DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

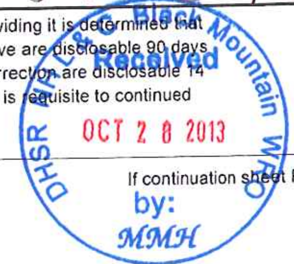
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING ______ B. WING ______	C 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	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 No deficiencies were cited as a result of the complaint investigation. Event ID# G4LW11.	F 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff interviews the facility failed to provide nail care for 1 of 4 residents reviewed for activities of daily living (Resident #24). The findings included: Resident #24 was admitted to the facility on 01/12/13 with diagnoses which included Alzheimer's dementia. The most recent quarterly Minimum Data Set (MDS) dated 06/20/13 revealed the resident was severely impaired for making decisions of daily living and required one person assistance with all activities of daily living (ADL) including assistance for personal hygiene and total assistance with bathing, toileting and transfers. The Resident #24's current care plan last reviewed 07/25/13 revealed the Resident required assistance with ADL due to diagnosis of Alzheimer's dementia. The ADL care plan included approaches to assist Resident #24 to	F 312	Corrective action for the alleged deficient practice was accomplished by nail care given to Resident #24 on 10/4/13 consisting of soaking, trimming, filing debris removal, and application of a coat of fresh polish. To ensure that others were not affected by the same alleged deficient practice, all residents were audited using a form that consists of the following items: nails trimmed with even edges, nails free from debris and free from chipped polish. NA were in serviced on 10/23/13 on appropriate nail care, monitoring tool completion, notification and immediate remedy of any adverse findings. Activity designee and Shower Technician were also in serviced and reminded to check nails during showers, manicures, or food related activities. The system put into place to maintain compliance is to have the nurses or designee use the tool for monitoring nails daily for each resident for 4 weeks beginning 10/23/13. After substantial compliance is achieved, the nurse or designee will monitor each resident weekly for 4 weeks. If no issues are noted, the nurse or designee will monitor monthly thereafter for 4 months. Total monitoring time will be no less than 6 months. Any issues noted will be corrected immediately and reported to the QAPI steering committee.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly W. Long
TITLE: Administrator
(X6) DATE: 10/25/13

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.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	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 312	Continued From page 1 have a clean and neat appearance, toileting, eating, and showers per facility policy. A review of Resident #24's Nursing Assistant (NA) Care Card for Resident #24 specified she was to receive nail care daily and as needed. During an observation on 10/01/13 at 8:42 AM Resident #24's right hand was visible and observed 5 finger nails were untrimmed with uneven edges, debris was noted under the nails and the polish was observed to be chipped. During an observation on 10/01/13 at 1:55 PM Resident #24 was observed with all 10 fingernails which were 1/8 to 1/4 inch long with uneven edges, chipped pale pink polish, and a brown colored substance was noted under the nails of the of the thumb, index and middle fingers of both hands. During an observation on 10/01/13 at 3:37 PM Resident #24's fingernails remained unchanged and were unclean and untrimmed. During an observation on 10/02/13 at 8:41 AM Resident #24 was observed all 10 fingernails remained unclean and untrimmed with uneven edges as observed the previous day which were 1/8 to 1/4 inch long with uneven edges, chipped pale pink polish, and a brown colored substance was noted under the nails of the of the thumb, index and middle fingers of both hands. During an interview on 10/02/13 at 11:12 AM NA #1 stated she was familiar with the care of Resident #24. NA #1 revealed showers were completed by the shower team which included hair shampoo, shaving and nail care. NA#1	F 312	To ensure that the system remains and is effective, a report will be compiled by the DON or designee weekly of the findings. Any adverse findings will result in a Process Improvement Plan. The findings will be reviewed monthly for 6 months in Quality Assessment and Performance Improvement meeting. Date of completion is 10/25/13	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	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 312	Continued From page 2	F 312		

stated Resident #24 often ate with her hands and fingers. NA #1 observed the fingernails of Resident #24 and confirmed the debris was present under the fingernails and the nails were untrimmed.

