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 _____	02/05/2015

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 An amended Statement of Deficiencies was provided to the facility on 03/05/15 because two examples from tag F-309 were deleted from the CMS 2567 report. Event ID# I3K711.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		3/5/15

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

Electronically Signed | 03/02/2015

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 _____	02/05/2015

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to notify the physician after a resident fall for 1 of 2 residents reviewed for unwitnessed falls. (Resident # 31). The findings included: A review of a facility document titled Fall Protocol with an updated date of 09/08/14 indicated the following in part: Upon admission a Fall Risk Assessment must be completed. If the score is greater than 10 and/or the resident has a history of falls, initiate the following Fall Protocol: the Physician, Director of Nursing (DON), and family must be notified. Resident #31 was re-admitted to the facility on 10/21/14 with diagnoses which included difficulty walking, general muscle weakness, lack of coordination, dementia, total vision impairment in one eye, glaucoma, macular degeneration (disease of the eye resulting in visual impairment), heart disease, depression, osteoporosis and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/05/15 indicated Resident #31 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS indicated Resident #31 required extensive assistance by staff for transfers and balance, was not steady during transitions and walking or moving from a seated to standing position, or moving off and on toilet or during	F 157	Corrective action for the alleged deficient practice was accomplished by documentation/completion of incident report with physician notification on 2/5/2015 by DON. The nurse responsible for not following facility policy was counseled on facility policy on 2/10/2015; details of incident discussed with physician on 2/24/2015. Corrective action will be accomplished for other residents having potential to be affected by the same alleged deficient practice by in-service of all licensed staff on 2/23/2015, 2/27/2015 and 2/28/2015 and a 90-day review of all nurses notes and incident reports was completed by Medical Records Personnel on 2/27/2015. The system put into place to ensure that the deficient practice will not occur again is for the DON or designee to compare nurses' notes, incident reports, physician notification and 24-hour report for accuracy and completion daily for 30 days, then 10% twice a week for 30 days, followed by 10% once weekly for 30 days, then 10% one time monthly for 3 months. Any findings will be corrected immediately and a report of the findings will be provided to the DON as completed. The facility plans to monitor its performance to make sure solutions are sustained through compiling a report of all	

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 _____	02/05/2015

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 157	Continued From page 2 surface-to-surface transfer and was only able to stabilize with staff assistance. A review of a care plan dated 01/25/15 indicated Resident #31 was at risk for falls due to a score of 10 or higher on a fall risk assessment, had balance disturbance, poor safety awareness, poor vision and daily use of psychotropic medications. The care plan indicated Resident #31 had a fall on 01/25/15 with skin tear on knee. The goals indicated Resident #31 would be free from injuries related to falls through nursing interventions and the approaches were listed in part as follows: call bell within reach and instruct Resident #31 to call for assistance, wear non-skid shoes/socks for transfer, anticipate toileting needs and assist to toilet routinely, keep personal care items within easy reach, ensure bed is in lowest possible position at all times and locked, reposition as needed in wheelchair to maintain correct body alignment and sensor alarm at all times to alert staff of unsafe movements A review of a nurse's note dated 01/25/15 at 7:30 PM indicated Resident #31's alarm was sounding and upon entry to room Resident #31 was observed on floor beside of bed, lying on her abdomen. The notes indicated Resident #31 was alert and shouted out that she had rolled out of bed and upon initial inspection the only injury sustained was a small skin tear on right knee with minimal bleeding and no edema or bruising present. The notes revealed Resident #31 had no change in level of consciousness, denied pain and was assisted from the floor to bed by 3 staff for skin audit. The notes further revealed skin intact at abdomen with slight redness. The notes indicated when Resident #31 was asked what happened she stated she was reaching for her	F 157	comparison data and reviewed by QA&A monthly for 6 months.	

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 _____	02/05/2015

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 157	Continued From page 3	F 157		

wheelchair and rolled out of bed before she could get to it. The notes further indicated Resident #31 was reminded to wait for staff assistance with transfers and she replied she had already waited long enough and she was ready to be in her wheelchair. The notes also indicated a message was left to the responsible party but there was no documentation that the physician or DON was notified.

A review of a 24 hour report sheet dated 01/25/15 indicated Resident #31 had a fall with a small skin tear to the right knee. There was no documentation on the report that the physician was notified.

During an interview on 02/05/15 at 10:08 AM the DON confirmed nurses notes did not indicate the physician was notified, the 24 hour report did not indicate physician was notified and there was no note in the physician's communication book that the physician was notified of Resident #31's fall. She stated it was her expectation for nurses to call the physician after a resident had a fall.

During an interview on 02/05/15 at 3:34 PM with Nurse #2 she explained she was not assigned to care for Resident #31 on 01/25/15 but she was at the nurse's station and went to Resident #31's room after she fell. She stated Resident #31 had slid out of her wheelchair into the floor and was lying on her right side and she assessed Resident #31 and found she had a skin tear on her right knee. She further explained she cleaned the skin tear, left the room and reported to the nurse who was assigned to the resident. She stated she did not call the physician because the nurse who was assigned to the resident was supposed to call the physician after a resident had a fall.

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 _____	02/05/2015

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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to maintain and promote the dignity of 4 residents during 1 of 2 meals which were observed for tray delivery services. Residents #4, #8, #25, and #46 were not served at the same time as their tablemates and had to watch others eat prior to being served themselves. The findings included: 1. Resident #42 was admitted to the facility on 11/21/13. Her annual Minimum Data Set (MDS) dated 12/01/14 coded her as having intact cognition, and requiring set up and supervision with eating. Resident #4 was admitted to the facility on 10/26/09. His annual MDS dated 12/29/14 coded him with long and short term memory impairment and having severely impaired decision making skills. He was also coded as needing extensive assistance with eating. Resident #25 was admitted to the facility on 09/27/10. Her most recent MDS, a quarterly dated 12/18/14 coded her with long and short term memory impairments and severely impaired decision making skills and requiring extensive	F 241	Corrective action for the alleged deficient practice was accomplished by ensuring resident #4, #8, #25 and #46 were served at the same time as their table mates for dinner on 2/5/2015. Resident #4, #8, #25 and #46 received an apology from the facility administrator concerning the event on 2/20/2015. To ensure that others were not affected by the alleged deficient practice, revised seating charts were developed for breakfast, lunch and dinner for both the dining area and for hall service on 2/25/2015. Dietary staff and licensed staff were inserviced on facility procedure on 2/25/2015, 2/26/2015, 2/27/2015 and 2/28/2015. The system put in place to ensure that the deficient practice does not occur again was the use of a tool designed to monitor tray delivery by the DON or designee, as follows: all meals for one week, one of each meal per week for 4 weeks, and one meal weekly for 3 months. To ensure the system remains in place and effective, an audit of the results of the	3/5/15

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 _____	02/05/2015

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 241	Continued From page 5 assistance with eating. Observations during the breakfast meal on 02/03/15 at 7:58 AM revealed an open cart (#1) of trays in the dining room with 8 breakfast trays on it. At 8:04 AM these 8 trays remained unpassed and 5 staff were observed standing around, not passing to the 19 residents still waiting to be served breakfast. At 02/03/15 at 8:08 AM cart #2 full of breakfast trays arrived from the kitchen. Staff began to serve the trays off this cart. At 8:14 AM the original cart #1 had 4 of the original trays (noted at 7:58 AM) not served as the 6 remaining trays on cart #2 were taken to the halls for service. There were 3 tables of residents not served in the dining room at this time including the table where Residents #4, #25 and #42 sat. Then nurse aide (NA) #2 came in and instructed the other nurse aides to pass out the 4 trays left on cart #1. Continued observations revealed that at 8:16 AM staff served Resident #42 her meal and she started feeding herself as Residents #4 and #25 remained sitting at the same round table without food. At 8:30 AM cart #3 was delivered from the kitchen. Resident #25 was immediately served and Resident #4 was served at 8:33 AM by the Director of Nursing (DON). Staff sat to feed both residents when they served these residents their trays. On 02/03/15 at 8:25 AM Nurse Aide (NA) #6 who was in the dining room was interviewed about the tray service. She stated that staff have been instructed and usually served the trays table by table so all residents at the same table were served together. She stated that typically they did not feed residents at a table where others were not yet served. She stated she could not explain	F 241	monitoring tool will be compiled and presented monthly to the facility QA&A Committee for review and recommendations as necessary.	

