PRINTED: 10/25/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345307	B. WING		I	C / 27/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	investigation survey through 08/23/24. A obtained on 8/26/24, 8/27/24. The facility		F 00	00		
	survey was conducted 08/23/24. The correct validated on 08/27/24 was changed to 8/27 The following complainvestigated: NC002 NC00210913, NC002	17416, NC00205580, 211258, NC00215834, C00220894. 3 of the 14				
	Past-noncompliance CFR 483.25 at tag F J.	e was identified at: 684 at a scope and severity				
	CFR 483.25 at tag F J.	689 at a scope and severity				
	The tags F684 and F Quality of Care.	689 constituted Substandard				
	An extended survey	was conducted.				
	and was removed or Jeopardy for F689 be removed on 10/10/23					
F 552		/Make Treatment Decisions	F 55			10/1/24
.aboratory i	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATURI	=	TITLE		(X6) DATE

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

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.

Electronically Signed

09/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 08/27/2024
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F 552	2 Continued From page 1		F 5	52		
SS=D	CFR(s): 483.10(c)(1)(4)(5)				
	§483.10(c) Planning The resident has the participate in, his or §483.10(c)(1) The rigilanguage that he or her total health statuthis or her medical colors (2483.10(c)(4) The rigadvance, of the care of care giver or professional, of the rigadvance, by the phyprofessional, of the rigadvance, of treatment ar treatment options an option he or she president in the statuth of the rigadvance.	and Implementing Care. right to be informed of, and her treatment, including: ght to be fully informed in she can understand of his or s, including but not limited to, andition. ght to be informed, in to be furnished and the type essional that will furnish care. ght to be informed in sician or other practitioner or isks and benefits of proposed and treatment alternatives or d to choose the alternative or				
	Based on record reversion (RP) interview the RP of a follow-up scheduled procedured Resident #19 urolog follow-up recomment to diagnose, monitor affecting the bladder recommended and sexident #19's RP was recommendations for on 6/04/24. This definition of the RP interview of the RP int	views, staff, and responsible ws, the facility failed to notify o urologist appointment for a e for Resident #19. During y appointment on 5/31/24, a dation for a cystoscopy (used , and treat conditions and urethra) procedure was cheduled for 6/04/24. vas not notified of the r the scheduled cystoscopy cient practice affected 1 of 3 or notification (Resident #19).		This Plan Of Correction const facilities written allegation of county with the deficiencies cited. Ho submission of this Plan of Cornot an admission that a deficient or that one was cited correctly of Correction is submitted to not requirements established by agreement by the provider of the facts alleged or the correct conclusions set forth in the state deficiencies. The Plan of Correction prepared and submitted solely requirements under state and laws.	compliance wever, rection is ency exists r. This Plan neet state of the the truth of tness of the atement of ection is r because of	

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NAME OF D	ROVIDER OR SUPPLIER	0-2007	1	STREET ADDRESS, CITY, STATE, ZIP CODE	08	3/27/2024
NAME OF FI	NOVIDER OR SUFFLIER					
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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 552	F 552 Continued From page 2		F 55	2		
	2/20/24 with diagnose reflex uropathy (block draining properly and	mitted to the facility on es including obstructive and kage preventing urine from cause urine to back-up into ntion, and use of indwelling		(1) Address how the corrective to be accomplished for those reside found to have been affected by the deficient practice; " All Residents have the poter affected by the deficient practice	ents he ntial to be	
	dated 5/25/24 revealed moderately cognitived having an indwelling Review of urology off revealed in part Residuate for urinary retenvoiding trials. Follow-	y impaired and assessed as catheter. ice note dated 5/31/24 dent #19 was seen on this tion and previously failed up recommendation for cystoscopy procedure in		(2) Address how the facility will other residents having the potent affected by the same deficient pr " The last 30 days of appoint to be reviewed by Admin Nursing To ensure all Responsible parties at on any follow up appointments a new appointments for current res Audit will be completed by 9/30/2	tial to be actice; nents will eam to re notified nd/or any sidents.	
	revealed in part Residurology office on this cystoscopy for urinary completed, Resident well, and follow-up retreatment included a implants placed to lift the way and allowing	y retention. Cystoscopy was #19 tolerated procedure commendations for referral for a Urolift (small or hold excess tissue out of urine to flow more freely)		(3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. " The Assistant Director of Nursing/Designee will educate Scheduler/Transportation Aide on		
	retention. A telephone interview 8/21/24 at 9:28 AM reguardian for Residen for reviewing all recorappointments. She st	vith longstanding urine viconducted with the RP on evealed she was the legal t #19 and was responsible mmendations from medical rated Resident #19 was seen 31/24 for urinary retention		ensuring all Responsible Parties made aware of any new or upcor Resident appointments. Education completed by 9/30/24. " The Assistant Director of Nursing/Designee will educate all nurses on ensuring all new admir Residents paperwork is reviewed upcoming appointments and giving	ming on will be Il licensed tted d for any	

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			A. BOILDI	_			С	
		345307	B. WING				/27/2024	
NAME OF P	ROVIDER OR SUPPLIER	2.000		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2112024	
	10115211 011 001 1 21211				414 WILKINSON BLVD			
THE IVY A	T GASTONIA LLC				GASTONIA, NC 28056			
0(0)15	CLIMMADY CT	ATEMENT OF DEFICIENCIES	10				0/5)	
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F 552	Continued From page	e 3	F	552				
	with recommendation			-00	to the scheduler/Transportation Aide to	,		
		4. She revealed the facility			ensure Responsible Parties are notified			
	transported Resident	_			about appointments. Education will be			
	urology appointment				completed by 9/30/24.			
		e. Resident #19's RP stated			" The Assistant Director of			
	she was not made av	vare of the			Nursing/Designee will educate all licen	sed		
		m Resident #19 urology			Nurses on reviewing all after summary			
		24 for the cystoscopy			visits and give all follow-up appointmer			
	l ·	prior to his appointment.			to the scheduler/transportation aide for			
		s notified by the Director of			notification to Responsible Parties.	1		
		05/24 of the outcome and dations from the urology			Education will be completed by 9/30/24 " The Director of Nursing/Designee			
		cedure on 6/04/24, and she			educate Admin Nursing team on brining			
	1	at she had not been made			all after summary visits and new reside			
		endations from Resident			packets to clinical meeting to ensure a			
	#19 urology appointm	nent on 5/31/24 or of the			follow up and/or new appointments have			
	scheduled cystoscop	y that was completed on			had Responsible Parties notified.			
		he DON was not aware			Education will be completed on 9/30/24			
		ad not been notified of the			" Education will be added to License	∍d		
		m Resident #19 urology			Nursing and Scheduler/Transportation			
		24 or of the scheduled			Aide new hire orientation. Education w			
		4 and assumed the urology sident #19's RP of the			be provided by the Assistant Director o Nursing/Designee.	ı		
		dure. Resident #19's RP felt			Nursing/Designee.			
		e contacted her about the			(4) Indicate how the facility plans to			
	·	m Resident #19 urology			monitor its performance to make sure t	hat		
		24 and the scheduled			solutions are sustained;			
	cystoscopy on 6/04/2	4 to assure that she was						
		of assuming the urology			" The Director of Nursing/Designee			
	office would contact h	ner.			ensure all Responsible Parties have be			
		DOM: 0/04/04 1			notified about any new and/or follow up			
		DON on 8/21/24 at revealed			appointments 5 days a week for 4 week	KS,		
		Resident #19 and his RP			then 3 days a week for 4 weeks and			
	_	ollow-up recommendations ire. She stated normally she			weekly for 4 weeks during clinical meeting.			
	would always notify a	_			" The results of the audits will be			
	follow-up recommend	_			discussed during the monthly Quality			
	· ·	ointments. She revealed in			Assurance Meeting for tracking, trending	na.		
	1 *	nt #19. she had received the			and recommendations from the IDT tea	-		

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no.				44	414 WILKINSON BLVD			
THE IVY A	T GASTONIA LLC			G	ASTONIA, NC 28056			
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F 552	appointment on 5/31/cystoscopy on 6/04/2 office had contacted recommendations an stated failing to notify the follow-up recommurology procedure was human error on her pnot made aware Resmade aware of the reurology appointment cystoscopy on 6/04/2 on 6/05/24 to discuss recommendations from realized Resident #19/1 the follow-up recommoversescopy. She statistically were responsible for notified of resident apprecommendations from follow-up appointment were provided with an interview with the revealed she was fart the incident with his furology appointment.	dations from his urology /24 for a scheduled /4 and assumed the urology Resident #19's RP about the d procedure. The DON / Resident #19's RP about nendations and scheduled as just an oversight or part. She revealed she was ident # RP had not been recommendations from his on 5/31/24 for the scheduled /4 until she contacted the RP // the follow-up // she follow-up // method the result of the // the scheduled // and in the cystoscopy and // she follow-up // method the result of the // the scheduled // the schedule	F	552	for 3 months.			
	revealed she was far the incident with his f urology appointment scheduled cystoscop although the DON an notify all resident RPs recommendations fro scheduled procedure usually notify the RPs	niliar with Resident #19 and RP not being notified of his recommendations for a y on 6/04/24. She stated and nursing staff typically do s of any follow-up						

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F 641 SS=B	DON assumed the un Resident #19's RP an after the scheduled pheen notified. The Adshould have contacted the follow-up recommappointment on 5/31 procedure on 6/04/24 and nursing staff worsure all resident RPs follow-up recomment procedures from app Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record revitable facility failed to accur Data Set assessmen (Resident #1, #6, and (Resident #1 and Reresidents reviewed for The findings included a. Resident #1 was a 1/25/24 with diagnos respiratory failure with obstructive pulmonar A review of Resident revealed an order data	rology office had contacted and was not made aware until procedure the RP had not diministrator stated the DON and Resident #19's RP about mendations from his urology (24 and his scheduled 4, moving forward the DON ald be responsible for making were made aware of any dations or scheduled ointments. The is not met as evidenced siew and staff interviews the ately code the Minimum to (MDS) for oxygen use down the sident #4) for 4 of 5 or accuracy of assessments. The is admitted to the facility on the state included chronic to the hypoxia and chronic to the disease (COPD). #1's physician orders the total results and the physician orders the ously via nasal cannula at 3	F 64		the

