DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	An unannounced Annual and Complaint survey was conducted at this facility from September 10, 2026, through September 15, 2026. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was fifty-three (53). The survey sample totaled fifteen (15) residents. Abbreviations/definitions used in this state report are as follows: DON - Director of Nursing; ED - Executive Director; EMR - Electronic Medical Record; LLAM - Limited Lay Administration of Medications; UAP - Unlicensed Assistive Personnel who have completed a Board of Nursing approved Limited Lay Administration of Medications curriculum.		Date of compliance for all citations is 10-30-26	
3225.0 **3225.1.0**	**Assisted Living Facilities** **Purpose** **The Department of Health and Social Services is issuing these regulations to promote and ensure the health, safety, and well-being of all residents of assisted living facilities. These regulations are also meant to ensure that service providers will be accountable to their residents and the Department, and to differentiate assisted living care from skilled nursing care. The essential nature of assisted living is to offer living arrangements to medically stable persons who do not require skilled nursing services and supervision. The**	**3225.11.0 - Infection Control** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; R5's annual UAI (Uniform Instrument Assessment) was completed by the Director of Nursing on 10/8/2026. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice;		

Provider's Signature John McDonough Title Interim Executive Dir. Date 10/27/2026

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	regulations establish the minimal acceptable level of services for residents of assisted living facilities. **Infection Control** **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R5) out of three residents reviewed for completion of the annual UAI (Uniform Assessment Instrument), the facility failed to ensure that R5's annual UAI was completed. Findings include: R5's clinical record revealed: 8/5/24 – R5 was admitted to the facility with diagnoses including dementia, anxiety, and osteoporosis. 8/5/25 – An annual UAI was completed. R5 was noted to be oriented to person, with short- and long-term "memory problems." 9/10/26 12:50 PM – Review of R5's EMR (Electronic Medical Record) lacked evidence that the annual UA1 for 2026 was completed. 9/10/26 1:55 PM - Finding was discussed with E2 (DON), who confirmed that 2026 UAI was not present in R5's EMR.	The DON/designee will review each current residents' UAI for annual compliance, or when there is a significant change. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur; R5's annual UAI was not completed in a timely manner due to a recent change in nursing administration on June 25, 2026. On 10/8/2026, The Director of Nursing was educated by the Executive Director on the Delaware UAI assessment regulations. The DON/designee will monitor the UAI schedule in Point Click Care for completion, to ensure all current residents annual/significant change assessments are timely completed. The DON/designee will conduct a quarterly audit to ensure all residents are compliant with their annual assessment, to include significant changes. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; The facility will conduct random audits on three (3) resident UAIs assessments, daily (for 4 weeks) until 100% is successfully achieved after three (3) consecutive evaluations; THEN, review three (3) resident UAI assessments once a week (for 4 weeks), until 100% is successfully achieved after three (3) consecutive evaluations. Finally, the facility will review residents annual UAI assessments one		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	9/11/26 10:30 AM – E2 confirmed that a paper copy of R5's 2026 UAI was not maintained in the office. 9/15/26 5:23 PM – Findings were reviewed with E1 (ED) and E2 during the Exit Conference.	more time (a month later) until 100% compliance is achieved. The Director of Nursing will ensure that 100% compliance is achieved at the facility's quarterly quality assurance meeting.		
3225.12.0 **3225.12.4** **S/S- E**	**Services** **In accordance with the service agreement, the assisted living facility shall provide or ensure the provision of all necessary personal services, including all activities of daily living, and shall ensure that personal care supplies are available.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for two (R5 and R9) out of three residents reviewed for ADL's (activities of daily living), the facility failed to ensure that the residents received their showers as outlined in their service agreements. Findings include: 1. R5's clinical record revealed: 8/5/24 – R5 was admitted to the facility. 8/5/25 – An annual UAI was completed. R5 was noted to be oriented to person and had short and long term "memory problems." 8/5/25 – R5's Resident Service Agreement documented that R5 would receive showers twice a week. 9/10/26 1:00 PM – Review of R5's EMR lacked evidence that R5 received scheduled showers on nine of nine opportunities in July 2026,	**3225.12.0 - Services** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; R5 is currently receiving her showers, twice weekly, as scheduled. R9 is currently receiving his showers, twice weekly, as scheduled. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice; The DON/designee will conduct an audit to ensure all residents are receiving their showers as scheduled. Completed on 10/6/2026. The Director of Nursing/designee will review each Resident Service Agreement to ensure each resident's shower schedule is assigned twice, weekly. The Clinical Care Coordinator/designee will post the shower schedule on each personal care assistant's assignment sheet, to ensure showers are being provided, as scheduled. The Charge Nurse/designee will notify the family when a resident refuses their shower and document resident's refusal, accordingly.	