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 _____	02/05/2015

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 241	Continued From page 6	F 241		

what was different this date.

On 02/04/15 at 2:16 PM, NA #2 was interviewed about the tray service observed on 02/03/15 at breakfast. NA #2 stated that she thought there was a new girl in the kitchen but was not sure why the trays came out of the kitchen so sporadically. She further stated that most mornings, staff were not sure which residents were coming to the dining room to eat. She stated that typically staff did not feed residents until all other residents were served. She stated that when she arrived in the dining room and saw the cart with 4 trays on it unserved, she instructed the nurse aides to pass the trays so the food would not get cold. She continued stating that staff were trained to serve table by table so residents at the same table ate at the same time.

On 02/05/15 at 8:30 AM interview with the Dietary Manager (DM) revealed that lunch was the only meal where the dietary staff knew if a resident ate in the dining room or in their room. Otherwise, the carts of trays came out as follows: first all 100 hall trays were on cart #1, all 200 hall trays were on cart #2, and all 300 hall trays were on cart #3. She stated as the kitchen filled each cart, the trays were to be served to the dining room first and then the remaining trays taken to the corresponding halls.

On 02/05/15 at 9:57 AM, NA #7 stated staff were taught to pass trays table by table.

On 02/05/15 at 10:38 AM the Director of Nursing (DON) was interviewed. DON stated she expected trays to be passed to the same table at the same time. She stated she had entered the dining room late on 02/03/15 and was not sure

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 _____	02/05/2015

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 241	Continued From page 7	F 241		

she was in the dining room when the trays were passed sporadically to tables, leaving other residents at the same table without food. She further stated that the trays left from cart #1 should have been reheated when the other trays came from the kitchen so all residents at the same table were served together. She also stated that her observations revealed that breakfast meal did not have the same system for tray delivery as the noon and evening meals.

On 02/05/15 at 12:01 PM the Administrator stated during interview that she expected trays to be served table by table in the dining room.

On 02/05/14 at 2:52 PM, NA #6 stated during interview that staff passed the trays from cart #1 to the residents while others were not yet served because the trays had been sitting so long and were getting cold.

2. Resident #29 was admitted to the facility on 03/24/14. The most recent Minimum Data Set (MDS), a quarterly dated 12/29/14 coded her as cognitively intact (scoring a 9 out of 15 on the brief interview for mental status (BIMS)) and requiring extensive assistance of one for eating.

Resident #3 was admitted to the facility on 01/11/05. Her most recent MDS, a quarterly dated 01/05/15, coded her as having long and short term memory impairment and severely impaired decision making skills and being totally dependent on staff for eating.

Resident #8 was admitted to the facility on 03/18/14. The most recent MDS, a quarterly dated 12/08/14 coded him as having long and short term memory impairment and severely

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 _____	02/05/2015

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 241	Continued From page 8	F 241		

impaired decision making skills and being totally dependent on staff for eating.

Observations during the breakfast meal on 02/03/15 at 7:58 AM revealed an open cart (#1) of trays in the dining room with 8 breakfast trays on it. At 8:04 AM these 8 trays remained unpassed and 5 staff were observed standing around, not passing to the 19 residents still waiting to be served breakfast. At 02/03/15 at 8:08 AM cart #2 full of breakfast trays arrived from the kitchen. Staff began to serve the trays off this cart. At 8:14 AM the original cart #1 had 4 of the original trays (noted at 7:58 AM) not served as the 6 remaining trays on cart #2 were taken to the halls for service. There were 3 tables of residents not served in the dining room at this time including the table where Residents #3, #8, and #29 sat. Then nurse aide (NA) #2 came in and instructed the other nurse aides to pass out the 4 trays left on cart #1. Continued observations revealed that at 8:16 AM, Residents #29 and #3 were served their trays. Staff sat to feed Resident #29 and Resident #3 began to feed herself, leaving Resident #8 at the round table without food. At 8:30 AM cart #3 was delivered from the kitchen and staff began passing those trays out immediately. However, Resident #8 was not setup and fed his first bite until 8:38 AM.

On 02/03/15 at 8:25 AM Nurse Aide (NA) #6 who was in the dining room was interviewed about the tray service. She stated that staff have been instructed and usually served the trays table by table so all residents at the same table were served together. She stated that typically they did not feed residents at a table where others were not yet served. She stated she could not explain what was different this date.

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 _____	02/05/2015

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 241	Continued From page 9	F 241		

On 02/04/15 at 2:16 PM, NA #2 was interviewed about the tray service observed on 02/03/15 at breakfast. NA #2 stated that she thought there was a new girl in the kitchen but was not sure why the trays came out of the kitchen so sporadically. She further stated that most mornings, staff were not sure which residents were coming to the dining room to eat. She stated that typically staff did not feed residents until all other residents were served. She stated that when she arrived in the dining room and saw the cart with 4 trays on it unserved, she instructed the nurse aides to pass the trays so the food would not get cold. She continued stating that staff were trained to serve table by table so residents at the same table ate at the same time.

On 02/05/15 at 8:30 AM interview with the Dietary Manager (DM) revealed that lunch was the only meal where the dietary staff knew if a resident ate in the dining room or in their room. Otherwise, the carts of trays came out as follows: first all 100 hall trays were on cart #1, all 200 hall trays were on cart #2, and all 300 hall trays were on cart #3. She stated as the kitchen filled each cart, the trays were to be served to the dining room first and then the remaining trays taken to the corresponding halls.

On 02/05/15 at 9:57 AM, NA #7 stated staff were taught to pass trays table by table.

On 02/05/15 at 10:38 AM the Director of Nursing (DON) was interviewed. DON stated she expected trays to be passed to the same table at the same time. She stated she had entered the dining room late on 02/03/15 and was not sure she was in the dining room when the trays were

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 _____	02/05/2015

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 241	Continued From page 10	F 241		

passed sporadically to tables, leaving other residents at the same table without food. She further stated that the trays left from cart #1 should have been reheated when the other trays came from the kitchen so all residents at the same table were served together. She also stated that her observations revealed that breakfast meal did not have the same system for tray delivery as the noon and evening meals.

On 02/05/15 at 12:01 PM the Administrator stated during interview that she expected trays to be served table by table in the dining room.

On 02/05/14 at 2:52 PM, NA #6 stated during interview that staff passed the trays from cart #1 to the residents while others were not yet served because the trays had been sitting so long and were getting cold.

3. Resident #27 was admitted to the facility on 11/21/14. Her admission Minimum Data Set (MDS) dated 11/28/14 coded her as having intact cognition and requiring supervision and set up with eating.

Resident #18 was admitted to the facility on 09/09/10. Her quarterly MDS dated 10/06/13 coded her with intact cognition (scoring a 12 out of 15 on the brief interview for mental status (BIMS)) and being independent with eating after tray set up.

Resident #46 was admitted to the facility on 12/06/13. The annual MDS dated 12/24/14 coded him with severely impaired cognition, (scoring a 6 out of 15 on the brief interview for mental status (BIMS)) and requiring supervision

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 _____	02/05/2015

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 241	Continued From page 11	F 241		

and set up for eating.

Observations during the breakfast meal on 02/03/15 at 7:58 AM revealed an open cart (#1) of trays in the dining room with 8 breakfast trays on it. At 8:04 AM these 8 trays remained unpassed and 5 staff were observed standing around, not passing to the 19 residents still waiting to be served breakfast. At 02/03/15 at 8:08 AM cart #2 full of breakfast trays arrived from the kitchen. Staff began to serve the trays off this cart. At 8:14 AM the original cart #1 had 4 of the original trays (noted at 7:58 AM) not served as the 6 remaining trays on cart #2 were taken to the halls for service. There were 3 tables of residents not served in the dining room at this time including the table where Residents #18, #27 and #46 sat. Then nurse aide (NA) #2 came in and instructed the other nurse aides to pass out the 4 trays left on cart #1. At 8:14 AM Resident #27 was served and set up. She immediately began to feed herself as Residents #18 and #46 sat at the same round table without food. At 8:30 AM cart #3 was delivered from the kitchen and staff began passing those trays out immediately. Residents #18 and #46 were served their breakfast trays at 8:33 AM and both began to feed themselves their breakfast trays.

