STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT GASTONIA LLC	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 3/21/22 to conduct a complaint investigation survey and exited on 3/21/22. Additional information was obtained on 3/24/22. Therefore, the exit date was changed to 3/24/22. A total of 4 allegations were investigated and all of them were unsubstantiated, NC00186376 and NC00186349. Event ID# 9Z2X11.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews with staff and the wound doctor, the facility failed to provide wound care to a venous ulcer per physician orders for 1 of 3 residents (Resident #4) reviewed for wound care. The findings included: Resident #4 was re-admitted to the facility on 2/3/22 with diagnoses that included chronic venous hypertension with ulcer of left lower extremity. The quarterly Minimum Data Set (MDS) assessment dated 2/7/22 indicated Resident #4	F 684	Resident #4 dressing change was completed immediately All residents receiving treatments have the potential to be affected. The Director of Nursing (DON) completed a 100% audit was completed on 3/22/2022 of all residents who had treatment orders to validate that the wound care was provided as well as the treatment was signed for completed. No discrepancies were identified. By 3/22/2022, the DON re-educated the	4/20/22

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

Electronically Signed | 04/13/2022

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F 684	Continued From page 1 was severely cognitively impaired and was totally dependent on staff assistance with bed mobility. The MDS further indicated Resident #4 had a total of three venous ulcers and received application of nonsurgical dressings and ointments/medications other than to feet. Resident #4's care plan revised on 3/10/22 indicated Resident #4 had a venous ulcer to the left lower medial leg, a venous ulcer to the left lower lateral leg and a venous ulcer to the left lateral foot which was resolved on 3/10/22. Interventions included treatments as ordered. A physician order dated 3/12/22 for Resident #4 indicated the following treatment to the left lower leg: cleanse left lower leg (medial and lateral) with ¼ (antiseptic) solution, apply (antifungal) cream, cover with oil emulsion dressings and abdominal pads, wrap site with a gauze bandage roll and change daily every day shift. A review of Resident #4's Treatment Administration Record (TAR) for March 2022 indicated the treatment order for Resident #4's left lower leg was marked as completed by Nurse #3 on 3/17/22 and 3/18/22, Nurse #5 on 3/19/22 and Nurse #4 on 3/20/22. During an observation of wound care on Resident #4 on 3/21/22 at 11:30 AM with Nurse #2, a dressing to Resident #4's left lower leg was noted with a date of 3/16/22. An interview with Nurse #2 on 3/21/22 at 2:13 PM revealed that when she did Resident #4's wound care she did not look at the date on the old dressing and did not notice that it had been dated 3/16/22 before she removed it. Nurse #2 stated	F 684	licensed nurses on regulation 483.25 regarding quality of care and ensuring residents receive treatment and care according to professional standards and practice. Education included the expectation of the licensed nurse to provide wound care as ordered by the physician, sign/initial and date dressing with each dressing change. Make sure TAR (treatment administration record) is signed to only reflect completion of dressing changes. The DON or Unit Manager will conduct reviews of 3 residents TARs to ensure that the treatment orders are signed for completed and visually inspect residents dressings to ensure it was changed, signed, and dated. At a frequency of 3 residents 3 times a week for 4 weeks, then one time a week for 8 weeks and then monthly. Schedule for QI monitoring will be modified based on findings. Results of QI monitoring will be recorded will be reported to the QAPI (quality assurance performance improvement) committee monthly by the DON or designee. The QAPI committee will evaluate the effectiveness of the monitoring / observation tools for making changes to the correction action if necessary to maintain substantial compliance. The QAPI committee members consists of but not limited to the Administrator, DON, MD, and at least 3 other members. Completion date: 4/20/2022	

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F 684	Continued From page 2	F 684		

that she was focused on the procedure and was thinking about what she needed to do while changing Resident #4's dressing. Nurse #2 stated that Resident #4's treatment to her left leg should have been done daily and she was not sure why it had not been changed since 3/16/22. Nurse #2 stated that she did notice that Resident #4's left leg wound looked drier than usual.

A phone interview with Nurse #3 on 3/21/22 at 2:10 PM revealed she worked with Resident #4 on 3/17/22 and 3/18/22 on the day shift from 7:00 AM to 7:00 PM. Nurse #3 stated she knew she was supposed to do Resident #4's treatment to her left lower leg but she didn't do it because the wound doctor was scheduled to come to the facility on either 3/17/22 or 3/18/22 but she couldn't remember which day he was supposed to come. Nurse #3 also stated that she worked with Resident #4 on 3/19/22 from 7:00 AM to 11:30 AM but she didn't do Resident #4's wound care because she thought she was only supposed to pass medications during the four hours that she worked on 3/19/22.