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	eight of eight opportunities in August 2026, and three of three opportunities from September 1, 2026, through September 11, 2026. 9/11/25 2:30 PM – During an interview, E7 (UAP) showed surveyor the unit's shower schedule posted in the medication room. The schedule indicated that R5 was to receive a shower every Monday and Thursday on the evening shift (7:00 PM-7:00 AM). Based on the schedule, R5 was due to receive a shower on 9/10/26. E7 reported that R5 did not receive a shower 9/10/26. The facility failed to ensure that R5 received her scheduled showers on twenty out of twenty opportunities. 9/11/26 3:00 PM – Findings were reviewed and confirmed with E2 (DON). 2. R9's clinical record revealed: 6/21/21 – R9 was admitted to the facility with diagnoses included, but not limited to, intracerebral hemorrhage, chronic obstructive pulmonary disease, glaucoma, and atrial fibrillation. 2/27/26 – A facility document titled, "Resident Service Agreement V1 – V2", under "Services" indicated for R9 "Bathing - needs assistance by caregiver, showers two times per week, prefers AM shower, standby assist, Dressing: assist by caregiver daily, Communication: speaks English, can communicate needs, Safety: fall risk".	3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur; The facility failed to ensure that R5 & R9 received their showers due to staff not documenting that showers had been given or refused. The DON/designee will educate personal care assistants on the process for resident bathing and PoC documentation. All Personal Care Assistants will document resident showers given/refusal in the Point of Care system and report resident refusals to the Charge Nurse. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; The facility will conduct random audits on three (3) resident shower schedules, daily (for 4 weeks) until 100% is successfully achieved after three (3) consecutive evaluations; THEN, review three (3) resident shower schedules once a week (for 4 weeks), until 100% is successfully achieved after three (3) consecutive evaluations. Finally, the facility will review residents shower schedules one more time (a month later) until 100% compliance is achieved. The Director of Nursing will ensure that 100% compliance is achieved at the facility's quarterly quality assurance meeting.	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED:** September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	3/10/26 – A facility document titled, "Uniform Assessment Instrument for Assisted Living Facilities" revealed for R9 "short-term memory OK, long-term memory OK". 1. 8/26/26 12:21PM – A progress note entered by E14 (LPN) documented, "Resident Refused Shower this Shift Resident stated [R9] Received Shower 2 day ago[sic] Resident alert and oriented x3". 9/10/26 10:00 AM – During an observation with R9 in his private room, a sour odor was noted. In the interview, R9 stated, "They don't have enough help here. I haven't had a shower for three weeks. I ask and they tell me they will help me later, but they never do. About three weeks ago I had diarrhea. I pressed my button because I needed help in the bathroom. They never came. Eventually I got myself cleaned up and back to bed, but I really wanted a shower after that. I still haven't had one". 9/10/26 – Facility document entitled "[Name of facility] Daily Schedule" indicated R9's room number was scheduled for six showers during August 2026. 9/10/26 – A facility document titled "Documentation Survey Report v2- August 2026", under "Bathing," lacked evidence that R9 was assisted with bathing/ showering from 8/1/26 – 8/25/26 and 8/27/26 – 8/31/26. "NA" (not applicable) was documented by E11 on 8/26/26. 9/10/26 2:00 PM – During observation of E3 (LPN) instilling eye drops for R9, R9 stated, "I really hope someone can help me with a			

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	shower today". E3 replied that he would "check on it". 9/10/26 6:43 PM – E3 documented in a progress note, "Resident was given shower this afternoon, [R9] was re-educated on the importance of hygiene, resident was also notified of his shower days and times, [R9] prefers shower in the morning, and his shower was changed to morning, and aides were also notified of his shower changes". 9/11/26 8:30 AM – E7 (UAP) stated in an interview, "Showers are really not documented. I don't usually work in this area. I haven't helped [R9] with a shower, but he told me it's been three weeks since he's had one, and I told him, 'That's terrible." E7 could not demonstrate where resident care, including assistance with showers, is supposed to be documented in the electronic record or on paper. "It's been so long since I've done it, I don't know how to find it". 9/11/26 11:20 AM – During an interview, E12 (UAP) assigned to R9's area stated, "I'm the only one who does showers around here". When the surveyor asked whether E12 assisted any residents with a shower the previous day (9/10) or on the morning of 9/11, E12 replied, "No." 9/11/26 12:05 PM – During an interview, E2 (DON) stated, "Showers are not documented anywhere that I know of. If a shower doesn't get done, the next shift does it. They hold each other accountable". 9/14/26 2:00 PM – Findings were reviewed with E2.			