On 02/03/15 at 8:25 AM Nurse Aide (NA) #6 who was in the dining room was interviewed about the tray service. She stated that staff have been instructed and usually served the trays table by table so all residents at the same table were served together. She stated that typically they did not feed residents at a table where others were not yet served. She stated she could not explain what was different this date.

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 _____	02/05/2015

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 241	Continued From page 12	F 241		

On 02/04/15 at 2:16 PM, NA #2 was interviewed about the tray service observed on 02/03/15 at breakfast. NA #2 stated that she thought there was a new girl in the kitchen but was not sure why the trays came out of the kitchen so sporadically. She further stated that most mornings, staff were not sure which residents were coming to the dining room to eat. She stated that typically staff did not feed residents until all other residents were served. She stated that when she arrived in the dining room and saw the cart with 4 trays on it unserved, she instructed the nurse aides to pass the trays so the food would not get cold. She continued stating that staff were trained to serve table by table so residents at the same table ate at the same time.

On 02/05/15 at 8:30 AM interview with the Dietary Manager (DM) revealed that lunch was the only meal where the dietary staff knew if a resident ate in the dining room or in their room. Otherwise, the carts of trays came out as follows: first all 100 hall trays were on cart #1, all 200 hall trays were on cart #2, and all 300 hall trays were on cart #3. She stated as the kitchen filled each cart, the trays were to be served to the dining room first and then the remaining trays taken to the corresponding halls.

On 02/05/15 at 9:57 AM, NA #7 stated staff were taught to pass trays table by table.

On 02/05/15 at 10:03 AM Resident #18 was asked how she felt about waiting for food at the same table with residents who were served and eating before she was served. She stated it did not bother her but that it happened often.

On 02/05/15 at 10:38 AM the Director of Nursing

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 _____	02/05/2015

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 241	Continued From page 13 (DON) was interviewed. DON stated she expected trays to be passed to the same table at the same time. She stated she had entered the dining room late on 02/03/15 and was not sure she was in the dining room when the trays were passed sporadically to tables, leaving other residents at the same table without food. She further stated that the trays left from cart #1 should have been reheated when the other trays came from the kitchen so all residents at the same table were served together. She also stated that her observations revealed that breakfast meal did not have the same system for tray delivery as the noon and evening meals. On 02/05/15 at 12:01 PM the Administrator stated during interview that she expected trays to be served table by table in the dining room. On 02/05/14 at 2:52 PM, NA #6 stated during interview that staff passed the trays from cart #1 to the residents while others were not yet served because the trays had been sitting so long and were getting cold.	F 241		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by:	F 242		3/5/15

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 _____	02/05/2015

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 242	Continued From page 14 Based on record reviews, and resident and staff interviews the facility failed to accommodate resident's preference for type of bath (Residents #15 and #44) and frequency of showers (Resident #20) for 3 of 3 residents reviewed for choices. The facility also failed to honor the rights to choose to smoke without supervision and at nondesignated times for 2 of 3 sampled residents deemed safe to smoke without supervision (Residents #40 and #50). The findings included: 1. Review of the medical record revealed Resident #15 was admitted on 03/28/05 with diagnoses including dementia and history of cerebrovascular accident. An annual Minimum Data Set dated 09/22/14 revealed Resident #15 had moderately impaired cognition and required one person physical assistance with bathing. Review of section F of the annual MDS, which assessed for customary routine and activities, revealed Resident #15 indicated it was very important for her to choose between a tub bath, shower, bed bath, or sponge bath. During an interview on 02/03/15 at 9:48 AM Resident #15 stated she would like to take a tub bath but no one has ever offered her one or asked her what type of bath she preferred. Resident #15 further stated she did not know if the facility had a bath tub. Review of Resident #15's quarterly activity evaluation completed on 09/18/14 revealed a section with resident preferences and instructions to check all that apply. The space for receiving a tub bath was blank and a check mark was noted in the space for receiving a shower. The activity	F 242	Corrective action for the alleged deficient practice was accomplished by offering resident #15 and #44 a choice between bed bath, shower or tub bath. Resident #15 and #44 were screened by Occupational Therapist to include interventions for use during tub bath. Resident #15 and #44 declined tub bathing. The facility purchased transfer equipment to facilitate tub bathing. Resident #20 received an apology from facility administrator on 2/26/2015; preferences and frequency preferences were updated. To ensure that no one else is affected by the same alleged deficient practice, a list of individual preferences for bathing options was compiled on 2/26/2015. The bathing schedule was revised to accommodate individual preferences. An initial audit for preferences was completed on 2/4/2015, revised on 2/10/2015 and verified on 2/24/2015. Inservice training was conducted on 2/24/2015, 2/27/2015 and 2/28/2015 to include preferences and documentation. A system was put into place to ensure that others will not be affected by the same alleged deficient practice to have Social Worker or designee ask preferences quarterly during completion of Section F of MDS, note changes on resident's Kardex and bathing schedule. A quarterly note will reflect any changes in Activity Notes by Social Worker, Activity Director or designee.	

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 _____	02/05/2015

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 242	Continued From page 15 evaluation completed on 09/18/14 was signed by the Activity Director. The activity evaluation completed on 12/22/14 was completed by the Activity Assistant and the space for receiving a tub bath was blank. An interview with the Social Worker (SW) on 02/04/15 at 4:13 PM revealed activity staff members were responsible for completing the interviews for section F of the MDS and she entered the information into the MDS. The SW noted the Activity Director who completed Resident #15's assessment on 09/18/14 no longer worked at the facility. During an interview on 02/05/15 at 10:39 AM the Activity Assistant confirmed she had completed Resident #15's activity evaluation including preferences on 12/22/14. The Activity Assistant stated that resident preferences were completed by observation and she did not speak to Resident #15 regarding bathing preferences when she completed the assessment on 12/22/14. An interview was conducted with the Administrator on 02/05/15 at 11:18 AM. The Administrator stated residents were not being assessed for preference between a shower and a tub bath. The Administrator further stated they had tried and could not get residents in and out of the bath tub and had talked about applying for a waiver. 2. Resident #44 was admitted to the facility on 01/25/14 with diagnoses of renal failure, coronary artery disease, and adult failure to thrive. The annual Minimum Data Set (MDS) revealed Resident #44 had moderately impaired cognition but could understand and be understood. The	F 242	To ensure that the system remains effective, Medical Records will audit quarterly notes to ensure preferences are properly documented in the Activities or Social notes and on the bathing schedule, and that Section F of the MDS reflects the preference correctly. The facility plans to monitor performance by having Medical Records compile a report for monthly review by the QA&A Committee for 6 months. Corrective action for alleged deficient practice regarding smoking preferences was accomplished for resident #50 due to resident #50 was a short-term resident who was discharged from the facility prior to receiving the statement of deficiencies for plan of correction. Corrective action for resident #40 was accomplished by updating resident #40's care plan to reflect his smoking preferences. In order to ensure that no one else is affected by the alleged deficient practice, the facility updated the policy and procedure for smoking, included the policy and procedure in the admission packet, which is discussed upon admission, and revised the safe smoking assessment tool. An inservice of all licensed staff and facility management on the smoking policy was conducted on 2/27/2015. All residents who smoke received an updated smoking evaluation and updated care plans. The system put in place to ensure compliance includes Medical Record audit	

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 _____	02/05/2015

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 242	Continued From page 16 MDS further revealed Resident #44 required one person physical assistance with bathing and it was very important for her to choose between a tub bath, shower or bed bath. An interview was conducted on 02/04/15 at 8:49 AM with Resident #44. She stated she hated taking a shower because she didn't like the cold water running all over her. Resident #44 stated she wanted a tub bath but she always received a shower. An interview was conducted on 02/04/15 at 2:37 PM with the Social Worker (SW). She stated she admitted new residents but the question of if they preferred a shower, tub bath or bed bath was not part of the admission process. The SW stated the nurse or nurse aide (NA) should ask what the residents bathing preference was. An interview was conducted on 02/04/15 at 2:44 PM with Nurse #1. She stated residents received 2 showers per week and the day and time they received their shower depended on what room the resident was in. She stated a resident could receive more showers if they asked. She further stated she was not aware of any residents that received a tub bath. An interview was conducted with the Administrator on 02/05/15 at 11:18 AM. The Administrator stated residents were not being assessed for preference between a shower and a tub bath. The Administrator further stated they had tried and could not get residents in and out of the bath tub and had talked about applying for a waiver. 3. Resident #20 was admitted to the facility on	F 242	monthly of admission records and significant change care plans. Findings will be recorded on an audit tool monthly. To ensure the system remains effective a report will be compiled monthly from audit findings and reviewed monthly by QA&A.	

