| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345307 | A. Building<br>B. Wing | 05/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Ivy at Gastonia LLC | 4414 Wilkinson Blvd<br>Gastonia, NC 28056 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476<br><br>Based on observation, record review and staff interviews, the facility failed to ensure a resident had been assessed to self-administer medications (Resident #8). This occurred for 1 out of 3 residents reviewed for medication administration.<br><br>The findings included:<br><br>Resident #8 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD and respiratory failure.<br><br>Resident #8's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact and required set up assistance of one staff member for most activities of daily living (ADL).<br><br>On 05/02/23 at 9:16 AM an observation was conducted of Nurse #1 preparing Resident #8's medication from the medication cart and put them into a cup. Nurse #1 then went into the room with the medication cup and the resident's Cyclosporine (immunosuppressant, used to increase tear production) eye drops. Nurse #1 then handed the medication to Resident #8. Resident #8 stated, I have already administered my eye drops to myself this morning. Nurse #1 stated to the surveyor that Resident #8 self-administered her nebulizer treatments and her eye drops. Nurse #1 stated she had brought the nebulizer treatment into the room earlier in the morning and handed the solution to Resident #8 in which the resident poured the solution into the machine and started her own breathing treatment.<br><br>Resident #8's physician orders from 01/02/23 through 05/02/23 were reviewed and did not reveal an order to self-administer medication.<br><br>Review of the medical record did not reveal an assessment for Resident #8 to self-administer medication.<br><br>An interview was conducted on 5/2/23 at 9:20 AM with Nurse #1. During the interview she stated she always allowed Resident #8 to self- administer her own eye drops and nebulizer treatment. She stated she was unsure if the resident had been assessed to administer her own medication by the facility.<br><br>(continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on 5/2/23 at 10:23 AM with Resident #8. She stated she felt she could take care of herself and she was able to dress herself and required limited assistance from staff. The interview revealed facility staff had asked her if she wanted to self-administer her medication and some nurses would not allow her to do so. She stated Nurse #1 was one of the only staff that would allow her to administer her eye drops and nebulizer treatment. Resident #8 stated Nurse #1 had brought her Albuterol nebulizer solution into the room that morning and handed it to her for her to start her own nebulizer treatment. She stated she wanted to administer her eye drops but did not want to be responsible for her pill medication or the nebulizer solution.<br><br>An interview conducted on 05/02/23 at 10:04 AM with the Director of Nursing (DON) revealed no residents in the facility had orders to self-administer their medication. She stated she expected nurses to administer the resident's medication and remain in the room with the resident until they took all of the medication that was ordered. The DON stated if a resident were to request to self-administer their medication, they would need to sign a form prior to doing so and be assessed. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019<br><br>Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of urinary catheter (Resident #97), discharge disposition (Resident #43), activities of daily living (Resident #29), and falls (Resident #24) for 4 of 18 residents reviewed for MDS accuracy.<br><br>The findings included:<br><br>1. Resident #97 was admitted to the facility on [DATE] with diagnoses which included hypertension, end stage renal disease and diabetes mellitus.<br><br>Resident #97 was observed on 04/30/23 at 1:09 PM sitting up in her wheelchair in her room and had an indwelling urinary catheter.<br><br>Review of Resident #97's admission Minimum Data Set (MDS) assessment dated [DATE], under Section H. Bladder and Bowel, H100 Appliance, the assessment was marked at A. Indwelling catheter due to the resident's urinary catheter. Under Section H300 Urinary Continence, the assessment was marked at 3. Always incontinent (no episodes of continent voiding) instead of 9. Not rated, resident had a catheter (indwelling, condom), urinary ostomy or no urine output for entire 7 days.<br><br>Interview on 05/02/23 at 3:26 PM with the Director of Nursing (the MDS Nurse was out of the building and unavailable by phone) revealed she would have expected the MDS nurse to have marked the urinary catheter as not rated instead of always incontinent of urine. She stated it was an error in coding on the part of the MDS nurse.<br><br>2. Resident #43 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, malnutrition, and muscle weakness. According to her nursing discharge note, Resident #43 was discharged home on 02/23/23.<br><br>Review of her discharge Minimum Data Set (MDS) assessment dated [DATE] under Section A. Identification Information, A2000, the assessment was marked with discharge date as 02/23/2023. Under Section A2100, Discharge Status, the assessment was marked 03. Acute Hospital instead of 01. Community.<br><br>Interview on 05/02/23 at 3:26 PM with the Director of Nursing (the MDS Nurse was out of the building and unavailable by phone) revealed she would have expected the MDS nurse to have marked the discharge status as community instead of acute hospital. She stated it was an error in coding on the part of the MDS nurse.