During an interview on 10/02/13 at 11:16 AM the Administrator observed Resident #24's fingernails were observed with a brown substance under the nails and were untrimmed. The Administrator confirmed Resident #24's fingernails needed nail care to be completed. The Administrator verified nursing assistants were expected to complete nail care during showers and daily as needed.

During an interview on 10/02/13 at 2:00 PM NA #2 stated she was familiar with the care of Resident #24 and was on the shower team. NA #2 further stated Resident #24 received showers on Wednesdays and Fridays. NA #2 revealed she completed a shower for Resident #24 during the morning of 10/02/13 and verified nail care was not provided. NA #2 verified the task of nail care was provided during showers and as needed and included, trimming, filing and cleaning under the nails.

During an interview on 10/03/13 at 12:36 PM NA #3 stated she was familiar with the care of Resident #24. NA #3 stated Resident #24 was normally pleasant but was sometimes confused and could be resistant to care. She further stated Resident #24 could be redirected or approached after a few minutes and would then allow nail care to be completed. NA #3 revealed that talking calmly with Resident #24 or doing partial care in short increments would allow successful completion of nail care for her.

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 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	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 312	Continued From page 3 During an interview on 10/03/13 at 12:36 PM Nurse #1 stated she was familiar with the care of Resident #24. Nurse #1 confirmed she had completed nail care for Resident #24 in stages. She further revealed that Resident #24 could be redirected easily.	F 312		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to provide extractions, restorations, and periodontal cleanings recommended as a result of a comprehensive dental exam for 1 of 1 sampled resident reviewed for dental status and services (Resident #13). The findings included: Resident #13 was admitted on 09/03/10 with diagnoses including dementia, blindness, and Parkinson's disease. A quarterly Minimum Data Set (MDS) 07/15/13 revealed Resident #13 had short and long-term memory problems and severely impaired cognitive skills for daily	F 412	Corrective action for the alleged deficient practice was accomplished for Resident #13 by scheduling an appointment for extractions. On 10/03/13 Long Term Care Associates (Consulting Dentist) was notified by the facility Social Service Director for the follow-up on prior recommendation of extractions. LTCA was asked to call the local hospital to schedule the appointment. On 10/08/13, Long Term Care Associates called the facility to report that the dentist was in agreement and that they would be working with the hospital to schedule an operating room. An order was obtained on 10/08/13 from the NP for teeth extractions. On 10/18/13 consulting dentist (LTCA) informed the facility of the scheduled 11/11/13 appointment for extractions. On 10/18/13 the appointment was added to the facility transportation schedule. On 10/18/13 the family was notified of the order, scheduled appointment, and transportation. Appropriate Social and Nursing documentation noted in the chart.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	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 412	Continued From page 4 decision making. The quarterly MDS noted Resident #13 was totally dependent on staff for activities of daily living including personal hygiene. Review of the medical record revealed a physician's order dated 08/15/13 for Resident #13 to be evaluated by a dentist for a teeth guard. Review of a social service progress noted dated 08/16/13 revealed the Social Work Director (SW) had received an order to make a dentist appointment to see if Resident #13 could benefit from a teeth guard due to a recent increase of grinding his teeth. There were no progress notes written by the SW after 08/16/13 which addressed Resident #13's visit to the dentist or any recommendations. Review of a consultation note dated 09/04/13 revealed Resident #13 had a comprehensive dental exam which noted tartar build up, tooth decay, and decay that could not be corrected. The treatment plan included extractions, restorations, and periodontal cleanings. The consultation note further stated Resident #13 could not transfer to the dental chair for treatment and referred him to another dental clinic. During an interview on 10/03/13 at 11:45 AM the SW stated she contacted Resident #13's family member after the dentist appointment on 09/04/13 and shared the recommendations and referral information. The family member did not think Resident #13 could tolerate the travel distance to the clinic recommended by dentist. The SW explained she had planned to investigate possible local options for the treatment plan recommended on 09/04/13 but had not made any	F 412	To ensure that others were not affected by the same alleged deficient practice, all medical records were audited for follow-up recommendations on 10/22/13 by the DON. On 10/22/13 the facility Social Service Director provided the DON with a list of all residents who have received dental services within the last 6 months. On 10/22/13 the DON called LTCA and compared her list and recommendations with theirs. Charts were audited by the DON to ensure that recommendations were met. The system put into place to ensure compliance is that the Licensed Nurses, Social Service Director, and Medical Records Clerk were in serviced on 10/24/13. The in service covered the following: Facility Policy & Procedure on Dental Services, System for follow-up on recommendations, Documentation, and auditing records for compliance. The system put into place to ensure that the facility remains in compliance includes discussing dental appointments and follow-up items daily in morning meeting. Appointment referrals will be given to the Social Service Director, and copies given to the DON and Medical Records Clerk. These items will be discussed and tracked by the DON through discussion in the morning meeting and weekly audit by Medical Records Clerk or designee to ensure: orders obtained, notes are written, appointments made, families notified and transportation arranged. Both the Medical Records Clerk and the Social Services Director will us a monitoring tool for tracking. Implemented 10/25/13. This will be an ongoing best practice.	