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 _____	02/05/2015

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 242	Continued From page 17	F 242		

10/08/07 with diagnoses of cerebrovascular accident and heart failure. The annual Minimum Data Set dated 12/15/14 revealed Resident #20 was cognitively intact. The MDS further revealed Resident #20 required one person physical assist with bathing and it was very important for her to choose between a tub bath, shower or bed bath.

Review of the nurse aide (NA) flow sheet revealed Resident #20 received 3 showers between 01/01/15 through 01/31/15 on the 3:00 PM to 11:00 PM shift. The flow sheet indicated Resident #20 received a bed bath every night in January 2015 on the 11:00 PM to 7:00 AM shift.

An interview was conducted on 02/04/15 at 8:49 AM with Resident #20. She stated she only received 1 shower per week and she would like to have more but had never been asked.

An interview was conducted on 02/04/15 at 2:44 PM with Nurse #1. She stated residents received 2 showers per week and the day and time they received their shower depended on what room the resident was in. She stated a resident could receive more showers if they asked.

An interview was conducted on 02/05/15 at 11:18 AM with the Administrator. She stated when she admitted a new resident she informed them they would receive 2 showers per week and if they wanted more they needed to ask and they would be accommodated. The Administrator stated she did not think the question of how many baths or showers a resident wanted was being asked on admission or throughout their stay in the facility.
4. An undated, unnamed policy provided by the Administrator relating to smoking in the facility read: "Policy: It (sic) (Facility Name) Policy to

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 _____	02/05/2015

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 242	Continued From page 18	F 242		

Evaluate all smokers upon admission and quarterly or if there is a significant change. In the event that a resident is deemed unsafe, a care plan will be written with individualized interventions."

A Smoking Schedule was located at the nursing station which stated the designated times to smoke were 9:30 AM; 10:45 AM; 1:30 PM; 4:00 PM; 6:30 PM and 8:00 PM. Instructions at the bottom of the smoking schedule stated "Residents must be supervised during smoke breaks. This means someone has to give the resident his/her 2 cigarettes, light the cigarettes, and stay with the resident until he/she has finished smoking the cigarettes."

Resident #50 was admitted to the facility on 12/09/04. Her diagnoses included chronic bronchitis, congestive heart failure, and muscle weakness.

A Safe Smoking Evaluation - Current Smoker evaluation dated 12/10/14 noted she was:
*able to light and smoke a cigarette or other smoking device while demonstrating safe technique for putting out the matches or lights and disposing of ash:
*able to physically hold the smoking device while smoking;
*able to communicate that they understand smoking materials are for their own personal use;
*able to communicate that they understand smoking materials are for use only in the designated smoking area; and
*determined to be a safe smoker.
The form checked that "frequent" supervision was needed for smoking and the additional comment that the resident walked out to the smoking area

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 _____	02/05/2015

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 242	Continued From page 19	F 242		

and left her wheelchair and oxygen indoors.

The admission Minimum Data Set dated 12/21/14 coded her as being cognitively intact (scoring a 14 out of 15 on the brief interview for mental status (BIMS)), having no mood or behaviors, being independent with set up only for bed mobility and transfers, walking in the room and in the hall independently, requiring extensive assistance with locomotion and having unsteady balance but being able to balance herself without assistance.

The Care Area Assessment dated 12/22/14 for activities of daily living skills noted she needed physical assistance with locomotion in her wheelchair at times due to shortness of breath with exertion. It was noted that her balance and strength were improving and her goal was to return to independent living.

A care plan was initiated on 12/29/14 for being at risk for injury due to smoking status. The goal was that Resident #50 would safely smoke at designated times, in designated areas with supervision of staff or family. Interventions included that "smoking will be supervised at all times."

On 02/03/15 at 1:56 PM Resident #50 was observed smoking in the designated area with 2 other residents and an activity staff member. The resident was observed to smoke without difficulty and stood up to extinguish the cigarette in the ashtray.

On 02/03/15 at 4:02 PM Resident #50 was observed smoking with another resident and staff in the smoking area without concerns. Once she

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 _____	02/05/2015

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 242	Continued From page 20	F 242		

was finished smoking, she extinguished her cigarette, stood and walked back into the facility. Once inside, staff assisted her by turning on the oxygen tank on the back of her wheelchair and Resident #50 replaced her own nasal cannula and wheeled herself back to her room located at the end of another hallway.

Resident #50 was interviewed on 02/04/15 at 8:52 PM. She was observed ambulating around the room independently with her oxygen in place. She stated that she was never allowed to go smoke without supervision. When asked why, Resident #50 responded that the facility did not want residents to hurt themselves. When asked if she wanted to smoke at times other than the posted designated times and without supervision, Resident #50 replied "oh yes, who wouldn't" and continued saying that she could not go without staff or someone in attendance.

An interview was conducted on 02/04/15 at 2:30 PM with the MDS nurse who completed the safe smoking evaluation on Resident #50. She stated that she completed the smoking assessments on admission, quarterly or whenever there was a significant change in a resident who smoked. When asked to explain Resident #50's smoking evaluation indicating that she was a safe smoker yet was checked for frequent supervision, MDS nurse stated that she always checked that each resident needed at least frequent supervision due to the facility being a nursing home environment and it was not safe for residents to smoke without some degree of supervision. She stated that a check for constant supervision on the assessment would indicate a staff person could not take their eyes off the resident for even a second while the resident was smoking. When

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 _____	02/05/2015

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 242	Continued From page 21	F 242		

asked why Resident #50 was checked for frequent supervision but the care plan was developed with the intervention for supervision at all times, she could not explain. MDS nurse stated Resident #50's safety needs centered more around her getting in and out of the building safely. The Director of nursing joined the conversation and added that going through the doors wore Resident #50 out. MDS nurse further stated that the resident needed someone out with her in case she dropped a cigarette. MDS nurse further explained that all residents were supervised as that was the facility's standard of practice. MDS nurse stated that the facility was playing it safe versus sorry and the DON agreed. MDS nurse stated that she would reassess if Resident #50 expressed a desire to smoke independently.

The Administrator was interviewed on 02/05/14 at 11:28 AM. The Administrator stated that upon admission, residents were informed that all smoking materials were kept at the nursing station. A smoking assessment was filled out on admission either by the hall nurse or by the MDS nurse. The Administrator stated she expected staff to visually watch a resident smoke when completing the smoking assessment. In regards to Resident #50, the Administrator stated the assessment indicated the resident was cognitively safe to smoke but she did not think physically she was safe. The Administrator explained Resident #50 knew to turn off the oxygen and leave it inside when she went outside to smoke but she would stumble into the chair and back inside the building. The Administrator stated that if Resident #50 was to tell staff she wanted to smoke independently, they would look at the assessment again. The administrator

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 _____	02/05/2015

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 242	Continued From page 22	F 242		

further stated that she did not look at smoking as part of care and she was not sure if she wanted anyone to be able to smoke anytime they wanted despite their assessment.

5. An undated, unnamed policy provided by the Administrator relating to smoking in the facility read:
"Policy: It (sic) (Facility Name) Policy to Evaluate all smokers upon admission and quarterly or if there is a significant change. In the event that a resident is deemed unsafe, a care plan will be written with individualized interventions."

A Smoking Schedule was located at the nursing station which stated the designated times to smoke were 9:30 AM; 10:45 AM; 1:30 PM; 4:00 PM; 6:30 PM and 8:00 PM. Instructions at the bottom of the smoking schedule stated "Residents must be supervised during smoke breaks. This means someone has to give the resident his/her 2 cigarettes, light the cigarettes, and stay with the resident until he/she has finished smoking the cigarettes."

Resident #40 was admitted to the facility on 09/16/14. His diagnoses included aphasia, hemiplegia on his nondominant side, hypertension, depressive disorder and anxiety.

A Safe Smoking Evaluation - Current Smoker evaluation dated 09/16/14 noted he was:
*not able to light and smoke a cigarette or other smoking device while demonstrating safe technique for putting out the matches or lights and disposing of ash:
*able to physically hold the smoking device while smoking;
*able to communicate that they understand

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 _____	02/05/2015

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 242	Continued From page 23	F 242		

smoking materials are for their own personal use;
*able to communicate that they understand smoking materials are for use only in the designated smoking area; and
*determined to be a safe smoker.
The form checked that "frequent" supervision was needed for smoking and the additional comment that the resident was to be supervised during smoking activity by staff.