<br><br>40476<br><br>3.Resident #29 was admitted to the facility on [DATE] with diagnoses which included hypertension and diabetes mellitus.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #29's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated dressing, eating, toilet use, personal hygiene and bathing did not occur or her family and/or non-facility staff had provided the care 100% of the time for those activities during the entire look back period.<br><br>Resident #29 was observed on 05/01/23 at 2:29 PM sitting up in her wheelchair in her room. Resident #29 was dressed and well groomed.<br><br>The MDS nurse was not available for an interview.<br><br>An interview on 05/02/23 at 3:26 PM with the Director of Nursing revealed she would have expected the MDS nurse to have included the functional status of Resident #29 to reflect she required extensive assistance of two staff members for activities of daily living. She stated it was an error in coding on the part of the MDS nurse.<br><br>4. Resident #24 was admitted to the facility on [DATE] with diagnoses which included hypertension, coronary artery disease and renal insufficiency.<br><br>Review of her quarterly Minimum Data Set (MDS) assessment dated [DATE] under Section J. Health Conditions, J1700C, the assessment was marked Resident #24 had experienced no falls resulting in a fracture in the last six months.<br><br>Review of the facility incident log revealed Resident #24 had experienced falls on the dates of 10/18/22, 10/29/22, 2/26/23 and 3/13/23. The falls on the dates of 2/26/23 and 3/13/23 resulted in a major injury.<br><br>Interview on 05/02/23 at 3:26 PM with the Director of Nursing (the MDS Nurse was out of the building and unavailable by phone) revealed she would have expected the MDS nurse to have marked Resident #29's falls on the MDS assessment. She stated it was an error in coding on the part of the MDS nurse. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019<br><br>Based on observations, record review, family and staff interviews, the facility failed to provide shaving of resident's face and clipping of toenails for 1 of 4 residents (Resident #40) reviewed for assistance with activities of daily living.<br><br>The findings included:<br><br>Resident #40 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. His diagnoses included hypertension and non-Alzheimer's dementia.<br><br>Review of Resident #40's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was moderately cognitively impaired and required total assistance of 2 staff with bathing and extensive assistance of 1 staff with personal hygiene and had impairment of both sides of upper and lower extremities.<br><br>Review of the shower schedule for Resident #40 revealed he received showers on Wednesday and Saturday on 1st shift (7:00 AM to 3:00 PM).<br><br>Review of Resident #40's care plan dated 03/23/23 revealed a focus area for his inability to complete activities of daily living care related to his cognitive impairment. The interventions included assist with picking out and putting on clothes appropriate for season and comfort, explain all procedures and purposes in terms understood prior to performing tasks and encourage self-performance, praise efforts, not just successes, provide encouragement and praise daily, provide resident education and family support, report changes in ADL self-performance to nurse, and turn and reposition, shifting weight to enhance circulation as needed.<br><br>Observation and interview with family member at bedside of Resident #40 on 04/30/23 at 3:11 PM revealed the resident resting in bed with covers pulled over him and his feet hanging out of the covers. The resident was noted to have 1/4 inch stubble on his face and his toes on each foot other than his big toes had nails that were 1/4 to 1/2 inch beyond the end of his toes. The family member at his bedside stated Resident #40 did not look like himself because he had always been clean shaven and did not typically have stubble on his face. She further stated he needed to be shaved and his toenails needed to be clipped because they were way too long. The family member indicated Resident #40 usually kept himself well groomed.<br><br>Observation of Resident #40 on 05/01/23 at 8:48 AM revealed him lying in bed and he still had 1/4 inch stubble on his face and his toenails on each foot were 1/4 to 1/2 inch beyond the end of his toes.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 05/01/23 at 2:08 PM with Nurse Aide (NA) #1 revealed Resident #40 had been going to the shower but since his decline he had been getting bed baths. NA #1 stated bed baths or showers usually included bathing resident from head to toe or assisting them, shaving men, and women with facial hair, shampooing their hair and clipping their fingernails unless they were diabetic and then the nurses clipped their nails. NA #1 further stated she didn't trim toenails but residents who needed their toenails trimmed were either done by the nurse or referred to the podiatrist for their nails to be trimmed. NA #1 stated she had not noticed Resident #40 had not been shaved or needed his toenails trimmed.<br><br>Interview on 05/01/23 at 3:02 PM with NA #2 revealed she took Resident #40 on the shower bed to the shower on his bath days. She stated his shower included cleaning him from head to toe, shampooing his hair, shaving him if needed and clipping and cleaning his fingernails as needed. NA #2 further stated the NAs typically did not cut resident's toenails but referred them to the nurse to be trimmed or to the podiatrist as needed. NA #2 stated she had not noticed Resident #40's toenails and whether they needed trimming and had not noticed he needed to be shaved.