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NAME OF T	NOVIDER OR SOLT LIER			4414 WILKINSON BLVD		
THE IVY A	T GASTONIA LLC					
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F 641	Continued From page	ed From page 6 F 641				
				" Review of MDS open asses	ssments	
	A review of Resident	#1's medical record		for accuracy prior to submission		
		mitted to hospice services		completed by the administrative		
	on 2/8/24. A review of the quarterly Minimum Data Set assessment (MDS) dated 5/20/24 indicated Resident #1 was not coded for receiving hospice services or oxygen.			team by 9/30/24.	· ·	
				(3) Address what measures wi		
				into place or systemic changes		
				ensure that the deficient practice occur;	e will not	
b. Resident #6 was admitted to the		admitted to the facility on		" The VP of Clinical		
	10/4/22 with diagnoses that included COPD,			Reimbursement/Designee will e	ducate the	
	_	onic respiratory failure.		Interdisciplinary Team (MDS, Di		
				Manger, Registered Dietician, S		
	A review of Resident	#6's physician orders		Services, Activities Director, and	d Therapy	
	revealed an order dat	ed 5/20/24 for oxygen to be		Manager) and other department	heads	
	administered via nasa	al cannula at 2 lpm as		responsible for completing secti	ons of the	
	needed.			MDS on the accuracy of MDS		
				assessments. Education will be		
	-	erly MDS assessment dated		completed by 9/30/24.		
		sident #6 was not coded for		" Education will be added to		
	receiving oxygen.			Department Head orientation. E		
				will be provided by the VP of clin	nical	
		dmitted to the facility on		Reimbursement/Designee.		
	_	es including nontraumatic		(4) Address how the facility pla	na ta	
	intracranial hemorrha			(4) Address how the facility pla		
	-	by trauma) and obstructive		monitor its performance to make solutions are substained;	sule mai	
	sleep apnea.			solutions are substained,		
	A review of Resident	#8's physician orders		" The VP of clinical services	will	
		ed 6/14/24 for oxygen		conduct 10 MDS assessment re		
	delivered via nasal ca	annula at 2 lpm as needed.		confirm the accuracy of assessr		
				prior to submission weekly for 4		
		sion MDS dated 6/19/24		then 5 MDS assessment review	•	
	indicated Resident #8	B was not coded for receiving		for 4 weeks, then 1 MDS assess	sment	
	oxygen.			review weekly for 4 weeks.		
				" The results of the reviews v		
	An interview was con			discussed during the monthly Q		
	Coordinator on 8/22/2	24 at 1:25 PM. She stated		Assurance meeting for tracking,	trending,	

Facility ID: 923314

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F 684 SS=J	they were receiving of MDS assessment shoreflect she was received oxygen. She further sinaccuracies were an An interview conducte 8/22/24 at 3:10 PM reflect she was assessment to be described. Resident #4 was as 01/09/24 with a diagran non-Alzheimer's demondered with the was admitted to be 08/01/24. A significant change if Set (MDS) assessment Resident #4 was not services. An interview with the 08/23/24 at 11:39 AM significant change MD to reflect she was receit was an oversight.	sident #8's MDS have been coded to reflect xygen and Resident #1's build have been coded to ring hospice services and tated the coding oversight on her part. But with the Administrator on evealed she expected the fine coded accurately. Individual record revealed codes services on In condition Minimum Data ant dated 08/02/24 revealed coded as receiving hospice MDS Coordinator on a revealed Resident #4's DS should have been coded eiving hospice services, and In with the Director of Nursing is 10:29 AM revealed she		641	and recommendations from the IDT teafor 3 months.	m	
	§ 483.25 Quality of ca	are					

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F 684	Continued From page Quality of care is a frapplies to all treatmer facility residents. But assessment of a residents receive accordance with propractice, the comprescare plan, and the residents record revenue care plan, and the resident facility's contracted to facility's contracted to leave Resident assessment of injury during transport. Residents properly the contract transport values of Resident #12 wheelchair onto the van off to the side of Resident #12 off the wheelchair and contider plans of the side of the comprehensive physical services as a facility of the side of the comprehensive physical services and the side of the comprehensive physical services and the side of the comprehensive physical services as a facility of the side of the comprehensive physical services and the side of the side of the comprehensive physical services are side of the side	undamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure e treatment and care in fessional standards of hensive person-centered esidents' choices. T is not met as evidenced view, resident, staff, physician ent company interviews, the transport driver (Driver #1) ent #12 in place for a clinical eafter a fall that occurred sident #12 was being m a medical appointment in a en while unsecured in her made a sudden stop which to to fall forward out of her evan floor. Driver #1 pulled the the road and transferred van floor back into her inued back to the facility. lialified to provide a	F 6	DEFICIENCY)			
	facility staff of the re- notified staff of the fa- assessed by nursing swelling and a skin to hospital computed to revealed Resident # (away from the cente the femur (break in to due to her fall in the	acility, Driver #1 did not notify sident's fall. Resident #12 all in the van and was a staff and noted to have ear to her left knee. A prography (CT) scan 12 had suffered a distaller of the body) left fracture to bone above left knee joint) van. This deficient practice ampled residents reviewed esident #12).					

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F 684	Continued From pag	e 9	F 6	84			
	The findings include	d:					
	3/26/21. Diagnoses (MS), muscle weakn knee, hip, wrist, and Review of quarterly dated 9/20/23 reveal cognitively intact, util mobility, and dependence Resident #12 was all	dmitted to the facility on included multiple sclerosis ess, contractures of the left of the right knee and hip. Winimum Data Set (MDS) ed Resident #12 was lized a wheelchair for lent for assist with transfers. so coded as having on-going					
	Review of a physicia revealed Resident # (used for pain) 300 r	n order dated 10/01/23 12 received Gabapentin nilligrams (mg) 1 tablet by as needed (prn) for pain.					
	revealed Resident #	n order dated 10/01/23 12 received Acetaminophen iin) 650 mg 1 tablet by mouth eded for mild pain.					
	through 10/5/23 reversible administrations of Remedications Gabape Acetaminophen 650 - 10/1/23: Gabape 1) (on a scale of 1 to pain possible) - 10/2/23: Acetamilevel 0), Acetaminop - 10/3/23: Gabape	rd (MAR) from 10/1/23 caled the following cesident #12's prn pain centin 300 mg and mg: centin at 10:44 AM (pain level control 10 with 10 being the worst co					