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	9/15/26 5:23 PM – Findings were reviewed with E1 (ED) and E2 during the Exit Conference.			
3225.17.0	**Environmental and Physical Plant**	**3225.17.0 Environmental and Physical Plant**		
3225.17.2	**Assisted living facilities shall:**	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;		
3225.17.2.3	**Assisted living facilities shall have a hazard-free environment.**			
S/S – E	This requirement was not met as evidenced by:	No. residents have been affected by this deficient practice.		
	Based on observation and interview, it was determined that for one out of one medication rooms observed, the facility failed to ensure that a hazard-free environment was provided for the residents on the memory care unit when the medication room was observed to be unlocked and unattended. The facility's failure to ensure that the doors were locked placed the residents at risk of accessing containers of chemicals that were stored in the unlocked closet in the room. Findings include:	During the moment of the identified findings on 9/11/2026, the Executive Director immediately removed the two bottles of Fantastik cleaner and Drug Disposal in a Bottle out of the unlocked closet in the medication room and placed it in a locked and secured cabinet outside of the Medication Room.		
		2. How will the facility identify other residents having the potential to be affected by the same deficient practice;		
	9/11/26 8:50 AM – Upon arrival at the locked memory care unit, the door to the medication room was propped open with a chair while the room was unattended. Inside the medication room were a locked medication cart, medical supplies, and an unlocked closet. On the floor of the unlocked closet were two spray bottles labeled "Fantastik" (cleaning solution) and two bottles labeled "Drug Disposal in a Bottle" (drug disposal solution).	The facility will ensure that the Medication room is closed and locked, unless a licensed professional or medication technician is using it.		
		The facility will ensure the closet located in the Medication Room is closed, locked and free from chemicals.		
		3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur;		
	9/11/26 - The memory care unit at the facility, according to their website, is "for seniors experiencing cognitive changes, including Alzheimer's or other forms of dementia, within	The facility failed to ensure that the medcation room was closed and locked when left		

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	a structured, secure, and supportive environment". Failure to secure chemicals, including two bottles of "Fantastik" cleaner and two bottles of "Drug Disposal in a Bottle," posed a serious health risk to residents if accidentally ingested. 9/11/26 – First aid measures if "Drug Disposal in a Bottle" is ingested instruct to "call Poison Control immediately or go to the nearest emergency room". https://www.mayoclinic.org 9/11/26 – First aid measures if "Fantastik" cleaner is ingested instruct to "call Poison Control immediately, and call 911 if the person is unconscious, having trouble breathing, or seizing". https://scienceinsights.org 9/11/26 8:55 AM – When asked in an interview if the medication door is usually left closed or open, E7 (UAP) replied, "I have to be honest. Sometimes it's closed. Sometimes it's open. But I know it's supposed to be closed". The medication room door was noted to include the signage, "Keep door closed/locked when not in use". E7 pulled the door closed after leaving the medication room. 9/11/26 2:15 PM – Findings were confirmed with E1 (ED) and E2 (DON). 9/15/26 5:23 PM – Findings were reviewed with E1 and E2 during the Exit Conference.	unattended. The facility failed to ensure the closet door was locked or free from chemical storage. The facility will place signage on the medication room door to remind staff to keep the door closed and locked when in use by a licensed professional or medication technician. The DON/designee educated licensed professional staff to ensure the medication room is closed and locked, unless a licensed professional or medication technician is using it. Completion: 10/8/2026 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; The facility will conduct checks of the medication room door and medication room closet, daily (for 4 weeks) until 100% is successfully achieved after three (3) consecutive evaluations; THEN, conduct checks of the medication room door and medication room closet once a week (for 4 weeks), until 100% is successfully achieved after three (3) consecutive evaluations. Finally, the facility will conduct checks of the medication room door and medication room closet one more time (a month later) until 100% compliance is achieved. The Director of Nursing will ensure that 100% compliance is achieved at the facility's quarterly quality assurance meeting.		
Title 16 Health and Safety **Chapter 11 Long Term**	**1131. Definitions**			

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
Care Facilities and Services **Subchapter III. Abuse, Neglect, Mistreatment, financial Exploitation, or Medication Diversion of Patients or Residents.** **S/S – J**	**(12) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** This requirement was not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that for one (R1) out of one resident reviewed for neglect, the facility failed to ensure that R1 did not leave the building unsupervised. R1, a cognitively impaired resident was able to exit the facility on 9/5/26 at 3:08 PM and was found by an EMT (emergency medical technician) at 4:18 PM at a street festival approximately five minutes away from the facility. R1 had sustained a fall and was unable to state her place of residence. This failure placed R1 at risk for a serious adverse outcome due to environmental hazards. Due to this failure, an Immediate Jeopardy (IJ) was called at 1:45 PM on 9/14/26. The IJ was abated at 5:00 PM on 9/15/26. Findings include: Review of R1's clinical record revealed: 8/5/26 – An UAI (Uniform Assessment Instrument) documented that R1 had confusion and was not oriented to time. The assessment also documented that R1 had short-term memory problems and a history of wandering inside buildings.			