A phone interview with Nurse #5 on 3/21/22 at 12:35 PM revealed she came in at 1:00 PM on 3/19/22 and worked with Resident #4 until the night shift. Nurse #5 stated the Director of Nursing (DON) had the keys to her cart when she reported for work because Nurse #3 had already left at 11:30 AM. Nurse #5 stated she didn't do Resident #4's treatment to her left leg because she thought Nurse #3 had already done it on her shift and just forgot to mark it off on her TAR. Nurse #5 also stated she didn't think to check Resident #4's left leg dressing before she marked it off as completed on Resident #4's TAR on 3/19/22 because she usually worked on the night

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F 684	Continued From page 3	F 684		

shift and treatments were usually scheduled to be done on the day shift.

A phone interview with Nurse #4 on 3/21/22 at 12:41 PM revealed she worked with Resident #4 on 3/20/22 from 7:00 AM to 3:00 PM but she never got around to doing Resident #4's treatment to her left leg. Nurse #4 stated when she got ready to do it, Resident #4 had requested for her to come back later in the shift. But when she had gathered the supplies she needed to do Resident #4's wound care, Resident #4 had already gotten up in her wheelchair and it was difficult for her to do it while she was in her wheelchair. Nurse #4 stated she reported this to the oncoming shift, but she could not remember the name of the nurse.

A phone interview with the wound doctor on 3/21/22 at 3:53 PM revealed he usually came to the facility on Thursday, but he did not do rounds on 3/17/22 so the last time he saw Resident #4 was on 3/10/22. The wound doctor stated he had requested for the nursing staff to do daily dressing changes to Resident #4 who had a venous ulcer to her left leg which had been a difficult wound to heal. The wound doctor stated he prescribed an antifungal cream to be applied to the wound to decrease inflammation and decrease the fungal load. He stated the medicated cream loses its effectiveness when Resident #4's dressing was not changed for several days and would not be as effective in eliminating the problem. He also stated that a new batch of antifungal cream and a new dressing should be applied daily to Resident #4's venous ulcer to her left leg.

An interview with the Director of Nursing (DON)

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F 684	Continued From page 4 on 3/21/22 at 4:00 PM revealed she remembered telling the nursing staff that the wound doctor was not coming to the facility on 3/17/22 so she was not sure why Nurse #3 did not know about it. The DON also came in to work on 3/19/22 to relieve Nurse #3 when she left at 11:30 AM but she did not tell her that Resident #4's treatment to her leg had not been completed. The DON stated Nurse #3 told her that she had everything done and all the DON had to do was wait for Nurse #5 to come in at 1:00 PM. The DON stated there had been poor communication between the nurses which led to Resident #4 not receiving her wound treatment for several days.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842		4/20/22

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F 842	Continued From page 5	F 842		

all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 6 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain an accurate Treatment Administration Record (TAR) for wound care to a venous ulcer for 1 of 3 residents (Resident #4) reviewed for wound care. The findings included: Resident #4 was re-admitted to the facility on 2/3/22 with diagnoses that included chronic venous hypertension with ulcer of left lower extremity. The quarterly Minimum Data Set (MDS) assessment dated 2/7/22 indicated Resident #4 was severely cognitively impaired and was totally dependent on staff assistance with bed mobility. The MDS further indicated Resident #4 had a total of three venous ulcers and received application of nonsurgical dressings and ointments/medications other than to feet. A physician order dated 3/12/22 for Resident #4 indicated the following treatment to the left lower leg: cleanse left lower leg (medial and lateral) with ¼ (antiseptic) solution, apply (antifungal) cream, cover with oil emulsion dressings and abdominal pads, wrap site with a gauze bandage roll and change daily every day shift. A review of Resident #4's Treatment Administration Record (TAR) for March 2022 indicated the treatment order for Resident #4's	F 842	Resident #4 dressing change was completed immediately All residents receiving treatments have the potential to be affected. The Director of Nursing (DON) completed a 100% audit was completed on 3/22/2022 of all residents who had treatment orders to validate that the wound care was provided as well as the treatment was signed for completed. No discrepancies were identified. By 3/22/2022, the DON re-educated the licensed nurses on regulation 483.25 regarding quality of care and ensuring residents receive treatment and care according to professional standards and practice. Education included the expectation of the licensed nurse to provide wound care as ordered by the physician, sign/initial and date dressing with each dressing change. Make sure TAR (treatment administration record) is signed to only reflect completion of dressing changes. The DON or Unit Manager will conduct reviews of 3 residents TARs to ensure that the treatment orders are signed for completed and visually inspect residents dressings to ensure it was changed, signed, and dated. At a frequency of 3	