AND BLAN OF CORRECTION IDENTIFICATION NUMBER		LE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	level 1), Acetaminop 10/5/23: Acetar level 0), Gabapentin Review of facility va 10/05/23 written by "[Resident #12] fell fi pressed the brakes transported by outsi stated, "he slammed the floor, he picked chair". Assessment company owner not signs taken, skin as: Review of Driver #1' indicated, "[Driver # through greenlight, s [Resident #12] went against driver seat of A phone interview w but he was unable to An interview was co 08/20/24 at 11:00 Al had been transported transport company a facility, Driver #1 ha the van but forgot to wheelchair, so wher stop she fell out of he floor. She stated Dri side of the road and wheelchair and trans facility. Resident #12 back to the facility, se	ninophen at 7:55 AM (pain when at 7:58 PM (pain level 0) ninophen at 5:19 AM (pain at 3:01 PM (pain level 2) In incident report dated Unit Manager #1 read in part: from chair after [Driver #1] while out of facility being de services. [Resident #12] If on the brakes, and I fell on me up and put me back in completed, transport fied, physician notified, vital sessment completed. Is statement dated 10/5/23 at was driving on my way suddenly had to brake, forward and hit her knee hair." The as attempted with Driver #1, to be reached. Inducted with Resident #12 on the reached on 10/05/23 sheed to an appointment by the land on her way back to the desecured her wheelchair in	F 6	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 08/27/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	her for injuries and a swollen some and h not in any real pain. believed Driver #1 s for help after the fall	ner what happened, assessed at the time her left knee was ad a skin tear, but she was Resident #12 revealed she hould have either called 911 prior to putting her back into	F 6	84		
	Review of a physicia revealed an order for completed on Resid left knee, left tibia (lo knee joint, and form	an order dated 10/05/23 or a mobile x-ray to be ent #12's left ankle, left foot, ocated on inside of leg, below is top of ankle joint), and left atside of leg, below knee joint, kle joint).				
	10/06/23 indicated of a fall from her whee Resident #12's left k complained of increaleft knee and leg, ar been received. Ibup days and Tylenol 50	I physician note dated on 10/05/23, Resident #12 had lichair on transportation van. Innee was swollen, she ased pain at a level 10 in her ad her x-ray results had not rofen 400 mg twice daily for 3 0 mg three times daily for 3 or Resident #12's acute pain				
	#12 dated 10/06/23 twice daily for 3 day	nysician orders for Resident indicated Ibuprofen 400 mg s for acute pain post fall and e times daily for 3 days for				
	Resident #12's left k displaced (more cor are out of alignment	x-ray dated 10/06/23 of tnee revealed a moderately nplex fracture because bones or in pieces) distal left of indeterminate age (not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345307	B. WING _			C 08/27/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	· · · · · · · · · · · · · · · · · · ·	00/2//2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Review of an on-cal 10/06/23 revealed F were reviewed with on-call physician incand follow-up with the physician was recorn. Review of Resident Administration Record through 10/8/23 revealed ministrations of R medications Tylenol mg and prn pain me - 10/6/23: Gabape 2), Tylenol at 2:00 F Ibuprofen at 8:00 Pl PM (pain level of 0), (pain level 1) - 10/07/23 Tylenol Gabapentin at 7:35 8:00 AM (pain level level 0), Gabapentin Ibuprofen at 8:00 Pl 10:00 PM (pain level level 0), Gabapentin Ibuprofen at 8:00 Pl 10:00 PM (pain level pain level of 0) Review of an on-cal 10/08/23 revealed F pain in her stomach requested to be sen	by long-ago fracture billow-up was recommended. If physician note dated desident #12's x-ray results no new treatment orders. The licated to continue to monitor ne resident's primary care nmended. #12's Medication ord (MAR) from 10/6/23 dealed the following desident #12's pain 500 mg and Ibuprofen 400 dication Gabapentin 300 mg: dicati	F6	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 08/27/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		00/21/2024
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F 684	10/09/23 revealed Femergency departments of breath abrasion and edem and a CT scan was distal femur fracture possible bruising to The consulting ED pany emergency interpretation of the consulting ED pany emerge	Resident #12 was seen at nent (ED) for a fall and a (swelling) to the left knee obtained and revealed a con the left and some the ribs as a result of the fall. Provider did not recommend the resident was an early of the facility and wheelchair bound. Discharged back to the facility approxen (treat fever and pain) wice daily and follow-up with the Resident #12 on 8/20/24 at aled on the day after the fall a had gotten worse around her cility administered her pain mpleted an x-ray of her left couple of days later (10/08/23) some trouble breathing and hospital where they confirmed the left leg and bruised her ribs Resident #12 revealed the ead her some more pain the roan orthopedist, and a facility.	F 6	· ·		
	afternoon of 10/05/2 the facility by herse after being transpor by their contract tra stated that she had	nt #12. She stated on the 23, Resident #12 had entered If in her electric wheelchair ted to a medical appointment insport company. The resident fallen on the van and Driver ind placed her back into her				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345307	B. WING				27/2024
	ROVIDER OR SUPPLIER		•	4	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	to the facility. She (the immediately assessed noted a skin tear to he swelling. The DON's physician of Residen received an order for knee. A mobile x-ray and revealed a distable to the fracture due to Reside follow-up was recomfon-call physician was did not order any furthey the facility physician when the facility physician when the requested to be sentiphysician was notified for her to be sent out completed at the hose Resident #12 had sufferent with an order to follow outpatient. The DON #12 had fallen into the have immediately comedical personnel to #12 prior to moving here.	fall and transported her back the DON) revealed she and Resident #12 for injury and ther left knee with some	F	684			
	familiar with Residen on 10/05/23. He state the accident had occ	v conducted with the at 4:55 PM revealed he was t #12 and her fall on the van ed he was notified on the day urred and approved a mobile					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	(X3) DATE SURVEY COMPLETED	
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		345307	B. WING _		•	8/27/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE		
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD			
	NI GAGIONIA LLO			GASTONIA, NC 28056			
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F 684	Continued From page	age 15	F	684			
	due to her left kner revealed the mobil the hospital both s suffered a left leg that and recommended orthopedic. The properties of the properties demineralization (In the properties of the pro	e showing signs of swelling. He e x-ray and the CT scan from howed Resident #12 had femur fracture due to the fall follow-up with outpatient sysician stated Resident #12 sed her to have contractures in					
	was familiar with F 10/05/23, Residen their contract trans appointment. She arrived back at the that during her trans was not secured in fallen out of her will Resident #12 state van and assisted his brought her back to revealed while the #12 for injury and #1 came into the fainterview him (Driving he refused to give	conducted with the //21/24 at 5:27 PM revealed she desident #12. She stated on the transported by sport company to an indicated when the resident facility, the resident reported asport back to the facility she at the her wheelchair and had neelchair onto the van floor. In the desire that the facility. The Administrator DON was assessing Resident contacting the physician, Driver acility and she attempted to er #1) about the incident, but statement and left the facility. Indicated she contacted the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 08/27/2024	
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F 684	them about the incice the transport compared a written statement with and was able to a van to corroborate in how the fall occurrence secured into her who contact medical personal for transport company, employed with the corror education on a included notifying the personnel when a rean accident prior to proceeding forward. A telephone interviee Contract Transport of at 9:29 AM indicated by the facility of the #1 and Resident #1: written statement frovideo footage from the statement	Company Owner to notify lent. She stated the owner of ny assisted her with receiving about the incident from Driver view camera footage from the Resident #12's statement of d, that she had not been eelchair, and Driver #1 did not sonnel to assess her the fall prior to transporting The Administrator revealed affered a left leg femur ribs from the fall. She stated formation received from the Driver #1 was no longer ompany and had received coident protocols which e facility and medical esident had been involved in moving resident or	F 6	· · · · · · · · · · · · · · · · · · ·			
	wheelchair onto the the fall, Driver #1 pu Resident #12 back i transported her back Driver #1 was no lor company and all driv transporting on van	sident #12 fell out of her van floor. He revealed after lled the van over, assisted into her wheelchair and is to the facility. He stated inger employed with the vers received training prior to safety and the protocol on dent occurred. The Contract					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 08/27/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 4414 WILKINSON BLVD GASTONIA, NC 28056		33/21/2324
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 684	Continued From page 17 Transport Company Owner stated Driver #1		F6	584		
	should have pulled of contacted 911 and the Resident #12 to be a	over, stopped the van, ne facility, and waited for assessed by medical er being moved to prevent any				
	8/22/24 at 5:50 PM. The facility provided action plan: 1. Address how co	the following corrective orrective action will be ose residents found to have deficient practice;				
	"The identified resident (Resident #12) is still a current Resident at the facility. Resident #12 was picked up by a contract transportation driver from a scheduled neurology appointment for transport back to the facility. Prior to leaving the appointment, the contracted driver secured Resident #12 wheelchair, but failed to secure Resident #12 seatbelt leaving her unsecured. During transport, the contracted driver had to slam on brakes causing Resident #12 to fall forward from her wheelchair into the van floor. Contracted Driver pulled off road and assisted Resident #12 back into her wheelchair and then continued to transport Resident #12 back to the facility. Contracted Driver failed to contact 911 and/or facility prior to moving Resident #12 from van floor and prior to placing her back into wheelchair after fall. The following actions after this incident:					
	investigation on 10/5 " On 10/5/23, Res	facility initiated immediate 5/23. sident #12 medical director e person (RP) made aware				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING	B. WING		C 8/27/2024	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 4414 WILKINSON BLVD GASTONIA, NC 28056		0/2//2024	
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F 684	" On 10/5/23, Ord left ankle, left foot, left bula. " On 10/6/23, Reson a level of 10 on a new orders obtained 400mg take 1 tablet for acute pain post fatab by mouth three tipain s/p fall. Pain mescale of 0 noted. " On 10/6/23, x-rashowed the following or dislocation is iden osteoporotic. Left and dislocation or osseon osteoporotic. Left Kn fracture of the distal indeterminate age. Neft Foot-soft tissue structures are osteop dislocation is identification in the distal indeterminate age. Neft Foot-soft tissue structures are osteop dislocation is identification in the distal indeterminate age. Neft Foot-soft tissue structures are osteop dislocation is identification in the distal indeterminate age. Neft Foot-soft tissue structures are osteop dislocation is identification in the distal indeterminate age. Neft Foot-soft tissue structures are osteop dislocation is identification. In the distal indeterminate age. Neft Foot-soft tissue structures are osteop dislocation is identification. In the distal indeterminate age. Neft Foot-soft tissue structures are osteop dislocation is identification. In the distal indeterminate age. Neft Foot-soft tissue structures are osteop dislocation is identification. In the distal indeterminate age. Neft Foot-soft tissue structures are osteop dislocation is identification. In the distal indeterminate age. Neft Foot-soft tissue structure are osteop dislocation is identification. In the distal indeterminate age. Neft Foot-soft tissue structure are osteop dislocation is identification of the distal indeterminate age. Neft Foot-soft tissue structure are osteop dislocation is identification of the distal indeterminate age. Neft Foot-soft tissue structure age. Neft Foot-soft tissue age. Neft Foot-so	ler obtained for x-ray to the left knee, left tibia and left sident #12 complained of pain level 0-10, MD notified, and for the following: Ibuprofen by mouth twice daily x3 days all and Tylenol 500mg take 1 mes daily x3 days for acute edication effective with a pain and ty results were obtained and g, Left tibia/fibula- No fracture tified, bony structures are kle-No acute fracture, us lesion, bony structures are kle-No acute fracture, us lesion, bony structures are lee- moderately displaced diaphysis of the femur of lo dislocation is identified. In swelling of the foot. Bony porotic. No acute fracture or led. There is moderate hallux that forms on joint at the base enerative change of the ge shaped joint in toe) joint, angeal (joint that connects and midfoot is present. Resident #12 complained of les in her stomach area per quad. Resident and for Resident to be sent out to luation and treatment. Vital are as follows: BP 114/72, P 97.8. Resident transported MD was notified of the loital x-ray revealed an acute into three or more pieces)	F 68	4			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345307	B. WING _			C 08/27/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	'	35/21/2024
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F 684	to the fracture. A le implant used to sta dislocation. No evic (abnormal fluid account of the facility via stretch emergency manage attendants. Resided discomfort to the lepain meds were adorders from emergency naproxen 375mg Fappointment with Copossible. "On 10/9/23, Famor of the facility translated management of the facility translated resident is not given knee contract long legicast at the alignment of the same deficient. "The Director of accidents for the lawere no other situated in the same deficient. "The Director of accidents for the lawere no other situated in the same deficient. "Address what or systemic changed deficient practice with the same deficient."	Soft tissue swelling adjacent ft hip gamma nail (metal bilize fractures) seen, no dence of knee joint effusion umulation within knee joint). Esident #12 returned back to cher accompanied by two ement technicians (EMT) and complained of pain and ft femur upon assessment ministered and effective. New ency department (ED) for EO BID. Ortho follow up orthopedic surgery as soon as acility made Resident #12 an on 10/10/23 at 2:15pm. RP are of the appointment. Resident #12 was taken to ensport. Ortho plan on 10/10/23 but a strong surgical candidate ture, would not recommend a time. Instead recommended and limit range of motion of earing. In facility will identify other the potential to be affected by practice; In Nursing reviewed the set three months and there tions where licensed nurses resident before the resident wormpleted on 10/9/23. In measures will be put into place the made to ensure that the	F6	84		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING			C 08/27/2024	
	ROVIDER OR SUPPLIER		1	44	TREET ADDRESS, CITY, STATE, ZIP CODE 414 WILKINSON BLVD 6ASTONIA, NC 28056	<u> U87.</u>	27/2024
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F 684	resident was to have event in the facility varior to moving the real ready a component orientation given by A "The Administrator transportation comparand stated that until princlude wheelchair prothen contracted trans "Beginning 10/9/2 contract services was driver's PASS (Passe Sensitivity) training to prior to transporting the These competencies Administrator/Designer The contracted tris PASS (Passenger Assitivity) Certified of contracted drivers on to transporting facility included both wheelch to contact 911 immediate emergencies with path 4. Address how the performance to make sustained. "Beginning 10/9/2 Nursing/Designee audito ensure no resident transportation and 91 Nursing/Designee revisions and 92 days a week for 4 weeks and weekly for "On 10/9/23 Administration and 923 Administration and 94 weeks and weekly for "On 10/9/23 Administration and 923 Administration and 94 Administration and 94 August a week for 4 weeks and weekly for "On 10/9/23 Administration and 94 August a weekly for "On 10/9/24 A	an the proper procedures if a a fall/injury or abnormal in, that 911 is to be called sident. The education was of the Transportation Driver idministrator/Designee. In notified the contract my on 10/5/23 via phone, proof of driver training to occedures and calling 911, portation will not be utilized. 3, Any transportation from a required to provide the inger Assistance Safety and of the Administrator/Designee in facilities residents. The are maintained by the electronsportation supervisor who assistance Safety and completed education for 10/12/23 and ongoing; prior residents. This education thair patent procedures and liately should any itents occur during transport. facility plans to monitor its sure that solutions are 3 Director of dited incident/accident logs had a fall during 1 wasn't called. Director of viewed incident/accident logs yeeks, 3 days a week for 4	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 08/27/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	•	00/2/12024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE D DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page 21 meeting for tracking, trending, and recommendations from the IDT team.		F 6	84		
		nediate Jeopardy Removal n plan completion: 10/13/23				
	on 8/27/24 by the for transporters revealed education on proper to have a fall, injury that 911 was to be of move resident until professional, and can the education was the transportation of company re-educated sensitivity training, we calling 911 immediated during transport. Reserview of the incidence completed with no is also conducted with who had been transwith no concerns, in identified. Interview revealed she had end drivers on proper proceeding 911 immediated calling 911 immediated.	tive action plan was validated bllowing: Interviews with facility at they had received a procedures if a resident was a cacident in the facility van, called immediately, do not assessed by a medical all facility to notify of incident. Included as a component of rientation. Contract transport for dated 10/12/23 verified on passenger safety and wheelchair procedures, and attely for any emergencies eview of the audit tool for the ent/ accident logs was assues noted. Interviews were a alert and oriented residents are ported since October 2023 accidents, or accidents with the Administrator ducated facility transport occedures if a fall, injury, or while transporting to include tely and not moving resident				
	facility of the incider verified the contract educated their drive procedures, calling during transport, an training. The facility	nedical personnel and notifying and the Administrator also are transport company had are on the proper wheelchair and for any emergencies and safety and sensitivity are corrective action completion				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345307	B. WING				27/ 2024
	ROVIDER OR SUPPLIER			44	TREET ADDRESS, CITY, STATE, ZIP CODE 414 WILKINSON BLVD ASTONIA, NC 28056	0011	21/2024
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F 684 F 689 SS=J	S483.25(d) Accidents The facility must ensu §483.25(d) (1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on record revi resident, staff, physic transport company's of contracted transport of provide safe transport lap belt was not appli her wheelchair. Resid transported back from when Driver #1 made Resident #12 falling fo onto the van floor on her left side. Driver # side of the road and t the van floor back into continued back to the swelling and a skin te hospital CT (compute revealed Resident #1 (away from the cente the femur (break in bo due to her fall in the v	ards/Supervision/Devices (2) 		684	Past noncompliance: no plan of correction required.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 689	F 689 Continued From page 23		F 6	889		
	The findings included	1:				
	for the 4-point wheel manual dated 2007 r manual provided dire wheelchairs for trans van. Tracks on the flowhere the pin connecin place and straps oby a J-hook (a J-shafabric straps that were pins). The manual illip pin connectors indica were directly behind front pin connectors and side of each side instructions directed in the illustration and wheelchair frame in tapply resident seather	port in the transportation our of the van (L-track) ctors of the retractors locked onnected to the wheelchair ped metal hook affixed to the re attached to the connector ustrated the position of the ated two rear connectors the wheelchair and the two were secured to the front e of the wheelchair. The to follow the tie down angles attached the J-hooks on the he proper locations and				
	3/26/21. Diagnoses i (MS), muscle weakn	ncluded multiple sclerosis ess, contractures of the left of the right knee and hip.				
	dated 9/20/23 reveal cognitively intact, util mobility, and depend Resident #12 was all pain and receiving so Review of a physicial revealed Resident #1	ent for assist with transfers. so coded as having on-going cheduled pain medications. In order dated 10/01/23 I2 received Gabapentin 300 olet by mouth every 8 hours				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING	B. WING		C 08/27/2024	
NAME OF PE	ROVIDER OR SUPPLIER	040001			STREET ADDRESS, CITY, STATE, ZIP CODE	08/	27/2024
	T GASTONIA LLC			4	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	2 24	F	689			
		n order dated 10/01/23 2 received Acetaminophen outh every 4 hours as					
	(on a scale of 1 to 10 possible) -10/2/23: Acetaminop 0), Acetaminophen at -10/3/23: Gabapentin Acetaminophen at 9:0 Acetaminophen at 3:2 -10/4/23: Acetaminophen at 1), Acetaminophen at	d (MAR) from 10/1/23 aled the following sident #12's prn pain ntin 300 mg and ng: at 10:44 AM (pain level 1) with 10 being the worst pain hen at 8:08 AM (pain level 3:27 PM (pain level 0) at 8:05 AM (pain level 7), 23 PM (pain level 8) hen at 7:55 AM (pain level 1:7:58 PM (pain level 0) hen at 5:19 AM (pain level					
	"[Resident #12] fell from pressed the brakes we transported by outside stated, "he slammed the floor, he picked mochair". Assessment of company owner notifications taken, skin assessment of the floor of the properties of the pro	nit Manager #1 read in part: om chair after [Driver #1] hile out of facility being e services. [Resident #12] on the brakes, and I fell on the up and put me back in completed, transport ed, physician notified, vital essment completed. statement dated 10/5/23					
		statement dated 10/5/23 was driving on my way					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 08/27/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	'	00/21/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	9 Continued From page 25		F 6	589		
		suddenly had to brake, forward and hit her knee chair."				
	A phone interview w but he was unable to	vas attempted with Driver #1, o be reached.				
	08/20/24 at 11:00 A had been transported transport company a facility, Driver #1 had the van but forgot to wheelchair, so when stop she fell out of he floor. She stated Driside of the road and wheelchair and tran facility. Resident #1 back to the facility, so Nursing (DON) and fall and they asked her for injuries and a swollen some and hot in any real pain. fall in the van happed have time to feel so had happened, but should have secure	Inducted with Resident #12 on M revealed on 10/05/23 she and to an appointment by the and on her way back to the discured her wheelchair in a secure her into her in he had to make a sudden her wheelchair onto the van a secure her back into her wheelchair onto the van a secured her back into her sported her back to the 2 revealed as soon as she got she notified the Director of the Administrator about the her what happened, assessed at the time her left knee was and a skin tear, but she was Resident #12 revealed the ened so fast that she didn't ared or even think about what she did feel that Driver #1 did her into her chair especially is diagnosis she was not able				
	revealed an order for completed on Resid left knee, left tibia (le knee joint, and form	order dated 10/05/23 or a mobile x-ray to be lent #12's left ankle, left foot, ocated on inside of leg, below s top of ankle joint), and left utside of leg, below knee joint,				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED		
		345307	B. WING			C 08/27/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		06/27/2024		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 689	indicated on 10/05, from her wheelchal Resident #12's left complained of increleft knee and leg, a been received. Ibut days and Tylenol 5 days was ordered to post fall. Review of on-call p #12 dated 10/06/23 twice daily for 3 da Tylenol 500 mg throacute pain post fall. Review of a mobile Resident #12's left displaced (more coare out of alignmer fracture of the femulable to determine hoccurred). Clinical Review of an on-ca 10/06/23 revealed were reviewed with	ohkle joint). Shysician note dated 10/06/23 23 Resident #12 had a fall ir on transportation van. knee was swollen, she eased pain at a level 10 in her and her x-ray results had not profen 400 mg twice daily for 3 300 mg three times daily for 3 3 for Resident #12's acute pain 3 shysician orders for Resident 3 indicated Ibuprofen 400 mg ys for acute pain post fall and ee times daily for 3 days for	F 68	,				
	Physician was reconstruction Review of Residen Administration Reconstruction 10/8/23 reviadministrations of I							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345307	B. WING		C 08/27/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	00/2//2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE COMPLETION	
F 689	mg (prn): -10/6/23: Gabapenti Tylenol at 2:00 PM (8:00 PM (pain level (pain level of 0) -10/07/23: Tylenol at Gabapentin at 7:35 at 8:00 AM (pain level (pain level 0), Gaball 1), Ibuprofen at 8:00 10:00 PM (pain level 11:24 PM (pain level -10/08/23 Tylenol at Ibuprofen at 8:00 AM at 10:47 AM (pain level pain level of 0) Review of an on-call 10/08/23 revealed Repain in her stomach requested to be sentended.	wice daily), Gabapentin 300 n at 12:14 AM (pain level 2), pain level of 10), Ibuprofen at 0), and Tylenol 10:00 PM t 6:00 AM (pain level 0), AM (pain level 1), Ibuprofen el 0), Tylenol at 2:00 PM pentin at 3:24 PM (pain level PM (pain level 0), Tylenol at 1 of 2), and Gabapentin at 1 of 2), and Gabapentin at 1 of 2), and Tylenol at 2:00 PM (pain level 0), Gabapentin vel 1), and Tylenol at 2:00 PM physician note dated esident #12 complained of area when inhaling and t out to the hospital. Resident	F 68	9		
	at 4:05 PM. Review of the hospit 10/09/23 revealed R emergency departm shortness of breath. abrasion and edema and a CT scan was distal femur fracture possible bruising to The consulting ED p any emergency inter #12 was non-ambula Resident #12 was distal to the consulting ED p any emergency interpretable in the consulting ED p any emergency in the consulting	al discharge summary dated desident #12 was seen at ent (ED) for a fall and Resident #12 had an a (swelling) to the left knee obtained and revealed a on the left and some the ribs as a result of the fall. It is a rovider did not recommend evention given that Resident atory, and wheelchair bound. It is scharged back to the facility proxen (treat fever and pain)				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 08/27/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	, , , , , , , , , , , , , , , , , , ,	3012112024
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	89 Continued From page 28		F 6	89		
	375 mg by mouth tw orthopedics.	ice daily and follow-up with				
	11:00 AM she revea (10/06/23), her pain left knee and the fac medications and cor side. She stated a co she started having s was sent out to the h she had broken her because of the fall. If hospital administere	Resident #12 on 8/20/24 at led on the day after the fall had gotten worse around her illity administered her pain inpleted an x-ray of her left puple of days later (10/08/23) ome trouble breathing and hospital where they confirmed left leg and bruised her ribs Resident #12 revealed the dher some more pain her to an orthopedist, and facility.				
	An interview conducted with Director of Nursing (DON) on 8/21/24 at 12:06 PM revealed she was familiar with Resident #12. She stated on the afternoon of 10/05/23, Resident #12 had returned to the facility after being transported to a medical appointment by their contract transport company and stated that she had fallen on the van. She revealed she immediately assessed Resident #12 for injury and noted a skin tear to her left knee with some swelling. The DON stated she notified physician of Resident #12's fall on 10/05/23 and received an order for a mobile x-ray of left knee. A mobile x-ray was completed on 10/06/23 and revealed a distal left leg fracture of the femur but was not able to determine the age of the fracture due to Resident #12's contractures and follow-up was recommended. She revealed the on-call physician was notified of the results and did not order any further treatment until reviewed by the facility physician. The DON stated on 10/08/23 Resident #12 was complaining of stomach pain when taking a deep breath and requested to					