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	8/5/26 – A facility document entitled, "Resident Service Agreement", completed by E2 (DON) documented, "...Elopement risk secondary to lack of safety awareness (dementia)..." The facility lacked evidence of interventions to address R1's risk of elopement. 8/21/26 – A facility document entitled, "Physician's Admission History and Physical", documented that R1 had memory impairment and a history of senile dementia. 8/25/26 – R1 was admitted to the facility with diagnoses including dementia. 8/25/26 – A facility document entitled, "Elopement Risk Screening", completed by E2 documented R1 was not at risk for elopement. 9/3/26 – A facility nursing document entitled, "Report 9/3 (9/3/26)" completed by E4 (LPN) documented, "...[R1]: Very confused this evening! Wandering around with her TV remote and keys. Frequently coming into [nurse's office] for help with TV remote...[R1] is not making sense. [R1] is trying to use our computer with her remote...". 9/5/26 – A facility incident report entered by E2 documented, "...EMT called [E5, Receptionist] at approximately 1608 [4:08 PM] and notified her that the resident was found at the [neighborhood] festival. According to the EMT [*sic*] a bystander reported to them that [R1] fell and sustained a scratch on her left 5th finger and was taken to [hospital] ER [emergency room] ...[E5] went to the festival to respond to the call, [E5] notified [E3, LPN]. [R1]	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • R1 was discharged from the facility 10-1-26, no other residents identified to have been effected. • All assisted living residents were reassessed to determine cognitive suitability for assisted living accommodations and ability to exit and return to the facility unsupervised by DON on 9-15-26		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	was taken to the hospital...". The facility incident report also documented that R1 would be moved to the "Hybrid Unit", have 1:1 supervision for 72 hours, and would be in the memory care unit during the day. 9/5/26 6:40 PM – An Alert Note entered by E3 documented, "...Notified by [E5] that she received a call from [EMT1] that they had [R1] at the [neighborhood] festival which is near the facility. [R1] was seen in the facility around 3 pm [3:00 PM] at the lobby speaking to front desk staff and with the aides providing care...[EMT1] later called to notify that they had taken [R1] to ER for evaluation...notified [E2] and [FM1]." 9/6/26 7:28 AM – A Health Status note documented, "[R1] returned from the hospital at 0530 [5:30 AM] [*sic*] no new orders from the hospital...[R1] taken to the memory care unit." 9/9/26 11:01 AM – During an interview, EMT1 (EMT) stated, "...4-5 bystanders walked [R1] over to our bus [ambulance vehicle]. [R1] had a laceration to her left hand that had stopped bleeding. [R1] was confused and alert to self only. I asked permission to look in her bag. [R1] had an ID [identification card] and a [facility] itinerary. I called the nurse's station and asked if [R1] lived there. They [facility] didn't know [R1] was missing...". EMT1 also stated that E5 did come to the location, but R1 could not be released because a wheelchair was needed, and that R1 was transported by another EMT ambulance to the emergency room for further assessment. 9/10/26 9:40 AM – During an interview, E2 stated, "When I did her assessment, she was	• Security door alarm device was replaced; all security doors verified to be operational 9-16-26 2. How will your facility identify other residents having the potential to be affected by the same deficient practice; • Hourly monitoring of newly admitted residents for dementia, confusion and wandering behaviors for 72 hours • Resident changes in condition will be reported to nursing supervisor or DON 3. What measures will be put into place or what systemic changes made to ensure that the deficient practice will not recur; and The DON/Designee will in-service: Started 9-15-26 • Staff in-service education on Dementia, Elopement, and Wandering Behaviors • Staff in-service reeducation on facility Hazardous and Wandering and Elopement Policy • Staff in-service education on Monitoring Residents with Dementia, Wandering and Confusion • Staff in-service education on facility Change in Condition Policy • Staff in-service education on Hybrid Assisted Living program • Staff in-service education on Elopement/Missing Resident procedure	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	alert and oriented. She does have baseline confusion and dementia, but [R1] was not appropriate for memory care [locked memory care unit]. We did not want to restrict [R1] because she likes to walk around. At the time of my assessment, [R1] was able to answer my questions. [R1] is still on 1:1 and is monitored during the day in the memory care unit. [R1] will remain on 1:1 until we can move her to the Hybrid Unit." 9/10/26 9:56 AM – During a joint interview with E1 (ED) and E2, E1 stated, "We looked at the video from when [R1] left the building. Another resident exited 4 minutes before [R1], and the door was closed." The Surveyor asked if there were any issues with the exit doors malfunctioning. E1 and E2 replied, "No". The Surveyor asked if the exit door was closed after the other resident left; how was R1 able to exit? E1 stated, "We don't know. We checked the door right after the incident and the door closed and locked. We can't figure out what happened." The Surveyor asked E1 and E2 what was the Hybrid Unit and if R1 had been moved there. E2 stated, "We don't have a vacancy to move [R1] right now. The Hybrid Unit is for residents who need to be monitored but are not at a cognitive level where they are appropriate for memory care." E1 and E2 also stated that during the day, residents on the Hybrid Unit are either taken to and monitored at activities or taken to the locked memory care unit. If residents stay on the Hybrid unit, an assigned caretaker monitors them while in their rooms. Hybrid residents are taken back to their rooms in the evening. The unit is locked overnight until the next morning.	• Elopement/missing resident drill was conducted by facility 9-15-26 @ 6:35PM, 9-10-26 @ 7:30PM • A security door lock audit each shift by Maintenance/designee 4. How will your facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes (quality assurance program). • Audits will be reviewed daily x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is achieved. • This plan was abated 9-15-26 @ 5pm • Date Certain 10-30-26		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	9/10/26 10:45 AM – During an interview, E5 (Receptionist) stated, "...[R1] was normally confused. [R1] was not allowed to go out. I was talking to her at the front desk. I did not know that she left. [EMT1] called at 4:18 PM and said that [R1] was there. I went over to meet [EMT1]. [EMT1] told me I couldn't take [R1] back because I needed a wheelchair. I went back to tell [E3]. E3 and I were walking back over to [EMT1] with a wheelchair to get [R1] when [EMT1] called and said [R1] was transported to the hospital...". 9/10/26 12:14 PM – During an interview, E3 stated, "I saw [R1] around lunchtime between 1:00 PM and 2:00 PM in the 1st floor hallway. I check on the residents every two hours. [R1] was very confused in the morning. [R1] is not allowed to go out on her own." The Surveyor asked E3 if R1's service agreement documented that R1 could go out of the building unsupervised. E3 stated, "No." 9/10/26 1:00 PM – During an interview, the Surveyor asked E2 why R1's service agreement had no documented elopement risk interventions. E2 stated, "Elopement risk was only checked off because of [R1]'s dementia diagnosis. [R1] did not have any previous behavior of exit-seeking or elopements, so [R1] was not considered to be an elopement risk". The Surveyor asked E2 if R1 was allowed to go out of the building unsupervised. E2 stated, "No, [R1] could not go out because [R1] would not be able to enter the code on the keypad to unlock the exit doors." 9/11/26 9:45 AM – During an interview, FM1 (Family Member) stated, "[R1]'s dementia had progressed and getting worse. We			