The admission Minimum Data Set (MDS) dated 09/26/14 coded him as being cognitively intact (scoring a 13 out of 15 on the brief interview for mental status (BIMS)), having no behaviors, requiring limited assistance with bed mobility and transfers and being independent with locomotion in his room and in the halls.

The Care Area Assessment (CAA) dated 09/29/14 relating to communication revealed he had a cerebral vascular accident and was aphasic communicating with other using gestures, pointing and responding to yes and no questions. The Activity of daily living skills (ADLs) CAA dated 09/29/14 noted he could position and reposition self in his wheelchair and transfer and toilet himself independently.

A care plan was initiated on 10/02/14 for the focus that Resident #40 participated in supervised smoking. The goal was for him to safely smoke at designated times, in designated areas with supervision of staff or family. Interventions included that smoking was to be supervised by staff members and he could smoke with family and visitor supervision outside of the smoking times.

The quarterly MDS dated 12/22/14 noted a BIMS

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 _____	02/05/2015

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 242	Continued From page 24	F 242		

was not attempted but his cognition was assessed and he was determined to have no long or short term memory impairments and he was independent in decision making abilities.

The smoking care plan was reviewed on 01/01/15 and it was noted he was compliant with smoking policies with no changes being made to his smoking care plan.

On 02/03/15 at 1:56 PM Resident #40 was observed smoking in the designated area with 2 other residents and an activity staff member. The resident was observed to smoke without difficulty and used the ash tray when extinguishing the cigarette.

On 02/03/15 at 4:02 PM Resident #40 was observed smoking with another resident and staff in the smoking area. when he was finished with his cigarette he extinguished it in the ashtray and then independently opened the door manually and reentered the building in his wheelchair.

On 02/04/15 at 12:25 PM, Resident #40 was interviewed via questions which he responded to in nods and gestures. Through this communication exchange, Resident #40 indicated that he was always supervised during smoking and that did not bother him. When asked if he could light his own cigarette, he nodded yes and proceeded to show the surveyor how he would pick up the cigarette, place it in his mouth, then pick up the lighter, flick it and light the cigarette all using his one functional arm/hand.

An interview was conducted on 02/04/15 at 2:30 PM with the MDS nurse who completed the safe

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 _____	02/05/2015

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 242	Continued From page 25	F 242		

smoking evaluation on Resident #40. She stated that she completed the smoking assessments on admission, quarterly or whenever there was a significant change in a resident who smoked. MDS nurse stated that she marked Resident #40 ad not being able to light and put out his cigarettes on his assessment as he was paralyzed on one side. She could not recall if she asked him to demonstrate any ability to light using one hand. MDS further stated that she always checked that each resident needed at least frequent supervision due to the facility being a nursing home environment and it was not safe for residents to smoke without some degree of supervision. MDS nurse further explained that all residents were supervised as that was the facility's standard of practice. MDS stated that the facility was playing it safe versus sorry and the DON, who joined the conversation agreed.

On 02/04/15 at 4:19 PM, Resident #40 indicated via nods and gestures that he could not recall staff asking him to show them if he was capable of lighting his own cigarette.

On 02/04/15 at 4:22 PM the MDS nurse stated she could not find the quarterly smoking assessment for Resident #40 and that the DON was going to reassess his ability to smoke independently.

The DON stated on 02/04/15 at 4:34 PM that she had just reassessed Resident #40 and determined him to be safe to smoke independently and he could light and extinguish his own cigarette.

The Administrator was interviewed on 02/05/14 at 11:28 AM. The Administrator stated that upon

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 _____	02/05/2015

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 242	Continued From page 26 admission, residents were informed that all smoking materials were kept at the nursing station. A smoking assessment was filled out on admission either by the hall nurse or by the MDS nurse. The Administrator stated she expected staff to visually watch a resident smoke when completing the smoking assessment. In regards to Resident #40, the Administrator stated he could not move one side of his body and she did not think he would be able to put a fire out if one started. She further stated that she would expect any individual, including a resident, who was able to pick up and use a fire extinguisher. The Administrator stated the current assessment did not accommodate physical impairments or other extenuating circumstances unless hand written in the comment section. She further stated that currently all resident's had to be supervised during smoking and that she did not look at smoking as part of care and she was not sure if she wanted anyone to be able to smoke anytime they wanted despite their assessment.	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to provide meaningful and preferred in room activities for 1 of 1 sampled resident reviewed for activities (Resident #5).	F 248	Corrective action for the alleged deficient practice was accomplished by updating preferences on the care plan for resident #5, and in Activity notes on 2/26/2015.	3/5/15

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 _____	02/05/2015

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 248	Continued From page 27 The findings included: Resident #5 was admitted on 02/10/05 with diagnoses including arthritis and congestive heart failure. An annual Minimum Data Set (MDS) completed on 08/14/14 revealed Resident #5 was cognitively intact, had moderate difficulty with hearing and her vision was adequate. Review of section F of the annual MDS, which assessed for customary routine and activities, revealed Resident #5 stated the following were very important to her: listening to music she liked, participating in religious services or practices, and having books, newspapers, and magazines to read. Review of a care plan dated 08/28/14, and reviewed on 11/20/14, revealed Resident #5 had a self-care performance deficit related to her osteoarthritis and multiple orthopedic conditions. The interventions stated Resident #5 liked sleeping in and spent most of her time in bed due to discomfort, enjoyed reading books with a magnification tool, and would be assisted to activities as she allowed. Review of a quarterly activity evaluation dated 11/17/14 revealed Resident #5 participated in 3 to 5 self initiated activities a week and had one-to-one visits. The activity evaluation further noted Resident #5 preferred listening to music, participating in religious services or practices, and reading books, newspapers, and magazines. In addition, the activity evaluation indicated Resident #5 wore glasses and was hard of hearing. This assessment was signed by the Activity Assistant and the Administrator.	F 248	Care plan was updated on 2/05/2015 to reflect individual's activities preferences to have the Bible read to her 3-5 times weekly, with tapes of scripture or sermons available at will and acquisition of headphones to facilitate listening to music without disturbing other residents. To ensure others are not affected by the same alleged deficient practice, an audit was conducted on 2/24/2015 by interviewing residents, or record review, to indicate activity preferences. Activities will update preferences on the care plan quarterly and in Activity notes. The system put in place to ensure compliance is preferences will be updated quarterly or significant change by the Activity Director or designee to update care plan and a note will reflect the preferences. An audit of updated preferences in quarterly notes and care plans will by compiled monthly by Medical Records or designee for six months. To ensure system effectiveness a report of the audit findings will be presented monthly to the QA&A Committee for six months.	

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 _____	02/05/2015

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 248	Continued From page 28	F 248		

Review of an activity progress noted dated 11/17/14 revealed Resident #5 participated in three to five self initiated activities per week of her choice including reading, talking on the phone, writing letters, watching TV, and socializing with family and friends. The progress note indicated Resident #5 refused all out of room activities due to pain but received five in room visits per week. This assessment was signed by the Activity Assistant and the Administrator.

During an an interview on 02/03/15 at 9:01 AM Resident #5 stated she used to read her Bible every day and would like for someone to read to her from her Bible because she could not see well enough to read, even with the magnifier. Resident #5 further stated she used to enjoy listening to her gospel tapes but stopped playing them because she felt it disturbed the staff and residents because she had to turn the volume up so high in order to hear.