<br><br>Interview on 05/02/23 at 1:13 PM with Nurse #3 who was assigned to Resident #40 on 1st shift (7:00 AM to 7:00 PM) revealed she had not noticed his facial hair and that he needed to be shaved and had not noticed his toenails and said no one had reported to her they needed to be trimmed. Nurse #3 observed Resident #40's facial hair and agreed he needed to be shaved and observed his toenails and agreed they needed to be trimmed and said she would take care of shaving him and clipping his toenails today on her shift.<br><br>Interview on 05/02/23 at 3:19 PM with the Director of Nursing (DON) revealed she expected the NAs and Nurses to observe the resident's full body when providing care, bathing them, and providing skin inspections. She said she would have expected the NAs and the Nurses to have noticed the resident's toenails needed to be trimmed and clipped prior to their getting so long. The DON indicated they would need to do education on assessing residents need for shaving and trimming nails. |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019<br><br>Based on observations, record review, resident and staff interviews, the facility failed to administer pain medication to 1 of 1 resident (Resident #97) reviewed for pain management when she complained of pain at a level of 9 on a scale of 0 to 10.<br><br>The findings included:<br><br>Resident #97 was admitted to the facility on [DATE] with diagnoses which included hypertension, diabetes mellitus and end stage renal disease.<br><br>Resident #97's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact, required extensive to total assistance of 1 staff member with all activities of daily living except eating. The assessment also revealed Resident #97 received as needed pain medication for pain and non-verbal sounds of pain related to stage IV pressure ulcer on the resident's sacral region.<br><br>Review of Resident #97's care plan dated 4/24/23 revealed a focus area for chronic pain. The interventions included evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, identify and record previous pain history and management of that pain and impact on function, identify previous response to analgesia including pain relief, side effects and impact on function, identify, record and treat the resident's existing conditions which may increase pain and or discomfort, monitor/document for probable cause of each pain episode, remove/limit causes where possible, monitor/document for side effects of pain medication, observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls, report occurrences to the physician, monitor/record/report to nurse loss of appetite, refusal to eat and weight loss, monitor/record/report to nurse resident complaints of pain or requests for pain treatment and notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain.<br><br>Observation during medication pass on 05/01/23 at 10:38 AM revealed Resident #97 getting her morning medications. Nurse #2 was administering her medications including Aspirin and asked the resident what her pain level was at that time and Resident #97 stated it was a 9 on a scale of 0 to 10. Nurse #2 administered the Aspirin and proceeded to the next resident without offering Resident #97 any pain medication.<br><br>Review of Resident #97's Medication Administration Record, revealed she had Oxycodone Hydrochloride (HCl) Oral tablet 5 milligrams (mg) - give 5 mg by mouth every 6 hours as needed for pain ordered. The MAR indicated the resident had not received the Oxycodone within the last 6 hours and the resident could have received the medication for her pain level of 9.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Observation and interview on 05/01/23 at 11:51 AM with Resident #97 revealed her sitting up in her wheelchair in her room and she was shifting in her wheelchair to try and get comfortable. Resident #97 stated she had not received anything for pain since yesterday and she guessed they were trying to extend the time between dosages since it was a narcotic. Resident #97 further stated her pain was still between an 8 and 9 and her face was grimaced and she stated she was going to put on her light and ask for pain medication.<br><br>Interview on 05/01/23 at 3:45 PM with Resident #97 revealed she had put her call light on earlier and requested pain medication but stated she had not received any yet. She stated her pain was still between 8 and 9 and said it was only relieved some when she took pain medication.<br><br>Interview and observation on 05/01/23 at 3:59 PM with Nurse #2 revealed she was taking care of Resident #97 from 7:00 AM to 7:00 PM and said she had not given her any pain medication because she had not asked for pain medication but said she had given her some Gabapentin at 2:00 PM. Nurse #2 stated she remembered Resident #97 had told her earlier in the day that her pain level was a 9 on a scale of 0 to 10 but said she had forgotten and had not given the resident pain medication. Nurse #2 stated she should have given her medication for pain when Resident #97 had said her pain level was a 9 but said she had forgotten and did not medicate the resident. Nurse #2 stated she was going to assess her pain level and get her something for pain if she needed it. An observation of her assessment revealed Resident #97 told Nurse #2 her pain level was an 8 and Nurse #2 stated she would get her medication for pain. Nurse #2 gave Resident #97 Oxycodone HCl 5 mg oral tablet by mouth at 4:05 PM.