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	needed to put [R1] in a place to be looked after. [R1] was becoming more forgetful and confused. I was under the impression that [R1] was going to be in the Hybrid Unit when we moved her from [prior facility]. I was talking to [E10, DOS] about it during the admission process because I thought [R1] needed more care. I remember asking [E1] about it. [E1] told me that [R1] is just assisted [assisted living]. I could have kept [R1] over at [prior facility] for assisted living." 9/11/26 10:41 AM – During an interview FM2 (Family Member) stated, "I thought we were putting [R1] in a place where she would be safe. We worried about [R1] wandering away. [R1]'s dementia was getting worse. I did the entrance interview with [E2]. I'm sure I expressed I was concerned about [R1]'s safety. I thought she would be getting structured care and that the doors would be locked. I just wanted to make sure [R1] wouldn't just wander off." 9/11/26 11:20 AM – During an interview, E10 stated, "I'm not aware of any concerns from the family about [R1] being in the Hybrid Unit." The Surveyor asked E10 who assigned R1 to an assisted living apartment. E10 stated, "I have conversations with E2 about if a resident is going to be placed in assisted living or memory care. [E2] said that [R1] was appropriate for assisted living." 9/11/26 11:39 AM – During an interview, E13 (MT) stated, "I have been checking the exit doors every day since I have been here." E13 also stated he had been employed at the facility for six months. The Surveyor asked E13 if there were any problems with the exit			

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	doors and if there was a log documenting the daily exit door checks. E13 stated, "No. I just knew there was a problem with this door after Saturday [9/5/26]. It is working but a new lock was ordered." 9/11/26 5:00 PM – R1 was relocated to the Hybrid Unit. 9/14/26 9:15 AM – During an interview E4 (LPN) stated, "That Thursday and Friday [9/3/26 and 9/4/26] we [staff] were all like [R1] is confused. [R1] was getting more confused. Then [R1] was wandering. [R1] kept coming into the office. I put it in the report. I remember saying we need to keep an eye on [R1] and I'm afraid [R1] is going to walk right out of here." The Surveyor asked E4 if the elopement concern was reported to anyone. E4 stated, "I don't know if I put that in the report. I was just like we need to keep an eye on her. I told [E2] that [R1] was very confused. [E2] just said that [R1] just confused about the time." 9/14/26 1:50 PM – An immediate jeopardy was called due to the facility's failure to supervise R1 after it was documented that R1 was at risk for elopement and staff acknowledgment of R1's confusion. It was also documented that R1 began to display wandering behavior and increased confusion, raising concern for R1's potential elopement that was not reported by staff. The facility lacked evidence of implementation of interventions to address R1's increased confusion, wandering, and potential for elopement. The facility's lack of supervision resulted in R1 exiting the facility unsupervised where she was			