During an interview on 02/05/15 at 10:24 AM the Activity Assistant stated residents preferences rarely changed and she did not interview Resident #5 regarding preferred activities when she completed the activity evaluation on 11/17/14. The Activity Assistant further stated Resident #5 used to love to read but had not been able to read lately due to her poor vision. Further interview revealed the Activity Assistant did not know if Resident #5 was able to hear her gospel tapes any longer but mentioned Resident #5 had not asked her to turn on her music lately. The Activity Assistant stated she and Resident #5 usually just talked during in room visits. The interview further revealed the Administrator currently functioned as the Activity Director and reviewed and signed off on all of the Activity Assistant's assessments and

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 _____	02/05/2015

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 248	Continued From page 29 progress notes. An interview was conducted with the Administrator on 02/05/15 at 11:04 AM. During the interview the Administrator stated she had her activity certification and currently worked additional hours in this position. The Administrator further stated she reviewed and signed off on all assessments and progress notes completed by the Activity Assistant. The Administrator stated she was aware Resident #5 was not reading using the magnifier but assumed this was due to pain while sitting up. The interview further revealed the Administrator was not aware Resident #5 was no longer able to listen to her gospel tapes due to further hearing loss. At the completion of the interview the Administrator stated they had not provided Resident #5 with meaningful and preferred activities and would need to assess residents regarding preferences for in room activities.	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label bedpans and a urine hat stored in plastic bags from hooks and label an uncovered urine hat lying in the floor in resident bathrooms in 4 bathrooms on 2 of 3 halls. The findings included:	F 253	Corrective action for the alleged deficient practice was accomplished on 2/5/2015 by replacing bedpans found between rooms 104 and 106 with new labeled and covered bedpans. Urine hat found between 206 and 208 was discarded. Urine hat found between 205 and 207 was	3/5/15

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 _____	02/05/2015

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 253	Continued From page 30 1. An observation was made on 02/03/15 at 8:08 AM, 02/04/15 at 9:30 AM and 02/05/15 at 9:25 AM of an unlabeled bedpan covered with a plastic bag hanging from the safety rail in the connecting bathroom between rooms 104 and 106. An observation was made on 02/05/15 at 9:26 AM of an unlabeled urine hat covered in a plastic bag hanging from a hook in the connecting bathroom between rooms 206 and 208. An observation was made on 02/05/15 at 9:28 AM of an unlabeled, uncovered urine hat lying in the floor of the connecting bathroom between rooms 205 and 207. An interview was conducted on 02/05/15 at 9:30 AM with nurse aide (NA) #3. She stated she did not know which resident the covered bedpan hanging from the safety rail in the connecting bathroom between rooms 104 and 106 belonged to because it wasn't labeled. NA #3 stated the bedpan should have been labeled with the residents name and room number with a permanent marker. NA #3 discarded the bedpan. An interview was conducted on 02/05/15 at 10:08 AM with the Director of Nursing (DON). She stated it was her expectation that bedpans and urine hats be labeled with the resident name and room number with a permanent marker, cleaned and covered after each use and stored under the residents sink. 2. During an observation on 02/03/15 at 08:00 AM in the bathroom which adjoined room 108 and room 110 there were 2 bedpans in clear plastic bags hanging separately on hooks attached to	F 253	discarded. To ensure others are not affected by the same alleged deficient practice, a room audit was conducted for proper labeling and storage of bedpans and urine hats. All bedpans and urine hats were properly labeled and stored on 2/19/2015. An inservice was conducted with CNAs regarding proper labeling and storage of bath basins, bedpans, urine hats, urinals and graduates on 2/26/2015, 2/27/2015 and 2/28/2015. A system to ensure compliance was initiated, which includes use of a monitoring tool by each CNA for their assigned track on all shifts for one week, and monitoring on random shifts twice weekly for 30 days, then once weekly for 30 days, and once monthly for 3 months. Any items requiring correction will be corrected immediately and reported to the DON. To ensure the system remains effective an audit will be compiled of the monitoring tools and findings will be reported to QA&A for six months.	

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 _____	02/05/2015

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 253	Continued From page 31	F 253		

the bathroom wall. There were faint black marks on the back of one of the bedpans but there was no resident name or room number on either of the plastic bags or bedpans.

During an observation on 02/04/15 at 10:35 AM in the bathroom which adjoined room 108 and room 110 there were 2 bedpans in clear plastic bags hanging separately on hooks attached to the bathroom wall. There were faint black marks on the back of one of the bedpans but there was no resident name or room number on either of the plastic bags or bedpans.

During an observation on 02/05/15 at 9:50 AM in the bathroom which adjoined room 108 and room 110 there were 2 bedpans in clear plastic bags hanging separately on hooks attached to the bathroom wall. There were faint black marks on the back of one of the bedpans but there was no resident name or room number on either of the plastic bags or bedpans.

During an interview on 02/05/15 at 9:50 AM with Nurse Aide (NA) #5 she stated resident bedpans were stored in clear plastic bags on hooks in the resident's bathroom and were supposed to be labeled with the resident's name and room number on the bottom of the pan with a permanent marker. She further stated she was not sure why the bedpans in the bathroom which adjoined rooms 108 and 110 were not labeled and was not sure which bedpan belonged to which resident because they were not labeled.

During an interview on 02/05/15 at 10:08 AM the Director of Nursing stated it was her expectation for resident's bed pans to be labeled with the resident's name and room number so that the

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 _____	02/05/2015

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 253	Continued From page 32 correct bedpan was used for the correct resident.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to revise a residents care plan to include meaningful and preferred in room activities for 1 of 1 sampled resident reviewed for activities (Resident #5). The findings included: Resident #5 was admitted on 02/10/05 with diagnoses including arthritis and congestive heart	F 280	Corrective action for this alleged deficient practice was accomplished by creating an activity care plan to include resident preferences for resident #5 on 2/5/2015. The activity care plan includes a staff member or volunteer reading the Bible to the resident 3-5 times per week, acquiring headphones for the resident to facilitate listening to music, audio books and recorded sermons without disturbing other	3/5/15

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 _____	02/05/2015

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 280	Continued From page 33 failure. An annual Minimum Data Set (MDS) completed on 08/14/14 revealed Resident #5 was cognitively intact, had moderate difficulty with hearing and her vision was adequate. Review of section F of the annual MDS, which assessed for customary routine and activities, revealed Resident #5 stated the following were very important to her: listening to music she liked, participating in religious services or practices, and having books, newspapers, and magazines to read. Review of a care plan dated 08/28/14, and reviewed on 11/20/14, revealed Resident #5 had a self-care performance deficit related to her osteoarthritis and multiple orthopedic conditions. The interventions stated Resident #5 liked sleeping in and spent most of her time in bed due to discomfort, enjoyed reading books with a magnification tool, and would be assisted to activities as she allowed. During an an interview on 02/03/15 at 9:01 AM Resident #5 stated she used to read her Bible every day and would like for someone to read to her from her Bible because she could not see well enough to read, even with the magnifier. Resident #5 further stated she used to enjoy listening to her gospel tapes but stopped playing them because she felt it disturbed the staff and residents because she had to turn the volume up so high in order to hear. Review of a quarterly activity evaluation dated 11/17/14 revealed Resident #5 participated in 3 to 5 self initiated activities a week and had one-to-one visits. The activity evaluation further noted Resident #5 preferred listening to music, participating in religious services or practices, and	F 280	residents, and inviting resident to scheduled activities. To ensure others are not affected by the same alleged deficient practice all residents were asked what their activities preferences were on 2/24/2015. In addition, care plans, to include activities approaches, were reviewed and updated with individual preferences for all in-room participants on 2/26/2015. The system put in place to ensure compliance is preferences will be updated quarterly or significant change by the Activity Director or designee to update care plan and a note will reflect the preferences. An audit of updated preferences in quarterly notes and care plans will by compiled monthly by Medical Records or designee for six months. To ensure system effectiveness a report of the audit findings will be presented monthly to the QA&A Committee for six months.	

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 _____	02/05/2015

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 280	Continued From page 34	F 280		

reading books, newspapers, and magazines. In addition, the activity evaluation indicated Resident #5 wore glasses and was hard of hearing. This assessment was signed by the Activity Assistant and the Administrator.

Review of an activity progress noted dated 11/17/14 revealed Resident #5 participated in 3 to 5 self initiated activities per week of her choice including reading, talking on the phone, writing letters, watching TV, and socializing with family and friends. The progress note indicated Resident #5 refused all out of room activities due to pain but received five in room visits per week. This assessment was signed by the Activity Assistant and the Administrator.

During an interview on 02/05/15 at 10:24 AM the Activity Assistant stated residents preferences rarely changed and she did not interview Resident #5 regarding preferred activities when she completed the activity evaluation on 11/17/14. The Activity Assistant further stated Resident #5 used to love to read but had not been able to read lately due to her poor vision. Further interview revealed the Activity Assistant did not know if Resident #5 was able to hear her gospel tapes any longer but mentioned Resident #5 had not asked her to turn on her music lately. The Activity Assistant stated she and Resident #5 usually just talked during in room visits. The interview further revealed the Administrator currently functioned as the Activity Director and reviewed and signed off on all of the Activity Assistant's assessments and progress notes.