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4414 WILKINSON BLVD GASTONIA, NC 28056	DDE	1 00/	21/2024
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F 689	notified, and orders we sent out. She indicate the hospital on 10/08 had suffered a left leg suspected bruised rib. Resident #12 returne to follow-up with orthor to follow-up with Resident He stated he was not had occurred and applicated for Resident #12's left left knee showing sign the mobile x-ray and hospital both showed a left leg femur fracture recommended follow orthopedic. The physical did have MS which contractures in all of suspected demineral minerals faster than deasier for injury, Resident #12 into her fall. He indicated he were sidents be secured their wheelchairs.	The on-call physician was vere received for her to be ed a CT scan completed at /23 revealed Resident #12 gracture of the femur and its from the fall in the van, it to the facility with an order opedics outpatient. It conducted with the at 4:55 PM revealed he was it #12 and her fall on the van. iffied on the day the accident proved a mobile x-ray order it side extremities due to her ins of swelling. He revealed the CT scan from the Resident #12 had suffered are due to the fall and the up with outpatient ician stated Resident #12 aused her to have the extremities and its attain (loss of bone can be replaced) making it dent #12 would still have to a hard surface to sustain a revealed he had been told the er #1 did not secure is wheelchair causing her to would expect that all while being transported in	F	689			
	was familiar with Res	ducted with the /24 at 5:27 PM revealed she ident #12. She stated on 12 had been transported by					