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	found by festival bystanders after sustaining a fall in the street. 9/15/26 11:30 AM – The facility's abatement plan for the immediate jeopardy included: - Hourly monitoring of newly admitted residents for dementia, confusion and wandering behaviors for 72 hours - All resident changes in condition will be reported to nursing supervisor or DON - All assisted living residents were reassessed to determine cognitive suitability for assisted living accommodations and ability to exit and return to the facility unsupervised - Security door alarm device was replaced; all security doors verified to be operational -Implementation of security door lock audit to be completed each shift by concierge, maintenance staff and nursing supervisor -Staff in-service education on Dementia, Elopement, and Wandering Behaviors -Staff in-service reeducation on facility Hazardous and Wandering and Elopement Policy -Staff in-service education on Monitoring Residents with Dementia, Wandering and Confusion -Staff in-service education on facility Change in Condition Policy -Staff in-service education on Hybrid Assisted Living program -Staff in-service education on Elopement/Missing Resident procedure			

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
S/S – E	- Elopement/missing resident drill was conducted by facility 9/15/26 3:45 PM – Staff interviews were conducted and in-service education and training verified. The IJ was considered abated on 9/15/26 at 5:00 PM. 9/15/26 5:23 PM – Findings were reviewed with E1(ED) and E2 (DON) during the exit conference. **c. "Failure to carry out a prescribed treatment plan for a patient or resident."** This requirement was not met as evidenced by: Based on interviews and record reviews, it was determined that seven (R8, R9, R10, R11, R12, R13 and R15) of twenty residents reviewed for medication administration, the facility failed to have evidence in the clinical record that the residents received their prescribed medications including anticoagulants, antiarrhythmics and antihypertensives on 8/1/26. Findings include: 1. R8's record revealed: 2/1/24 – R8 was admitted to the facility with diagnoses included, but not limited to, stroke, atrial fibrillation, type 2 diabetes, and hypertension. 2/5/26 – Review of a document for R8 titled, "Uniform Assessment Instrument for Assisted Living Facilities", revealed that R8 "required administration of medication and was oriented to person, place, and time with short-			

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	term memory 'OK' and long-term memory 'OK". 9/10/26 11:15 AM – R8 stated, "...A few weeks ago they forgot to give me my medication three nights in a row. The third night, I pressed my button to remind them, and all night no one came... I never received my medications, and it upsets me because they work for me and they are expensive". 9/11/26 – Review of R8's MAR (medication administration record) lacked evidence that R8 received the following medications on 8/1/26: diltiazem (used to treat high blood pressure and control heart rate) 24H ER (24 hour extended release) 360 mg (milligrams) ordered on 4/1/25 to give one capsule daily; eliquis (blood thinner used to prevent or treat stroke/blood clots) 5mg, ordered on 10/20/25 to give one table twice a day – R8 did not receive the 8:00 AM dose; amiodarone HCL (used to treat abnormal heart rhythm) 100 mg, ordered on 5/19/26 to give once daily. 2. R9's record revealed: 6/21/21 – R9 was admitted to the facility with diagnoses included, but not limited to, intracerebral hemorrhage, chronic obstructive pulmonary disease, glaucoma, and atrial fibrillation. 9/11/26 – Review of R9's MAR lacked evidence that R9 received the following medications on 8/1/26:	**S/S - E** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	metoprolol succinate extended-release 50 mg tablet orally one time a day at 10 AM for essential primary hypertension. Physician order start date: 4/1/2025 1000 (10 AM); bumetanide 2 mg tablet orally two times a day for edema. Physician order start date: 4/1/2025 1000 (10 AM); dorzolamide hcl timolol ophthalmic solution 2-0.5 %, instill 1 drop in left eye three times a day for glaucoma. Physician order start date: 2/12/2026 2100 (9 PM); brimonidine tartrate ophthalmic solution 0.2 %, instill 1 drop in left eye three times a day for glaucoma. Physician order start date: 2/13/2026 0910 (9:10 AM); latanoprost pf ophthalmic solution 0.005 %, instill 1 drop in the left eye at bedtime for glaucoma. Physician order start date: 4/1/2026 2100 (9 PM). 3. R10's chart revealed: 3/5/26 – R10 was admitted to the facility with diagnoses including paroxysmal atrial fibrillation, heart failure, coronary artery disease, hypertension. 9/10/26 – Review of R10's MAR lacked evidence that R10 received the following medications on 8/1/26: rivaroxaban (blood thinner used to prevent or treat stroke/blood clots) 5 mg, ordered on 3/5/26 to give one tablet daily at bedtime; amlodipine (used to treat high blood pressure) 10 mg, ordered on 3/6/26 to give one tablet once daily;	The Director of Nursing evaluated the identified residents and determined there were no adverse effects from these findings. R8 had no adverse effects of the undocumented evidence of medication administration. R9 had no adverse effects of the undocumented evidence of medication administration. R10 had no adverse effects of the undocumented evidence of medication administration. R11 had no adverse effects of the undocumented evidence of medication administration. R12 had no adverse effects of the undocumented evidence of medication administration. R13 had no adverse effects of the undocumented evidence of medication administration. R15 had no adverse effects of the undocumented evidence of medication administration. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice; On 10/8/2026, the DON/designee audited all medication administration records to identify any missed or not administered medications.		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	furosemide (a diuretic used to treat heart failure) 40 mg, ordered on 3/6/26 to give one tablet once daily; isosorbide Mononitrate (used to prevent chest pain and treat high blood) 24H ER 30 mg, ordered on 3/6/26 to give one tablet once daily. 4. R11's record revealed: 1/28/26 – R11 was admitted to the facility with diagnoses included, but not limited to, chronic atrial fibrillation, atrial flutter, type 2 diabetes mellitus and essential hypertension. 9/11/26 – Review of R11's MAR lacked evidence that R11 received the following medications on 8/1/26: losartan potassium oral tablet 25 mg. Give 1 tablet by mouth one time a day for essential primary hypertension. Physician order start date: 02/04/2026 0800 (8 AM); metformin tablet extended-release 24-hour 500 mg. Give 1 tablet by mouth one time a day related to type 2 diabetes mellitus. Physician order start date: 02/04/2026 0800 (8 AM); metoprolol succinate er oral tablet extended-release 24 Hour 25 mg. Give 1 tablet by mouth one time a day related to essential primary hypertension. Physician order start date: 02/04/2026 0800 (8 AM); apixaban oral tablet 5 mg. Give 1 tablet by mouth two times a day related to chronic atrial fibrillation. Physician order start date: 02/03/2026 1900 (7 PM). 5. R12's record revealed:	Any missed medications identified will be reported to the physician and family and residents will be monitored for any adverse effects. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur; The facility failed to monitor medication administration reports daily, to ensure residents received their medications as prescribed. The DON/designee will educate licensed nurses and certified medication technicians to check medication pass completion, prior to the end of the shift, to ensure medication administration is completed on every shift. The DON/designee will educate licensed nurses, and certified medication technicians to check resident medications marked as "not administered", be reported to the nurse, physician and monitored by the Director of Nursing for adverse effects. The DON/designee will conduct medication administration audits 5 times weekly, to ensure medications are administered to residents on every shift. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; The DON/designee will conduct daily audits of medication administration, daily (for 4 weeks) until 100% is successfully achieved after three (3) consecutive evaluations; THEN,		