An interview was conducted with the Administrator on 02/05/15 at 11:04 AM. During the interview the Administrator stated she had 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 _____	02/05/2015

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 280	Continued From page 35 activity certification and currently worked additional hours in this position. The Administrator further stated she reviewed and signed off on all assessments and progress notes completed by the Activity Assistant. The Administrator stated she was aware Resident #5 was not reading using the magnifier but assumed this was due to pain while sitting up. The interview further revealed the Administrator was not aware Resident #5 was no longer able to listen to her gospel tapes due to further hearing loss. At the competition of the interview the Administrator stated residents should be assessed quarterly for preferred activities and their care plans revised accordingly.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assess and implement a bowel protocol for a resident who had not had a bowel movement for 9 days for 1 of 5 residents reviewed for unnecessary medications (Resident #17). The findings included: Resident #17 was admitted to the facility on	F 309	Corrective action for the alleged deficient practice number 1 was accomplished on 2/3/2015 for resident #17 by giving a laxative. The physician was notified on 2/3/2015; he gave an order for senikot and miralax daily as needed for diagnosis of IBS. Nurses assigned resident #17 from 1/10/2015 through 1/15/2015 were educated on facility policy and procedure.	3/5/15

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 _____	02/05/2015

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 309	Continued From page 36 12/24/14 with diagnoses which included Parkinson's Disease, difficulty walking; generalized muscle weakness, dementia, anxiety, depression, high blood pressure and heart disease. The admission Minimum Data Set dated 12/31/14 indicated Resident #17 had short term and long term memory problems and was moderately impaired in cognition for daily decision making. The MDS further indicated Resident #17 required extensive assistance with transfers, toileting and hygiene and was frequently incontinent of bladder and bowel. A review of a facility document titled Bowel Movement (BM) Audit Tool with a handwritten date of January 2015 indicated there were no bowel movements (BMs) documented for Resident #17 for a 9 day period from 01/07/15 through 01/15/15. A review of a facility document titled Certified Nurse Aide (CNA) Flow Sheet with a handwritten date of January 2015 indicated no BMs were documented for Resident #17 for a 9 day period from 01/07/15 through 01/15/15. A review of standing orders that was not dated indicated in part for constipation to check for impaction. If not impacted, give Milk of Magnesia 30 cubic centimeters (cc) by mouth. If no results in 24 hours, insert Dulcolax Suppository 1 rectal. If no results in 24 hours, give Fleets Enema x 1. (Any and all not to exceed 3 days). A review of nurse's notes from 01/07/15 through 01/15/15 revealed no documentation regarding BMs or assessments for constipation.	F 309	To ensure others are not affected by the same alleged deficient practice, licensed staff and CNAs were inserviced on 2/27/2015, 2/28/2015 and 3/1/2015 on facility bowel protocol, policy and procedure for completing flow sheets, review of flow sheets and BM audit tool. The system put into place to ensure this issue does not occur again is a daily audit of all flow sheets and BM audit tools by the DON or designee for completion for 1 week, if no issues, then a review of 10% daily for 1 month and, if no issues exist, a review of 10% monthly for 1 month. To ensure the system remains in place and is effective, a report of the audit findings will be compiled monthly and presented to the QA&A Committee by the DON or designee for 3 months.	

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 _____	02/05/2015

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 309	Continued From page 37	F 309		

A review of the monthly medication administration record (MAR) dated 01/07/15 through 01/15/15 indicated there were no medications listed on the bowel protocol given to Resident #17.

During an interview on 02/05/15 at 11:24 AM with the MDS nurse she confirmed the BM Audit Tool and the CNA flow sheet were the 2 places where BMs were documented. She explained she thought the BM Audit Tool was completed by the nurses and given to the Director of Nursing (DON) and the CNA Flow Sheet was where Nurse Aides (NAs) documented resident's BMs.

During an interview on 02/05/15 at 3:11 PM with Nurse #1 she explained Resident #17 required assistance by staff for transfers and was not able to toilet herself independently. She further explained Resident #17 was prone to have constipation because of medications she took. She confirmed there were no BMs documented on the BM Audit Tool or the CNA Flow Sheet from 01/07/15 through 01/15/15. She explained the facility had a bowel protocol to follow and if a resident had not had a BM in 3 days the NAs were to report it to the nurse and the nurse was supposed to assess the resident and initiate the bowel protocol. She stated nurses were expected to write the bowel protocol as a telephone order for the physician to sign. She explained the nurse was also expected to write the medication from the bowel protocol on the MAR when they gave it to the resident. She further explained the third shift nurse was also supposed to review the audit tool and if they saw a resident had no BM in 3 days they were supposed to initiate the BM protocol. She stated nurses were supposed to report results to the

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 _____	02/05/2015

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 309	Continued From page 38 next nurse during shift report and if the resident had results they were supposed to document results as effective related to what medication they gave. She stated if a resident had no results when they got to the end of the protocol then the nurse should contact the physician to find out what to do next. She stated she was not aware Resident #17 had not had a BM for 9 days because the NAs had not reported it to her and she had not assessed the resident because she was unaware. She further stated no one had addressed the zeros documented on the BM Audit Tool and CNA Flow Sheet. During an interview on 02/05/15 at 3:32 PM with Nurse #2 she stated nobody had told her Resident #17 had not had a BM for 9 days. She stated Resident #17 should have been started on the bowel protocol after 3 days of not having a BM. During an interview on 02/05/15 at 3:45 PM the Director of Nursing stated she was not sure if Resident #17 had a BM from 01/07/15 through 01/15/15 but the zeros on the BM Audit Tool and the CNA Flow Sheet indicated Resident #17 had not had BMs during that time period. She stated it was her expectation for the bowel protocol to be initiated if a resident had no BM in 3 days and the nurse should assess the resident and document in the nurse's notes.	F 309		
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.	F 312		3/5/15

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 _____	02/05/2015

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 39	F 312		

This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility failed to provide the physical and verbal assistance established by the occupational therapist to maintain self feeding abilities for 1 of 4 residents reviewed for activities of daily living skills (ADLs). (Resident #4).

The findings included:

Resident #4 was admitted to the facility on 10/26/2009. His diagnoses included senile dementia.

The Minimum Data Set (MDS), a quarterly dated 07/07/14, coded Resident #4 with long and short term memory impairment, severely impaired decision making skills and requiring extensive assistance with feeding. The dietary progress note dated 07/07/14 indicated he received large portions of pureed no added salt diet with nectar liquids. On 07/18/14, a speech therapy evaluation changed his diet to pureed, no added salt, with honey thick liquids.

On 08/12/14 a therapy screen was requested for occupational therapy due to reports from the nurse aides that Resident #4 used to feed himself but now he needed to be fed and did not initiate feeding himself. Occupational therapy was started on 08/14/14 and he was provided a built up spoon and moved to the dining room for his meals. On 08/21/14 a diet requisition form was completed per occupational therapy for the dietary department to place all drinks at meals in

Corrective action for this alleged deficient practice was accomplished for resident #4 by inservicing CNAs on plan for ADL care by DON on 2/4/2015, rescreen by OT of resident #4 on 2/27/2015, and inservicing all licensed staff on plan for ADL care of resident #4 on 2/27/2015 and 2/28/2015.

To ensure others are not affected by the same alleged deficient practice, residents who have ADL plans for meal assistance were reviewed by OT on 2/4/2015. All licensed staff and dietary staff were inserviced on 2/27/2015 and 2/28/2015 on ADL plans for meal assistance and adaptive equipment.

The system put into place to ensure compliance is a list of residents requiring assistance at meals will be maintained, reviewed and updated as necessary by the MDS Coordinator or designee, as changes occur. A copy of the individual ADL plan for meal assistance will be maintained with the flow data and a copy provided to the dietary department and DON.