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 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	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 412	Continued From page 5 contacts thus far. The SW further stated she did not typically wait a month to schedule an appointment after a referral had been made but could not explain why she had not contacted dentists and/or scheduled Resident #13's dental appointment. An interview was conducted with the Administrator on 10/03/13 at 12:50 PM. The Administrator stated she expected referrals to be scheduled when ordered and also noted there should be a system in place to assure all referrals were scheduled promptly.	F 412	To ensure that this system remains in place the DON will monitor compliance by reviewing the tool each business day with the Social Services Director or designee three times per week for 4 weeks. Any findings will be corrected immediately and the Administrator notified. The DON or designee will monitor the tool weekly for one month, then monthly for 6 months. A report will be compiled by the DON or designee and presented to the Quality Assessment and Performance Improvement meeting monthly for 6 months. Date of completion is 10/25/13.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	Corrective action for the alleged deficient practice was met by registering for a State approved course on 10/25/13. The Administrator phoned Dr. Allen to inquire about the certification class on 10/25/13 and the DON was on the registration list for the next available SPICE program beginning in late January 2014. Because of the requirements for certification, the online course for which she had originally been registered did not meet State requirements. To ensure others are not affected by the same practice, the Administrator added the requirement to the Job Description for DON. This will be a basic requirement before employment is offered and certification must be kept current. To ensure that this system remains in place, the BOM will check for certification prior to any job offer and monthly as long as the current DON holds the certificate. Any issues will be discussed immediately with the Administrator. All findings will be discussed monthly with a report given to the Quality Assessment and Performance Improvement Council.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	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 441	Continued From page 6 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide the training required for the facility designated Infection Control Preventionist and failed to provide training to nursing staff to ensure blood glucose meters (glucometers) were disinfected/sanitized by the manufacturer's instructions during 1 of 1 observation of a glucometer being disinfected. The findings included: 1. On 10/01/2013 at 4:30 PM in an interview the Director of Nurses (DON) revealed she was hired in August of this year as the DON and also accepted the position of Infection Preventionist (IP) to implement and carry out the infection control program for the facility. The DON further revealed she had never taken an infection control course on implementing an infection control program in a healthcare setting but had been instructed to use the manual and policies provided by the facility Administrator. The DON	F 441	Corrective action for providing the training for Nursing Staff to ensure blood glucose meters were disinfected in accordance with manufacturer's instructions was met on 10/2/13 by instructing Nurse #2 on the proper disinfectant procedure. Nurse #2 as required to complete a return demonstration of competency before using the blood glucose machine again. Nurse #2 demonstrated 100% competency. To ensure that others were not affected by the same alleged deficient practice, training of all licensed staff began on 10/3/13. Each licensed staff member attended an in service and completed a competency return demonstration prior to their next scheduled shift. Training was completed on 10/23/13. The supply clerk was instructed to order the same product without deviation. Instruction and training on proper disinfectant procedure was added to new employee orientation. New employees are required to complete a return demonstration of competency scoring 100% prior to administering blood glucose testing. To make sure that the system remains in place the DON or designee will complete return demonstration exercises on random shifts and with random Licensed Staff three times per week for 4 weeks. Anyone that does not present 100% competency will be retrained and not allowed to administer the check until 3 additional 100% competency demonstrations by the individual have been completed. Any findings of less than 100% competency will be discussed immediately with the Administrator and a Process Improvement Plan will be developed. The random demonstrations will continue with	