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	12/5/26 – R12 was admitted to the facility with diagnoses included, but not limited to, hypertension, asthma, and chronic obstructive pulmonary disease. 9/11/26 – Review of R12's MAR lacked evidence that R11 received the following medications on 8/1/26: incruse ellipta 62.5 mcg in 1 puff, inhale orally one time a day related to chronic obstructive pulmonary disease. Physician order start date: 04/01/2025 0800 (8 AM); amlodipine besylate tablet 5 mg, give 1 tablet by mouth one time a day for blood pressure. Physician order start date: 05/16/2025 0800 (8 AM). 6. R13's record revealed: 7/30/24 – R13 was admitted to the facility with diagnoses included, but not limited to, chronic atrial fibrillation, personal history of pulmonary embolism, syncope and collapse, and hypertension. 9/11/26 - Review of R13's MAR lacked evidence that R11 received the following medications on 8/1/26: carvedilol 3.125 mg tablet, give one tablet orally two times a day related to hypertension. Physician order start date: 04/01/2025 0800 (8 AM); eliquis 2.5 mg tablet, give one tablet orally two times a day for A-FIB. Physician order start date: 04/01/2025 2000 (8 PM). 7. R15's chart revealed:	review three (3) daily audits once a week (for 4 weeks), until 100% is successfully achieved after three (3) consecutive evaluations. Finally, the DON/designee will review daily audits one more time (a month later) until 100% compliance is achieved. The Director of Nursing will ensure that 100% compliance is achieved at the facility's quarterly quality assurance meeting.		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	2/6/23 -R15 was admitted to the facility with diagnoses including stroke, carotid stenosis, chronic thrombosis (blood clot) of the lower extremity. 9/10/26 – Review of R15's MAR lacked evidence that R15 received the following medications on 8/1/26: warfarin (blood thinner used to prevent or treat stroke/blood clots) 4 mg, ordered on 5/1/26 to give one tablet in the evening every Mon., Tues., Wed., Thur., Fri., Sat; amlodipine (used to treat high blood pressure) 10 mg, ordered on 4/8/25 to give one tablet once daily; losartan (used to treat high blood pressure) 50 mg, ordered on 4/1/25 to give one tablet once daily. 9/11/26 – Review of a document titled "IVY GABLES DAILY SCHEDULE" for Saturday 8/1/26 7 AM – 7:30 PM, recorded as supervisor: E4 (LPN). Call placed to E4 was not immediately returned. 9/11/26 2:15 PM - During interviews with E1 (ED) and E2 (DON), findings were reviewed. E1 and E2 had no recollection of computer downtime and offered no other explanation for the missing doses on 8/1/26. 9/14/26 9:00 AM – In a phone interview E4 (LPN) stated, "I did work that day. I can't explain why the medications are not signed off. I always sign them off. Sometimes people steal the chargers on the med carts. But even then, I can just sign them off in the office." When the Surveyor asked how E4 would determine which medications and dosages to			