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			A. BOILD	_		، ا	c	
		345307	B. WING			1	27/2024	
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 007	2172024	
				4	414 WILKINSON BLVD			
THE IVY A	AT GASTONIA LLC			(GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	arrived back at the fathat during her transpowas not secured into fallen out of her whee Resident #12 stated van and assisted her brought her back to trevealed while the Dought for injury and condition attempted to interview incident, but he left that the Contract Transported to interview incident, but he left that the Contract Transported to interview incident, but he left that the Contract Transported Transportation Compreceiving a written stafform Driver #1 and we footage from the van #12's statement of he she had not been seen The Administrator reviewed a left leg fen from the fall. She state information received Driver #1 was no long company and had resecuring residents are transport. A telephone interviewed Contract Transport Cat 9:29 AM revealed by the facility of	ort company to an dicated when the resident recility, the resident reported port back to the facility she her wheelchair and had elchair onto the van floor. Driver #1 had stopped the back into her chair and he facility. The Administrator ON was assessing Resident entacting the physician, she we Driver #1 about the me facility, so she contacted ent Company Owner to notify ent. She stated the Contract eany Owner assisted her with eatement about the incident eas able to view camera to corroborate Resident ow the fall occurred and that cured into her wheelchair. Wealed Resident #12 had nour fracture and bruised ribs ted according to the from the transport company, ger employed with the ceived prior education on and their wheelchairs during	F	689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	'	00/21/2024
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F 689	Continued From pag	ge 31	F 6	89		
	appointment back to Resident #12's when to secure her into he belt. He stated durin had to stop suddenly out of her wheelchair revealed after the fa over, assisted Resid wheelchair and transfacility. He stated Dremployed with the creceived training prisafety and proper wheelchairs in vans. Company Owner state secured Resident #1 to keep her from fall wheelchair and once should have stopped the facility, and waite	Resident #12 from an the facility and secured elchair into the van but failed er wheelchair by using the lap g this transport, Driver #1 y causing Resident #12 to fall r onto the van floor. He II, Driver #1 pulled the van ent #12 back into her sported her back to the iver #1 was no longer ompany and all drivers or to transporting on van ays to secure residents in The Contract Transport ated Driver #1 should have I2 lap belt in her wheelchair ing forward out of her et the fall had occurred, he did the van, contacted 911 and end for Resident #12 to be all personnel prior to her being				
	8/22/24 at 5:50 PM. The facility provided action plan: 1. Address how co	the following corrective orrective action will be ose residents found to have deficient practice;				
	current Resident at a picked up by a contra scheduled neurolo back to the facility. Fappointment, the co	esident (Resident #12) is still a the facility. Resident #12 was act transportation driver from gy appointment for transport Prior to leaving the intracted driver secured chair, but failed to secure				