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

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F 842	Continued From page 8 A phone interview with Nurse #4 on 3/21/22 at 12:41 PM revealed she worked with Resident #4 on 3/20/22 from 7:00 AM to 3:00 PM but she never got around to doing Resident #4's treatment to her left leg. Nurse #4 stated she went ahead and marked Resident #4's wound care to her left leg as completed on the TAR when she got ready to do it but Resident #4 had requested for her to come back later and when she did, Resident #4 had already gotten up out of the bed. Nurse #4 stated she reported this to the oncoming shift, but she could not remember the name of the nurse. An interview with the Director of Nursing (DON) on 3/24/22 at 9:05 AM revealed the nurses should have documented Resident #4's treatment on her left leg on the TAR after they had completed it and if they weren't able to do it on their shift, they should have documented that it had not been completed and verbally communicated that it still needed to be done to the oncoming shift nurse.	F 842		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.	F 888		4/20/22

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F 888	Continued From page 9 §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary	F 888		

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F 888	Continued From page 10	F 888		

vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive

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F 888	Continued From page 11 and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement an effective process for tracking COVID-19 vaccinations status of 1 of 3 staff reviewed for COVID-19 Vaccination Status (Nurse #1). The facility was not in outbreak status and had no positive cases for COVID-19 among the residents.	F 888	The Director of Nursing reviewed the listing on 3/21/2022 of the facility employees, licensed practitioners, students, trainees, and volunteers and contract personnel to ensure completion of a primary vaccination series for COVID and/or exemption waiver has been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 888	Continued From page 12 The findings included: A review of the facility's policy titled COVID-19 Vaccination, undated read in part: 2. COVID-19 vaccinations will be offered as per Centers for Disease Control (CDC) and/or Food and Drug Administration (FDA) guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. The facility staff vaccination spreadsheet was reviewed. The spreadsheet included in-house staff, staff exemptions, and contract/agency staff. A review of the facility spreadsheet revealed Nurse #1 was documented for receiving only one dose of the Moderna vaccination dated 1/26/22. A review on 3/21/22 of the National Healthcare Safety Network (NHSN) data for the week ending on 3/6/22 revealed the following staff vaccination information: Recent Percentage of Staff who are Fully Vaccinated = 83.5% A phone interview conducted with Nurse #1 on 3/21/22 at 3:52 PM revealed she had received her first dose of the COVID-19 vaccine on 1/26/22 but had not received a second dose. Nurse #1 further revealed she did not need to take her second dose until 3/27/22 because that was the expiration date on her card. Nurse #1 stated no one had told her the second dose of the vaccine needed to be completed. An interview conducted with the Director of Nursing (DON) on 3/21/22 at 4:12 PM revealed	F 888	submitted. Individuals that have not submitted proof of completion of their vaccination series and/or exemption waiver will not be allowed to enter the facility or report to work until provided. Director of Nursing and/ or Infection Preventionist will ensure compliance of COVID 19 documentation regarding vaccination completion and / or exemptions for all facility employees, licensed practitioners, students, trainees, and volunteers and contract personnel by utilizing the COVID 19 spreadsheet to ensure all documentation is received for data accuracy.. Results of ongoing COVID 19 vaccination tracking will be reported to the QAPI (quality assurance performance improvement) committee monthly by the DON or designee. The QAPI committee will evaluate the effectiveness of the monitoring / observation tools for making changes to the correction action if necessary to maintain substantial compliance. The QAPI committee members consists of but not limited to the Administrator, DON, MD, and at least 3 other members. Completion date: 4/20/2022	

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F 888	Continued From page 13	F 888		

she had been in the facility since 3/4/22 and her duties included handling staff's vaccination status. The DON further revealed she was not aware Nurse #1 had not received a second dose of the COVID-19 vaccine and she did not have an exemption or waiver. The DON indicated she was unable to find copies of staff's vaccination records and had to go by a spreadsheet that was left by the prior DON. The DON stated Nurse #1 should had already been fully vaccinated and received both doses of the COVID-19 vaccine.

An interview conducted with the Administrator on 3/21/22 at 3/21/22 at 4:30 PM revealed she was not aware Nurse #1 had not received a second dose of the COVID-19 vaccine. The Administrator further revealed copies of COVID-19 vaccine status were lost due to multiple management positions changing. The Administrator indicated Nurse #1 had thought the expiration date on the vaccine card was when the second dose was due but was in fact an expiration date. The Administrator revealed Nurse #1 did not have a waiver or exemption and should have been fully vaccinated.