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	give if there is no computer access, E4 responded, "I have them memorized. I pretty much know what everyone takes. I think I was the only one there that day who could give medications. I think it was the day I was pulled to [Name of unit]". When the Surveyor questioned how one staff member could administer the medications for over 50 residents, E4 replied, "It's really hard". 9/14/26 1:00 PM – Timecard for E4 indicated hours worked on 8/1/26 6:48 AM – 7:29 PM. 9/14/26 2:15 PM – Findings were reviewed and confirmed with E1 and E2. 9/15/26 5:23 PM – Findings were reviewed with E1 (ED) and E2 (DON) during the Exit Conference.			
S/S – E	**Title 24 Regulated Professions and Occupations** **1900 Board of Nursing** **5.0 Limited Lay Administration of Medications (LLAM)** **5.4.2 LLAM - Trained UAPs are required to renew their status annually by successfully demonstrating competency in the LLAM process with no errors and by achieving a minimum score of 85% on the annual review exam. A letter of completion will be issued after successful renewal of competencies each year.** This requirement was not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that for four (E6, E7,			

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	E8, and E9) out of five Unlicensed Assistive Personnel (UAP) staff members reviewed for annual recertification, it was determined that the facility failed to ensure that the annual recertifications were completed. Findings include: Facility's documentation revealed: 1. 6/6/24 – E6, Unlicensed Assistive Personnel (UAP) training record revealed the initial certification of training. The facility's record lacked evidence that E6 received the annual recertification training, which was due on 6/6/26. 2. 7/8/24 - R7, Unlicensed Assistive Personnel (UAP) training record revealed the initial certification of training. The facility's record lacked evidence that R7 received the annual recertification training which was due on 7/8/26. 3. 10/24/24 – R8, Unlicensed Assistive Personnel (UAP) training record revealed the initial certification of training. The facility's record lacked evidence that R8 received the annual recertification training, which was due on 10/24/25. 4. 6/3/25 – R9, Unlicensed Assistive Personnel (UAP) training record revealed the initial certification of training. The facility's record lacked evidence that R9 received the annual recertification training, which was due on 6/3/26. 9/11/26 1:30 PM – During an interview, E1 (ED) stated, "I thought the training was due every two years."			

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
	The facility failed to ensure that the annual UAP recertification training course were completed per the State Regulations. 9/15/26 5:23 PM – Findings were reviewed with E1 (ED) and E2 (DON) during the Exit Conference.	**S/S – E** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 9/14/2026, the DON audited five (5) of the identified LLAM certified technicians for compliance. Three (3) were identified to be out of		

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC **DATE SURVEY COMPLETED: September 15, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
		compliance (one of the 3 is no longer employed) and two (2) of the remaining five (5) were compliant. On 9/14/2026, three (3) of the expired LLAM certified medication technicians were immediately removed from the duties of administering medication to residents. 2. How will the facility identify other employees having the potential to be affected by the same deficient practice; The DON/designee will conduct monthly audits of LLAM certified medication technicians to ensure their certification is current. The Director of Nursing will enroll in the next upcoming LLAM Certification Train the Trainer course, to ensure annual certifications are following the regulation. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur; On 9/14/2026, the Director of Nursing educated the LLAM certified medication technicians to reinforce their responsibility in maintaining their certification. On 9/14/2026, the Director of Nursing educated the LLAM certified medication technicians on notifying the DON when certification is approaching expiration for a renewal course.		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: Asbury Ivy Gables LTD, LLC

DATE SURVEY COMPLETED: September 15, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		C
		4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; The Director of Nursing/designee will conduct random audits on each LLAM certified medication technician for current certification, daily (for 4 weeks) until 100% is successfully achieved after three (3) consecutive evaluations; THEN, audit each LLAM certified medication technician for current certification, once a week (for 4 weeks), until 100% is successfully achieved after three (3) consecutive evaluations. Finally, the Director of Nursing will review LLAM certified medication technicians for current certification one more time (a month later) until 100% compliance is achieved. The Director of Nursing will ensure that 100% compliance is achieved at the facility's quarterly quality assurance meeting.		

Provider's Signature _____ Title _____ Date _____