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	ROVIDER OR SUPPLIER	340007		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		08/27/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	During transport, the slam on brakes caus forward from her wh Contracted Driver por Resident #12 back in continued to transport facility. Contracted Endor facility prior to van floor and prior to wheelchair after fall. this incident: " On 10/5/23, Facility on 10/5/23, Resident #12 back in continued to transport for the sincident: " On 10/5/23, Facility on 10/5/23, Resident for an exponsible of incident. " On 10/5/23, Ordeft ankle, left foot, left ankle, left foot, left bulla. " On 10/6/23, Resident for acute pain post for acute pain s/p fall. Pain mescale of 0 noted. " On 10/6/23, x-rashowed the following or dislocation is idenosteoporotic. Left and dislocation or osseo osteoporotic. Left Kr fracture of the distal indeterminate age. Note the content of the distal indeterminate are osteo structures are osteo	elt leaving her unsecured. contracted driver had to sing Resident #12 to fall eelchair into the van floor. Illed off road and assisted into her wheelchair and then out Resident #12 back to the priver failed to contact 911 or moving Resident #12 from o placing her back into The following actions after sility initiated immediate	F 68	39		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	COMPLETED		
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F 689	of big toe), mild deginterphalangeal (hing first metatarsophalantoes to foot bone) jo "On 10/8/2023, Fain when she inhale especially the left up Daughter requested the Hospital for Evalsigns at that time we 68, Resp. 18, Temp. via ambulance and It transport. "On 10/8/23 hos comminuted (break and mildly displaced minimal angulation. to the fracture. A left implant used to stab dislocation. No evide (abnormal fluid accumum of 10/9/23, Restendants. Resident discomfort to the left pain meds were adnorders from emergen Naproxen 375mg Possible. "On 10/9/23, Facortho appointment of and MD made award "On 10/10/23, Resident is not state Resident is not state Resident is not state Resident is not state to the left pain meds were adnorders from emergen Naproxen 375mg Possible. "On 10/9/23, Facortho via facility transtate Resident is not state Resident is not state to football the proposition of the left pain meds were adnorders from emergent Naproxen 375mg Possible. "On 10/9/23, Facortho via facility transtate Resident is not state to football the proposition of the left pain meds were adnorders from emergent Naproxen 375mg Possible. "On 10/9/23, Facortho via facility transtate Resident is not state Resident is not state the left pain meds were adnorders from emergent Naproxen 375mg Possible."	hat forms on joint at the base enerative change of the ge shaped joint in toe) joint, ngeal (joint that connects int and midfoot is present. Resident #12 complained of es in her stomach area per quad. Resident and for Resident to be sent out to uation and treatment. Vital ere as follows: BP 114/72, P 97.8. Resident transported MD was notified of the pital x-ray revealed an acute into three or more pieces) distal femoral fracture with Soft tissue swelling adjacent hip gamma nail (metal ilize fractures) seen, no ence of knee joint effusion mulation within knee joint). Sident #12 returned back to her accompanied by two ment technicians (EMT) at complained of pain and femur upon assessment hinistered and effective. New not department (ED) for D BID. Ortho follow up thopedic surgery as soon as callity made Resident #12 an en 10/10/23 at 2:15pm. RP er of the appointment. Pesident #12 was taken to asport. Ortho plan on 10/10/23 at a strong surgical candidate are, would not recommend a	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	, , , , , , , , , , , , , , , , , , ,	50/21/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	long leg cast at that a knee immobilizer including weight-be 2. Address how the residents having the same deficient including weight-be are deficient including the same deficient including the same deficient including transportation are during transported for all facility van drivers put the resident. Education during them company had a safe re-educating them components during the during the during them components during the during transportation Drivers definition during the during transportation Drivers definition during the during transportation Drivers definition during the during transportation Drivers during the deficient property during the def	itime. Instead recommended and limit range of motion of aring. The facility will identify other is potential to be affected by practice; Inave had a fall/accident/or is port due to not being properly sportation. Director of its 3 months of its 3 months of its 9 menure no other falls insport to and from the facility is portly secured. Audit was 23. It measures will be put into thanges made to ensure that it will not recur; in-service initiated on 10/9/23 ector on Q-straint system in perly secure a resident in the insportation drivers. This is do fhands on and return verbal education. Transport safety checklist to it transports completed by the perior to leaving the facility with the tion completed on 10/9/23. Contracted transportation in eaty meeting with all drivers on ensuring Residents are van prior to transports on eadded to new it instructor added education to	F 68	39		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	1 00/2//2024	
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F 689	performance to mak sustained; "Beginning 10/9/will review transport. Driver Transport Saft completed by The Ivfor 12 weeks. "Beginning 10/9/Administration obse being transported viproperly secured in for transport, Adminiweek for 4 weeks, 3 weekly for 4 weeks. "On 10/9/23 the decision to take the the monthly Quality tracking, trending, at the IDT team. Alleged Date of Imm 10/10/23 Alleged Date of Con 10/13/23 The facility's correct on 8/27/24 by the fot transporters reveale education on restrait properly secure a rethe driver safety che completed prior to let The facility transport verbalize their under they had received at showing they were consulted to make the substitution of	facility plans to monitor its e sure that solutions are 23, Administrator/designee ation book and ensure that fety checklist for all transports by van drivers Monday-Friday 23, someone from rived Residents that were a van to ensure Resident was van prior to leaving the facility istration observed 5 days a days a week for 4 weeks and Administrator made the results of the observations to Assurance meeting for and recommendations from Mediate Jeopardy Removal: Frective Action Completion: Frective Action Completion: Frective Action Plan was validated and the system in van and how to sident in the van as well as	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	•	0/21/2024
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From page transporters revealed residents in manual wans and any resider geriatric-chair (a pade base) for transport, wby non-emergent EM with an electric whee transported by their of Contract transport co 10/06/23 verified staff residents are secured manufacturer's instructive facility oriel hire transport drivers included the driver safeducational and vide system and securing prior to transport. Redriver safety checklis issues noted. An obs 8/23/24 of facility transported. Interview alert and oriented restransported since Ocidentified. No addition	they only transported wheelchairs inside the facility of that required a ded chair with a wheeled would have to be transported S transport and any resident lichair would have to be contract transport company. Impany re-education dated if were educated on ensuring in the ctions prior to transport. Intation education for new verified the education aftery checklist and to material on van restraint residents properly into van view of the audit tools and the was completed with no ervation was made on asporter securing a resident side the van in accordance r's instructions prior to being we were also conducted with	F 6	DEFICIENCY)		
	facility transport driver residents into the var checklist, hands-on of securing residents into completed audits and checklist with no issue stated the facility had with manual wheelch residents who require	r revealed she had educated ers on properly securing as, completing van safety observations of drivers to vans prior to transport, dreviews of driver safety es. The Administrator also only transported residents airs in their facility vans, ed a geriatric chair were mergent EMS transport and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		C 08/27/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	33,2112021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 689	transported by contra immediate jeopardy	ctric wheelchair were act transport. The facility's removal date was validated corrective action completion	F 689		
SS=E	S 483.25(i) Respirator tracheostomy care and tracheostomy care and tracheal surcare, consistent with practice, the comprescare plan, the reside and 483.65 of this surchis REQUIREMENT by: Based on observation interviews the facility safety signage outsion indicated the use of (Resident #1, #6, #8 respiratory care. The findings included a Resident #1 was 1/25/24. A review of the quart (MDS) dated 5/20/24 not coded for receiving the respiratory care.	and tracheal suctioning. The professional standards of the profes	F 695	(1) Address how corrective action will accomplished for those residents foun have been affected by the deficient practice; "Resident #1 was identified, and Oxygen in Use sign placed on door fraby Admin Nursing. "Resident #6 was identified, and Oxygen in Use sign placed on door fraby Admin Nursing. "Resident #8 was identified, and Oxygen in Use sign placed on door fraby Admin Nursing. "Resident #42 was identified, and Oxygen in Use sign placed on door fraby Admin Nursing. "Resident #42 was identified, and Oxygen in Use sign placed on door fraby Admin Nursing.	me me
	revealed an order da	ated 1/26/24 for oxygen to be lously via nasal cannula at 3		" Oxygen in Use sticker placed at fr entrance door on 9/1/24 by Administra	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION	1, ,	E SURVEY PLETED	
				·		С	
		345307	B. WING _	B. WING		/27/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE NAVA	T GASTONIA LLC			4414 WILKINSON BLVD			
INEIVIA	II 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 695	Resident #1 was lying cannula with oxygen l/min. There was no	n). 19/24 at 4:03 PM revealed g in bed wearing a nasal being administered at 3 cautionary or safety signage e to Resident #1's room to	F 6	(2) Address how the facility will other Residents having the poter affected by the same deficient programment of the same deficient of the same defi	ntial to be ractice;		
	An observation of Re 8/20/24 at 11:00 AM in the side of her bed with administered via nasa was no safety signag. Resident #1's room to use.	sident #1 conducted on revealed she was sitting on ith oxygen being al cannula at 3 l/min. There e posted at the entrance to be indicate oxygen was in		Oxygen in use had Oxygen in Use placed on door frame. Audit was completed by Administrative Nur team. (3) Address what measures will into place or systemic changes rensure that the deficient practice occur;	se sign s rsing I be put made to		
	A review of the quarter indicated Resident #6 oxygen. A review of Resident revealed an order data administered via nasa needed. An observation on 8/2 Resident #6 was sitting a nasal cannula with at 2 l/min. There was	20/24 at 11:00 AM revealed in her wheelchair wearing oxygen being administered no cautionary or safety entrance to Resident #6's		" Assistant Director of Nursing/Designee will educate a nurses on ensuring if a new oxyg is obtained, then a Oxygen in Us must be placed on the door fram Residents room. Education will be completed by 9/30/24. " Assistant Director of Nursing/Designee will educate a nurses on ensuring that any new admitted to the facility with Oxyg has an Oxygen in Use sign placed Door frame. Education will be completed by 9/30/24. " Education will be added to Nursing/Designee ducation and g Assistant Director of Nursing/Designee."	gen order se sign ne of oe Ill licensed v Resident gen orders ed on ompleted New Hire given by		
	Resident #6 was lying	22/24 at 9:45 AM revealed g in bed and wearing a nasal being administered at 2		(4) Address how the facility plat monitor its performance to make solutions are substained;			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 08/27/2024	
		345307 B. WING					
	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP 4414 WILKINSON BLVD GASTONIA, NC 28056	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE	
F 695	posted at the entran indicate oxygen was 6/14/24. A review of the admindicated Resident # oxygen. A review of Residen revealed an order dadministered via nas needed. An observation condept of the entrance of the entrance of the entrance to Residen oxygen was in use. An observation condept revealed Resident # oxygen was in use. An observation condept revealed Resident # and wearing a nasal administered at 2 l/r signage posted at the room to indicate oxyden. A review of the administered Resident # oxygen therapy duri	cautionary or safety signage ce to Resident #6's room to in use. admitted to the facility on dission MDS dated 6/19/24 at 8 was not coded for receiving at #8's physician orders ated 6/14/24 for oxygen to be sal cannula at 2 l/min as ducted on 8/19/24 at 12:21 and #8 was lying in bed g a nasal cannula with distered at 2 l/min. There was ety signage posted at the at #8's room to indicate at #8's room to indicate at 2 l/min bed sleeping and cannula with oxygen being for in. There was no safety the entrance to Resident #8's	F 6	" Director of Nursing/D review new order listing re week for 4 weeks, 3 days weeks and weekly for 4 w any Resident with a new of a Oxygen in use sign place of room. " The results of the revidiscussed during the mon Assurance meeting for training and recommendations frof for 3 months.	eport 5 days a a week for 4 weeks to ensure oxygen order h ce on door fram wiews will be athly Quality acking, trending	as ne g,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 08/27/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 4414 WILKINSON BLVD GASTONIA, NC 28056	•	00/2//2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	•	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 695	Continued From pag	ge 40	F 6	695		
		ated 8/14/24 for oxygen to be sal cannula at 3 l/min				
	revealed Resident # nasal cannula with collimin. There was no	lucted on 8/19/24 at 4:43 PM 42 was lying in bed wearing a exygen being delivered at 3 cautionary or safety signage ce to Resident #42's room to in use.				
	on 8/20/24 at 11:30 in bed wearing a nad delivered at 3 l/min.	esident #42 was conducted AM. Resident #42 was lying sal cannula with oxygen being There was no safety signage ce to Resident #42's room to in use.				
	the facility on 8/19/2 was no cautionary o	lucted at the main entrance of 4 at 5:30 PM revealed there r safety signage posted to the building that oxygen was				
	she had not noticed posted at the facility oxygen was in use b The Administrator fu for oxygen use was	nducted with the 2/24 at 3:10 PM. She stated there was no safety signage is main entrance to indicate but that it should be posted. In the stated safety signage not posted outside of resident was not aware that was still a				
	Nursing on 8/23/24 a safety signage for the posted at the facility	nducted with the Director of at 10:56 AM. She stated e use of oxygen was not entrance or outside of use they were not aware the				