<br><br>A follow up interview on 05/01/23 at 4:50 PM revealed Resident #97's pain level was now a 2 and she had some relief from the pain medication administered.<br><br>Interview on 05/02/23 at 1:45 PM with Nurse Aide (NA) #3 revealed she was assigned to care for Resident #97 on 05/01/23 and 05/02/23 from 7:00 AM to 3:00 PM. NA #3 stated Resident #97 had complained about pain both days but had not asked her to tell the nurse that she needed pain medication. NA #3 further stated Resident #97 always complained about pain and had told NA #3 that her pain was constant. NA #3 stated she had been trained to let the nurse know when a resident requested pain medication but said she had not requested pain medication but had said she was having pain. NA #3 indicated she should have told the nurse Resident #97 was complaining of constant pain.<br><br>Interview on 05/02/23 at 3:26 PM with the Director of Nursing (DON) revealed Nurse #2 should have medicated Resident #97 when she told the nurse her pain level was a 9 on a scale of 0 to 10. The DON stated Resident #97 had chronic pain and should not have gone that long without being medicated for pain. She further stated it might be beneficial for Resident #97 to be on scheduled pain medication instead of as needed and said they could discuss with the physician and get her medication adjusted. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>45380<br><br>Based on observations, staff interviews and record review, the facility failed to ensure leftover food items stored for use in the reach-in freezer were labeled, dated and sealed. The failure occurred in 1 of 3 cold storage units and had the potential to affect food served to residents.<br><br>The findings included:<br><br>An observation occurred on 04/30/23 at 12:10 PM with Dietary Aide #1, of the kitchen's reach-in freezer revealed the following leftover food items stored for use:<br><br>- an opened undated bag half full of frozen chicken tenders<br><br>- an opened undated bag half full of frozen diced chicken<br><br>- two opened undated bags three-fourth full of frozen chicken breast<br><br>- two opened undated bags half full of frozen chicken drumettes and wings<br><br>An interview conducted with Dietary Aide #1 on 04/30/23 at 12:20 PM revealed all items in the reach in freezer should be sealed and have a label on them with the date the items were opened.<br><br>An interview conducted with [NAME] #1 on 4/30/23 at 12:25 PM revealed all items in the reach in freezer should be sealed and have a label on them with the date the items were opened.<br><br>An interview with the Dietary Manager (DM) on 04/30/23 at 1:00 PM revealed she expected staff to label foods after opening with the date opened and store in sealed containers. She stated that dietary staff were expected to round daily during their shift to monitor all cold storage units for unlabeled, undated foods. The DM also stated she believed the opened undated items found had been overlooked by staff.<br><br>An interview with the Administrator on 05/02/23 at 3:40 PM revealed she expected dietary staff to label, date and seal all foods before storage. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>37019<br><br>Based on record reviews, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the complaint investigation survey of 06/23/22 and a recertification survey of 07/14/21. The repeated deficiency was in the area of accuracy of assessments. The facility's continued failure during three Federal surveys showed a pattern of the facility's inability to sustain an effective QAA program.<br><br>The findings included:<br><br>This tag was cross referenced to:<br><br>F-641: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of urinary catheter (Resident #97), discharge disposition (Resident #43), activities of daily living (Resident #29), falls (Resident #24) and antipsychotic medications (Resident #21) for 5 of 18 residents reviewed for MDS accuracy.<br><br>During the complaint investigation of 6/23/22 the the facility failed to obtain a resident's weight within 30 days of the Minimum Data Set (MDS) Assessment Reference Date (ARD, the last day of the look back period) for 1 of 4 MDS assessments reviewed (Resident #10).<br><br>During the recertification survey of 07/14/21 the facility failed to accurately code a Pre-Admission Screening and Resident Review (PASRR) Level II and failed to code a resident accurately in the area of diagnoses and range of motion. During the revisit and complaint investigation survey of 06/23/22 the facility failed to obtain and record a resident's weight within 30 days of the assessment.<br><br>F-677: Based on observations, record review, family and staff interviews, the facility failed to provide shaving of resident's face and clipping of toenails for 1 of 4 residents (Resident #40) reviewed for assistance with activities of daily living.<br><br>During the recertification and complaint survey of 2/7/20 the facility failed to provide incontinence care to keep residents clean and dry (Resident #20 and Resident #12) and failed to provide nail care (Resident #26) for 3 of 3 dependent residents reviewed for activities of daily living (ADL).<br><br>An interview on 05/02/23 at 3:26 PM with the Director of Nursing and Administrator revealed they would have expected the Minimum Data Set (MDS) Nurse to have coded all assessments accurately and said it was an error in documentation on the part of the MDs Nurse. The Administrator felt like the failure of the QAA was due to the high rate of turnover in the position of the MDS Nurse and as the position stabilized so would the issues with the program. |