br>time period or refuses<br>The facility staff vaccin<br>reviewed. The spread<br>staff, staff exemptions<br>A review of the facility<br>Nurse #1 was docume<br>dose of the Moderna<br>A review on 3/21/22 of<br>Safety Network (NHS)<br>on 3/6/22 revealed the<br>information:<br>Recent Percentage of<br>Vaccinated = 83.5%<br>A phone interview cor<br>3/21/22 at 3:52 PM re<br>her first dose of the C<br>1/26/22 but had not re<br>Nurse #1 further reveat<br>take her second dose<br>was the expiration dat | 's policy titled COVID-19<br>read in part: 2. COVID-19<br>fered as per Centers for<br>C) and/or Food and Drug<br>guidelines unless such<br>cally contraindicated, the<br>been immunized during this<br>to receive the vaccine.<br>Ination spreadsheet was<br>sheet included in-house<br>a, and contract/agency staff.<br>spreadsheet revealed<br>ented for receiving only one<br>vaccination dated 1/26/22.<br>If the National Healthcare<br>N) data for the week ending<br>e following staff vaccination<br>E Staff who are Fully<br>inducted with Nurse #1 on<br>vealed she had received<br>OVID-19 vaccine on<br>eceived a second dose.<br>aled she did not need to<br>until 3/27/22 because that<br>te on her card. Nurse #1<br>d her the second dose of the |                     | Individuals that have not submitt<br>of completion of their vaccination<br>and/or exemption waiver will not<br>allowed to enter the facility or re-<br>work until provided.<br>Director of Nursing and/ or Infect<br>Preventionist will ensure complia<br>COVID 19 documentation regard<br>vaccination completion and / or<br>exemptions for all facility employ<br>licensed practitioners, students,<br>and volunteers and contract pers-<br>utilizing the COVID 19 spreadsh<br>ensure all documentation is rece<br>data accuracy<br>Results of ongoing COVID 19 va<br>tracking will be reported to the Q<br>(quality assurance performance<br>improvement) committee month<br>DON or designee. The QAPI cor<br>will evaluate the effectiveness of<br>monitoring / observation tools for<br>changes to the correction action<br>necessary to maintain substantia<br>compliance. The QAPI committee<br>members consists of but not limi<br>Administrator, DON, MD, and at<br>other members.<br>Completion date: 4/20/2022 | n series<br>be<br>port to<br>tion<br>ance of<br>ding<br>vees,<br>trainees,<br>sonnel by<br>eet to<br>sived for<br>accination<br>API<br>y by the<br>mmittee<br>the<br>r making<br>if<br>al<br>se<br>ted to the |                                    |
|                          | An interview conducte   |  |                     |   |   |                                    |

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| DEPARTMENT OF HEALTH AND HUMAN SERVICES<br>CENTERS FOR MEDICARE & MEDICAID SERVICES |  |   |   |   |                       | PRINTED: 08/15/2023<br>FORM APPROVED<br>OMB NO. 0938-0391 |                            |
|---|--|---|---|---|-----------------------|---|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                 |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |   |                       | (X3) DATE SURVEY<br>COMPLETED                             |                            |
|   |  | 345307  | B. WING   |   | -                     | C<br>03/24/2022   |                            |
| NAME OF PROVIDER OR SUPPLIER  |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE   |   |                       |   |                            |
|   |  |   | 4414 WILKINSON BLVD   |   |                       |   |                            |
| THE IVY AT GASTONIA LLC   |  |   | GASTONIA, NC 28056  |   |                       |   |                            |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |   | ID PROVIDER'S PLAN OF CORRECTION<br>PREFIX (EACH CORRECTIVE ACTION SHOULD<br>TAG CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) |   | TIVE ACTION SHOULD BE |   | (X5)<br>COMPLETION<br>DATE |
| F 888   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                      |   | F 888   | ID PROVIDER'S PLAN OF CORRECTION<br>PREFIX (EACH CORRECTIVE ACTION SHOULD<br>TAG CROSS-REFERENCED TO THE APPROP |                       |   |                            |

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