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1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3)	(X3) DATE SURVEY COMPLETED	
	345307		B. WING_			C 08/27/2024	
NAME OF P	ROVIDER OR SUPPLIER	0.000.	1	STREET ADDRESS, CITY, STA	TE. ZIP CODE	08/27/2024	
				4414 WILKINSON BLVD	,		
THE IVY A	T GASTONIA LLC			GASTONIA, NC 28056			
(V4) ID	SHWWWDV ST	TATEMENT OF DEFICIENCIES	ID		PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	COMPLETION DATE	
F 695	Continued From page		F 6	95			
	signage was required						
	Residents are Free of CFR(s): 483.45(f)(2)	of Significant Med Errors	F 7	60		10/1/24	
	medication errors. This REQUIREMENT by: Based on record rev Consultant Pharmaci Physician interviews, administer medication Physician that include leukemia) and Olanz medication). This oc (Resident #9 and Resignificant medication) Findings included: 1. Resident #9 was a 08/24/22 with a diagr myelocytic leukemia Review of Resident # revealed an order da milligrams (mg) 2 tab related to leukemia. Review of Resident # Set (MDS) assessme she was cognitively in Review of Resident # Administration Recor 2023 through August	ris not met as evidenced riew, resident, staff, st, Nurse Practitioner, and the facility failed to ns as ordered by the ed Bosulif (medication for apine (an antipsychotic curred for 2 of 5 residents sident #13) reviewed for n errors. admitted to the facility nosis including chronic (cancer of white blood cells). #9's Physician orders ted 01/20/23 for Bosulif 100 olets by mouth every day #9's annual Minimum Data ent dated 08/31/23 revealed intact with no behaviors.		accomplished for the have been affected practice; "Resident #9 was to toe skin assessm Director of Nursing of negative findings not a Resident #13 whead to toe skin assessmed	as identified and a head ent was completed by on 8/1/24, with no oted. vas identified and a sessment was tor of Nursing on gative finding noted. he facility will identify ving the potential to be e deficient practice; cart audit will be in Nursing team to osages of medication per doctors orders.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED			
		345307	B. WING		C 08/27/2024	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/2//2024	
TVAIVIL OF T	TO VIDER OR OUT FIER			, , ,		
THE IVY A	T GASTONIA LLC			4414 WILKINSON BLVD		
				GASTONIA, NC 28056		
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F 760	760 Continued From page 42		F 760	0		
	ordered.					
				(3) Address what measures will be p	ut	
	An interview with the	Assistant Director of Nursing		into place or systemic changes made	to	
	(ADON)/Infection Pre	ventionist (IP) on 08/21/24		ensure that the deficient practice will r	iot	
	at 11:53 AM revealed	the facility became aware		occur;		
		dent #9 had a surplus of				
		tion cart. She explained		" Assistant Director of		
		by an outside specialty		Nursing/Designee will educate all lice		
	pharmacy and the facility only received 60 pills a			Nursing staff and Medication aides on	the	
		sure why there would be		7 rights of medication administration.		
		the cart. The ADON/IP		Education will be completed by 9/30/2	4.	
		ne medication cart where		" Assistant Director of		
		was stored, and she noted		Nursing/Designee will educate all lice	ısed	
	three opened bottles			nurses staff and Medication aides on		
		ch bottle. She stated one		ensuring when refilling medications th	at	
		dispensed in December		the correct dosage is being ordered.		
		ated it was dispensed in		Education will be completed by 9/30/2	4.	
	•	e last bottle indicated it was		" Assistant Director of		
		y 2024. The ADON/IP		Nursing/Designee will educate all lice		
	stated Resident #9 wa			Nursing staff and Medication aides on		
		gram which provided her		ensuring Physician □s orders are bein	·	
	Bosulif. She stated th	-		followed when administering medicati		
	all-inclusive care prog			Education will be completed by 9/30/2		
	Resident #9 did have			" Education will be added to Licens		
	medication and the fa	-		Nursing staff and Medication aides ne	W	
		would be a surplus of the		hire orientation and give by Assistant		
	medication.			Director of Nursing/Designee.		
	An interview with the	Director of Nursing (DON)		(4) Address how the facility plans to		
		PM revealed the facility		monitor its performance to make sure	that	
		sident #9 having a surplus of		solutions are substained;	uidt	
		ition cart on 08/01/24 and		Solutions are substained,		
		of the surplus. The DON		" Director of Nursing/Designee will		
	-	s provided by a specialty		conduct MAR to cart audits three days	sa	
	pharmacy that was as			weeks for 4 weeks, 2 days a week for		
	all-inclusive care prog			weeks and weekly for 4 weeks to ensi		
		stated the Physician for the		no excessive amounts of medication f		
		gram came to the facility and		residents are on the carts.		
	she checked the med	· · · · · · · · · · · · · · · · · · ·		" Director of Nursing/Designee will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345307	B. WING _	B. WING			C 08/27/2024	
	ROVIDER OR SUPPLIER			44	TREET ADDRESS, CITY, STATE, ZIP CODE 414 WILKINSON BLVD ASTONIA, NC 28056	1 001	21/2024	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 760	bottles of Bosulif with medication in each bot and one bottle indicated December 2023, one dispensed in January indicated it was dispensed in January 2024, Febnarmacy called his office and the propared the medication pharmacy called his office and the pharmacy called his office and pharmacy called his office and in January 2024, Febnarmacy called his office and in J	stated they found three varying amounts of ottle in the medication cart and it was dispensed in bottle indicated it was 2024, and another bottle ansed in February 2024. She was with the Physician at the gram on 08/21/24 at 2:49 PM and been taking Bosulif for anately 2 years. He tion was very expensive and 1-inclusive care program in as a member. The sulif was prepared each pharmacy, was delivered facility. He stated that he call from one of the nurses in first of August 2024, that to the facility and she is a surplus of the medication in the Physician stated he and found three bottles of an ga differing amount of the exwere 87 extra tablets. He cated they were dispensed ruary 2024, and March stated the specialty office every month to make	F	760	conduct one Medication Administration observation daily 5 days a week for 4 weeks, then one daily 3 days a week for 4 weeks and then one daily weekly for 4 weeks to ensure Residents are receiving correct dosages and amounts of medication. "The results of the reviews will be discussed during the monthly Quality Assurance meeting for tracking, trending and recommendations from the IDT teafor 3 months.	or 4 ng		
		d not been hospitalized in appeared there were days						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 8/ 27/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		0/2//2024
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	she did not receive the she was supposed to stated the surplus of medication cart would medication error. He Resident #9's oncolor situation with Bosulif her laboratory tests with did not suffer any har checked Resident #9 error occurred in Augwork was unchanged. An interview with the 5:28 PM revealed she with Resident #9 not ordered. She stated #9 was alert and orie staff if her medication and she felt that Resimedication as ordere. An interview with Resident #9 not ordered. She stated #9 was alert and orie staff if her medication and she felt that Resimedication as ordere. An interview with Resident there was receiving her Bosulif of the time frame) and medication cup each received Bosulif. A telephone interview at 11:57 AM with Nurse aware of concern received her Bosulif a recent laboratory wor	rough March 2024 when e two tablets of medication receive. The Physician Resident #9's Bosulif on the dependence of the considered a significant stated he reached out to gist and explained the and he was informed that if the end he was aware of the concerns receiving her Bosulif as she felt that since Resident the end he would have asked cup did not contain Bosulif dent #9 did receive her d. Sident #9 on 08/22/24 at 9:25 as a time when she was not as ordered (she was unsured now she checked her morning to make sure she was conducted on 08/23/24 as e Practitioner (NP) #2 from the end of the end of the was conducted on 08/23/24 as ordered but her most ke in August 2024 revealed mission and did not suffer	F 7	60		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345307	B. WING	B WING			07/2024
NAME OF D	ROVIDER OR SUPPLIER	0-10007	1	9	TREET ADDRESS, CITY, STATE, ZIP CODE	08/	27/2024
	AT GASTONIA LLC			4	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	2. Resident #13 was 04/10/19 with a diagn schizophrenia. Review of Resident # 02/24/24 revealed an milligrams (mg) one transcription of the schizophrenia. Review of Resident # Medication Administration administration administration the Ola Resident #13's quarte (MDS) assessment drawas moderately cogn other behaviors 4 to 6 period. An interview with the on 08/23/24 at 7:53 A became aware on 02/2 receiving Olanzapine 10 mg da #13 received Olanzapine Olanzapine 10 mg da #13 received Olanzapine, but wher attention she notified and Responsible Part Olanzapine 20 mg froordered the correct depharmacy. The DON	admitted to the facility osis including 13's Physician orders dated order for Olanzapine 10 ablet at bedtime for 13's February 2024, ation Record (MAR) initialed the MAR as nzapine as ordered. Perly Minimum Data Set ated 07/21/24 revealed he itively impaired and had days during the look back Director of Nursing (DON) M revealed the facility (16/24 of Resident #13 20 mg once daily instead of ily. She stated Resident pine 20mg daily from 14. The DON stated she he facility became aware of the facility became aware of the incorrect dose of a it was brought to her the Nurse Practitioner (NP) by (RP), removed on the medication cart, and ose of Olanzapine from the stated she was not sure e was able to be requested by the error occurred.	F	760			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
345307		B. WING _		08/27/2024		
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		0/21/2024
(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 SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 880 SS=E	Resident #13 had act mg and Olanzapine 1 when staff requested March 2024, they che refilled instead of 10 is sure why Resident #1 the computer for Olar requested a 20 mg re refill. A telephone interview (NP) #3 on 08/23/24 awas aware Resident Olanzapine 20 mg da 2024, instead of the codaily. She stated eleveceive the incorrect considered that a sign NP #3 stated when sl #13 receiving the incomplete when the wrote orders to grow 20 mg to 10 mg. had taken Olanzapine not suffer any harm. Infection Prevention & CFR(s): 483.80(a)(1) §483.80 Infection Contrable environmed designed to provide a comfortable environmed evelopment and trandiseases and infection	24 at 1:35 PM revealed ive orders for Olanzapine 20 0 mg in the computer and a refill of Olanzapine in ecked 20 mg needed to be mg. She stated she was not 13 had two active orders in nzapine, but since the facility of fill, they received a 20 mg. With Nurse Practitioner at 12:13 PM revealed she #13 had received illy for 11 days in February ordered Olanzapine 10 mg oven days was a long time to dose of Olanzapine and she inficant medication error. The was notified of Resident orrect dose of Olanzapine, radually reduce the dose She stated Resident #13 in 20 mg in the past and did as Control (2)(4)(e)(f) Introl blish and maintain an and control program in safe, sanitary and ment and to help prevent the insmission of communicable	F 7			10/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345307	B. WING _			C 08/27/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	:	00/2//2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	and control program a minimum, the followard follows \$483.80(a)(1) A system of survey arrangement based conducted according accepted national sites \$483.80(a)(2) Written procedures for the put are not limited to (i) A system of survey possible communication infections before the persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and training investigation of the persons in the facility (iii) Standard and training investigation of the persons in the facility (iii) Standard and training investigation of the persons in the facility (iii) Standard and training investigation of the persons in the facility (iii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiii) Standard and training investigation of the persons in the facility (iiiii) Standard and training investigation of the persons in the	rablish an infection prevention (IPCP) that must include, at owing elements: tem for preventing, identifying, ing, and controlling infections diseases for all residents, itors, and other individuals nder a contractual upon the facility assessment g to §483.70(e) and following tandards; en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be	F 8				
	(iv)When and how is resident; including be (A) The type and du depending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstance must prohibit emplo disease or infected.	ration of the isolation, infectious agent or organism hat the isolation should be the sible for the resident under the es under which the facility yees with a communicable skin lesions from direct ts or their food, if direct					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345307	B. WING _			08/:	27/2024
NAME OF PROVIDER OR SUPPLIER THE IVY AT GASTONIA LLC				4	TREET ADDRESS, CITY, STATE, ZIP CODE 414 WILKINSON BLVD GASTONIA, NC 28056	, 00	.,,_v
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	by staff involved in direction with the facility Droplet Contact Precauting Aided (NA) #1 ewithout donning Personnel most reversible to ensure infection control policing Nurse #2 failed to ensure infection control policing Nurse #2 failed to we administration and person unit Manager #1 failed after removing dirty golean gloves during with the facility proplet Contact Precauting Nurse #2 failed to ensure infection control policing Nurse #2 failed to we administration and person unit Manager #1 failed after removing dirty golean gloves during with the facility reviewed for infection #4, Resident #28, Refindings included: The Special Droplet Control Droplet Contact Precauting with the facility person with the facility reviewed for infection #4, Resident #28, Refindings included:	procedures to be followed rect resident contact. Im for recording incidents incility's IPCP and the en by the facility. It, store, process, and to prevent the spread of riew. It an annual review of its reprogram, as necessary. It is not met as evidenced ins, record review, and staff failed to implement Special autions when Nurse #1 and intered Resident #4's room onal Protective Equipment e staff implemented their by for hand hygiene when ar gloves during insuling insuling inform hand hygiene after for Resident #28; and when individual to perform hand hygiene loves and before donning found care for Resident #12. In the following insuling insuling the following and cover for Resident #12. In the following insuling the following a COVID-19 of for 3 of 5 residents control practices (Resident insuling insuling a COVID-19 of for 3 of 5 residents control practices (Resident insuling insuling a COVID-19 of for 3 of 5 residents control practices (Resident insuling insuling a COVID-19 of for 3 of 5 residents control practices (Resident insuling insuling a COVID-19 of for 3 of 5 residents control practices (Resident insuling insuling a COVID-19 of for 3 of 5 residents control practices (Resident insuling insuling a COVID-19 of for 3 of 5 residents control practices (Resident insuling insuling insuling a COVID-19 of for 3 of 5 residents control practices (Resident insuling	F	8880	(1) Address how corrective action will accomplished for those residents found have been affected by the deficient practice; " Nurse # 1was identified and Direct of Nursing provided one on one educat on donning and doffing PPE when need for isolation rooms. Education complete on " Nurse Aide #1 was identified and Director of Nursing provided one on one education on donning and doffing PPE when needed for isolation rooms. Education completed on 9/20/24. " Nurse #2 was identified and no lore employee at facility as of 9/13/24. " Unit Manager #1 was identified and Director of Nursing provided one on one education on facilities clean dressing change and hand hygiene policy. Education completed on 9/20/24.	tor ion ded ed e	