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 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	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 441	Continued From page 7 confirmed she was unaware the infection control training was regulatory. The DON also stated she had no knowledge of being signed up for a course or when she would receive infection control training. On 10/02/2013 at 8:50 AM in an interview the Administrator revealed the facility had sent the last person in the IP position to Infection Control Training in March 2013 and even though she left their employment in June she felt the facility was still covered. The Administrator stated when she hired the new DON she asked her if she was interested in the IP position. The Administrator confirmed she planned to sign the DON up for infection control training which was scheduled for March of 2014 in Chapel Hill but had been busy and had not signed her up yet. 2. A facility policy entitled Cleaning and Disinfection of Glucometers dated 04/30/10 specified in part to disinfect the exterior surface with a germicidal agent after each use following manufacture direction and allow to self dry. A review of the Instructions provided by the manufacturer of the germicidal disposable wipe utilized by the facility was conducted. The directions specified to accomplish disinfection of a hard surface, treated surface must remain visibly wet for a full 3 minutes. Use additional wipes if needed to assure continuous 3 minute wet contact time. Let air dry. An observation was conducted on 10/01/13 at 4:40 PM of Nurse #2 obtaining finger stick blood sugar (FSBS) readings. Nurse #2 was observed entering Resident #10's room and following proper procedure for obtaining a FSBS reading.	F 441	weekly random audits for 4 weeks and monthly thereafter for 6 months. A monthly report of all findings will be compiled by the DON or designee and reviewed with the QAPI committee for 6 months. Completion 10/25/13	

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 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	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 441	Continued From page 8 Upon completion, Nurse #2 returned to the medication cart. At 4:45 PM she wiped the glucose meter (glucometer) with a germicidal wipe, tossed the wipe into the trash bin, and wiped the glucometer off with a tissue paper and left the glucometer sitting on the medication cart. The glucometer appeared dried. She did not ensure the glucometer remained wet with germicidal solution for a full 3 minutes. An interview with Nurse #2 on 10/01/13 at 4:58 PM revealed it was facility procedure after utilizing a glucometer to wipe the glucometer down with a germicidal wipe. She stated the glucometer was allowed to dry for 3 minutes or more before it was utilized again. Nurse #2 was unaware of ensuring the glucometer remained wet with germicidal solution for 3 minutes to complete the disinfecting process. On 10/02/13 at 10:32 AM the Director of Nursing (DON) was interviewed. The DON stated she was responsible for Infection Control monitoring in this facility. The DON stated nurses were instructed to clean the glucometer before and after each use. She added nurses were to wipe the glucometer with a germicidal wipe and allow the glucometer to dry for 3 minutes before used for resident blood glucose monitoring. The DON was unaware the glucometer had to remain wet for 3 minutes to accomplish disinfection. She further added if Nurse #2 was not disinfecting per manufacture guidelines none of the nurses were because they were not in-serviced to disinfect by leaving the glucometer visibly wet for 3 minutes.	F 441		