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		345307	B. WING			C 8/27/2024	
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	, -	9.2202.	
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F 880	before entering the rincluded, "All health hands before entering room, 2) wear a gow before leaving, 3) we respirator before entafter exiting, 4) wear shield or goggles), a entering room and respirator before entafter exiting, 4) wear shield or goggles), a entering room and respirator of the facility's policy to revised 10/26/23 respirator of the spirator of the s	the instructions on the signage resident's room which care personnel must: 1) cleaning and when leaving the virtual when entering room and the virtual ering the room and remove the protective eyewear (face and 5) wear gloves when the emove before leaving". It it it is a state of the personnel, and hygiene procedures to be infection to other personnel, are hands by handwashing or the use of an antiseptic and a salcohol-based hand rubbene is indicated and will be a conditions listed in the hand including gloves, and 4) after intially contaminated with the personnel with the personnel entry of the personnel entry o	F 88	(2) Address how the facility will in other Residents having the potent affected by the same deficient practice. " All Residents have the potent affected by deficient practice. (3) Address what measures will the into place or systemic changes may ensure that the deficient practice woccur; " Assistant Director of Nursing/Designee will educate all nursing staff on Facilities Insulin Facilities and procedures. Education completed by 9/30/24. " Assistant Director of Nursing/Designee will educate all nursing staff on facilities Clean Drachange Policy and Procedure. Edwill be completed by 9/30/24. " Assistant Director of Nursing/Designee will educate all facilities Hand Hygiene policy and procedure. Education will be completed. Education will be completed by 9/30/24. " Assistant Director of Nursing/Designee will educate all Facilities Infection Prevention and Program policy and procedure. Educated by 9/30/24, will not be a	ial to be ctice; ial to be ctice; ial to be pe put ade to will not licensed ren will be licensed essing fucation staff on control ducation of not llowed to		
	on the room door. No lunch meal tray wea	age posted and PPE supplies IA #1 entered the room with a ring only a surgical mask PPE per the instructions on		work until education is completed. " Assistant Director of Nursing/Designee will educate all proper donning and doffing of PPI	staff on		

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/2//2024	
				4414 WILKINSON BLVD		
THE IVY A	T GASTONIA LLC			GASTONIA, NC 28056		
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F 880	380 Continued From page 50		F 880			
	overbed table, sanitized and exited the room. An interview with NA revealed she did not a SDCP until she was a stated she had been to the sand stated she had	#1 on 08/19/24 at 1:06 PM realize Resident #4 was on already in the room. She trained to read and follow from doors and it was an		needed for isolation rooms and/or Residents requiring isolation precauti Education will be completed by 9/30/2 Staff not educated by 9/30/24, will no allowed to work until education is completed. "Education will be added to Licens Nursing staff and all staff new hire orientation and will be given by Assist Director of Nursing/ Designee.	24. t be	
	(ADON)/Infection Pre at 2:12 PM revealed staff to follow posted doors by donning and instructed. An interview with the on 08/23/24 at 7:53 A staff to follow posted doors by using PPE at b. A continuous obseroom on 08/19/24 from PM revealed SCDP supplies on the room Resident #4's room without donning any fithe signage. Nurse # blood glucose, remove hand hygiene with (Al glucometer, and exited An interview with Nur PM revealed she did	Director of Nursing (DON) M revealed she expected signage on resident room as instructed. Prvation of Resident #4's m 12:32 PM through 12:34 ignage posted and PPE door. Nurse #1 entered rearing only a surgical mask PPE per the instructions on 1 checked Resident #4's ed her gloves, performed BHR), picked up the d the room. See #1 on 08/19/24 at 12:34 not don the PPE listed on		(4) Address how the facility plans to monitor its performance to make sure solutions are substained; " Director of Nursing/Designee will conduct 4 random audits 5 days a we for 4 weeks, then 3 random audits 3 days a week for 4 weeks, to ensure staff is donning and doffing the proper PPE for Residents requiring isolation precauti " Director of Nursing/ Designee will conduct 4 random audits 5 days a week for 4 weeks, then 3 random audits for days a week for 4 weeks, then 1 random audit weekly for 4 weeks, then 1 random audit weekly for 4 weeks to ensure staffollowing proper hand washing procedures. " Director of Nursing/Designee will conduct 1 dressing change observation days a week for 4 weeks, then 1 dressing change observation weekly for 4 weeks to en Licensed Nursing staff is following	ek days udit or ons. I leek 3 dom aff is	
	the sign was for Enha	ent #4 because she thought inced Barrier Precautions (a in't require full PPE with		Licensed Nursing staff is following facilities clean dressing change policy procedure during dressing changes.	<i>r</i> and	

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	should have looked a it was an oversight. An interview with the (ADON)/Infection Pre at 2:12 PM revealed staff to follow posted doors by donning and instructed. An interview with the AM revealed she exp signage on resident r instructed. 2. A continuous obse 08/20/24 from 8:16 A she gathered Resider alcohol swab, entered alcohol swab, swabbethe alcohol swab, swabbethe alcohol swab, swabbethe alcohol swab, adrinjection into his right insulin pen and exited apply gloves to admir injection and did not padministering the insulin An interview with Nur AM revealed she got did not wear gloves we Resident #28's insulin have performed hand the insulin. An interview with the AM revealed she exp	Assistant Director of Nursing eventionist (IP) on 08/19/24 she expected all nursing signage on resident room d doffing all PPE as DON on 08/23/24 at 7:53 ected staff to follow posted oom doors by using PPE as ervation of Nurse #2 on M through 8:18 AM revealed in #28's insulin pen and an d his room, opened the ed his right upper arm with ministered the insulin upper arm, collected the d the room. Nurse #2 did not nister Resident #28's insulin perform hand hygiene after	F 88	" Director of Nursing/Desiconduct 4 insulin pen adminisobservation 5 days a week for insulin pen administration obdays a week for 4 weeks, the pen administration observation 4 weeks to ensure licensed rare wearing gloves while adminsulin. " The results of the review discussed during the monthly Assurance meeting for tracki and recommendations from the for 3 months.	stration or 4 weeks, 3 servation 3 en 1 insulin on weekly for nursing staff ministering vs will be y Quality ng, trending,		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
345307 B.		B. WING			C 08/27/2024	
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F 880	880 Continued From page 52		F 8	880		
	10:59 AM revealed ginsulin was administed should be performed. 3. A continuous obson 08/20/24 from 4:4 revealed with gloved #12's ischial (the curthe pelvis) wound wither gloves, opened a applied clean gloves applied calcium algirand a dry dressing to gloves, and sanitized Manager #1 did not premoving dirty gloved dressing. An interview with Unrevealed she usually each time she removituouching other items providing wound care oversight. An interview with the AM revealed hand he after gloves were reclean gloves. An interview with the 10:59 AM revealed hand he can gloves.	ADON/IP on 08/23/24 at alloves should be worn when ered, and hand hygiene after removing gloves. ervation of Unit Manager #1 to PM through 5:00 PM hands she cleaned Resident eved bone forming the base of the wound cleanser, removed a clean gauze dressing, measured the wound, mate (an absorbent dressing) to the wound, removed her allowed her hands with ABHR. Unit thereform hand hygiene after and before touching a clean sit Manager #1 at 5:07 PM performed hand hygiene eved her gloves and before and she did not when the for Resident #12 due to an allowed and before putting on ADON/IP on 08/23/24 at and hygiene should be calculated and and hygiene should be calculated and hygiene should				
	before putting on cle	gloves are removed and an gloves.				