To ensure the system remains effective an audit by Medical Records or designee of the availability of meal assistance plans and implementation of changes recommended by OT will be conducted daily for 1 week, weekly for 1 month, and

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 _____	02/05/2015

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 40 coffee cups to increase independence. Resident #4 was discharged from occupational therapy on 09/11/14 having met his goal to hold a spoon and complete eating with minimal assistance and with minimal spillage. Discharge recommendations were for staff to follow occupational therapy recommendations to increase resident's functional ability to feed himself. The medical record and the kardex (a book with residents' individual needs for staff reference when providing care) contained a handwritten guide on helping Resident #4 maintain independence with eating. This form read as follows: "1. set him up at a shorter table 2. initiate first bite with him (hand over hand) 3. best with built up spoon in left hand (bent slightly) 4. uses coffee cups with minimal spillage (there is an order for this) 5. verbally cue every now & then. He can self feed consistently 75% 6. has hard time c (with) small bowl (put on plate)" There was a sign in sheet for the inservice relating to Resident #4's feeding instructions by the occupational therapist (OT) dated 09/09/14. 4 staff signed this sheet. Interview with the OT on 02/05/14 at 11:05 AM verified that OT developed these 6 steps to promote Resident #4's self feeding and educated the 4 staff who signed the inservice. OT further stated that the steps were given to the previous Director of Nursing in order to continue inservicing the rest of the staff. The annual MDS dated 12/29/14 coded Resident	F 312	monthly for 4 months. Findings will be compiled and presented to the QA&A Committee on a monthly basis for 6 months.	

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 _____	02/05/2015

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 41	F 312		

#4 with long and short term memory impairment, severely impaired decision making skills and requiring extensive assistance with eating the mechanically altered therapeutic diet. The ADLs Care Area Assessment dated 01/05/15 noted that he had advanced dementia but was able to feed himself at times and staff assisted to ensure adequate intake.

Observations on 02/03/15 at 7:58 AM revealed Resident #4 sitting in the dining room awaiting breakfast. At 8:33 AM, the Director of Nursing (DON) set up Resident #4's tray. The tray came with extra coffee cups and a blue foam spoon. DON sat and began to feed Resident #4 his meal using the adaptive spoon. She was observed holding the cup to his lips for him to drink and feed him with the spoon with no attempts to cue or encourage him to feed himself any of the breakfast meal.

On 02/04/15 at 8:01 AM, Resident #4's plate was placed in front of him. At 8:16 AM his plate was taken to the kitchen and reheated by staff. At this time Nurse Aide (NA) #2 started by putting a plastic glass (not coffee mug) to his lips for him to drink. Once the plate was returned from being reheated, NA #2 proceeded to feed Resident #4. Continuous observations through 8:29 AM revealed NA #2 continued to hold his drinks up to his mouth for him to drink and to feed him without any encouragement or attempt to cue him to hold the spoon or cup independently. Continuous observations revealed that at 8:33 AM, NA #2 offered him some coffee which she prepared in a coffee cup. When the resident started to raise his hand, NA #2 put her hand over his and told him to put his hand down and then placed the coffee cup up to his mouth to drink. Again continuous

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 _____	02/05/2015

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 42	F 312		

observations revealed no attempts to have Resident #4 try to feed himself or drink independently. At 8:39 AM, NA #2 transferred the coffee from the coffee mug into the plastic glass which had contained water. When asked at this time about the plastic glass, she stated she felt she was hitting his nose with the larger coffee cup when she assisted him with drinking. He was fed 100% of his meal and his tray was removed at 8:42 AM. NA #2 then poured the cranberry juice into a coffee cup and held to his lips to drink. At 8:43 AM, NA #2 encouraged him for the first time to hold the cup of juice. Holding the cup, he drank the entire amount of cranberry juice himself using multiple cup to mouth motions. Then another nurse aide (NA) #3 poured the remaining coffee from the plastic cup and handed it to him and he proceeded to finish all his liquids independently.

On 02/04/15 at 11:57 PM Resident #4 was observed to pick up the built up spoon in his left hand and feed himself. When he had trouble with the coffee cup, staff assisted him to grab a hold of the cup. He proceeded to feed and drink by himself with a little cueing through a good portion of the meal. He was left drinking independently once he finished eating at 12:43 PM.

On 02/04/15 at 12:44 PM, NA #2 was interviewed. NA #2 stated that it had been awhile since she assisted Resident #4 eat and she thought he needed to be fed. NA #2 stated she was aware of the instructions for getting Resident #4 to feed himself but stated she was not sure if those instructions were still expected to be followed.

On 02/05/15 at 10:38 AM the DON was interviewed. DON stated that she expected staff

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 _____	02/05/2015

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 43 to encourage residents to do what they can for themselves and assist them with feeding as necessary. Regarding Resident #4, DON stated she did not encourage him to feed himself on 02/03/15. She stated she did not know he was able to feed himself.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to complete an incident report, investigate a fall and failed to do a therapy screen for 1 of 2 residents reviewed for unwitnessed falls. (Resident # 31). The findings included: A review of a facility document titled Fall Protocol with an updated date of 09/08/14 indicated in part the following: Upon admission a Fall Risk Assessment must be completed. If the score is greater than 10 and/or the resident has a history of falls, initiate the following Fall Protocol: A rehabilitation (rehab) screen must be completed with all falls, even if resident is currently receiving rehab services and Physician, Director of Nursing (DON), and family must be notified, and an	F 323	Corrective action for this alleged deficient practice for resident #31 was accomplished by the DON completing an incident report on 2/5/2015. A therapy screen for resident #31 was completed on 2/5/2015. The nurse responsible was educated on facility policy and procedure concerning falls and notification, including the need to notify therapy of the fall. To ensure others are not affected by the same alleged deficient practice, an inservice of all licensed staff was conducted on 2/27/2015 and 2/28/2015, including policy and procedure for the completion of incident reports, fall protocol and therapy referrals. An audit was conducted on 2/27/2015 of all falls for the	3/5/15

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 _____	02/05/2015

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 323	Continued From page 44 incident report must be completed the day fall occurs, and documented in chart. Resident #31 was re-admitted to the facility on 10/21/14 with diagnoses which included difficulty walking, general muscle weakness, lack of coordination, dementia, total vision impairment in one eye, glaucoma, macular degeneration (disease of the eye resulting in visual impairment), heart disease, depression, osteoporosis and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 01/05/15 indicated Resident #31 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS indicated Resident #31 required extensive assistance by staff for transfers and balance, was not steady during transitions and walking or moving from seated to standing position or moving off and on toilet or surface-to-surface transfer and was only able to stabilize with staff assistance. A review of a care plan dated 01/25/15 indicated Resident #31 was at risk for falls due to a score of 10 or higher on fall risk assessment, had balance disturbance, poor safety awareness, daily use of psychotropic medications and poor vision. The care plan indicated Resident #31 had a fall on 01/25/15 with skin tear on knee. The goals indicated Resident #31 would be free from injuries related to falls through nursing intervention and the approaches were listed as follows: call bell within reach and instruct Resident #31 to call for assistance, wear non-skid shoes/socks for transfer, anticipate toileting needs and assist to toilet routinely, keep personal	F 323	past 90 days by Medical Records to ensure that therapy referrals were initiated in accordance with facility policy and procedure. A system was put into place to ensure that the facility fall protocol is followed. The system consists of auditing notes pertaining to all falls and reconciling them to incident reports and therapy referrals for screening daily for 1 month, 10% weekly for 1 month then 10% monthly for 3 months. The facility plans to monitor the system for effectiveness by preparation of a report of findings from audits for review monthly by the QA&A Committee for 5 months.	

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 _____	02/05/2015

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 323	Continued From page 45	F 323		

care items within easy reach, ensure bed is in lowest possible position at all times and locked, assess cause, pattern of previous falls, complete a fall risk assessment quarterly, reposition as needed in wheelchair to maintain correct body alignment and sensor alarm at all times to alert staff of unsafe movements

A review of a nurse's note dated 01/25/15 at 7:30 PM indicated Resident #31's alarm was sounding and upon entry to room Resident #31 was observed on floor beside of bed, lying on her abdomen. The notes indicated Resident #31 was alert and shouted out that she had rolled out of bed and upon initial inspection the only injury sustained was a small skin tear at right knee with minimal bleeding and no edema or bruising present. The notes revealed Resident #31 had no change in level of consciousness and denied pain and was assisted from the floor to bed by 3 staff for skin audit. The notes further revealed skin intact on abdomen with slight redness. The notes indicated when Resident #31 was asked what happened she stated she was reaching for her wheelchair and rolled out of bed before she could get to it. The notes further indicated Resident #31 was reminded to wait for staff assistance with transfers and she replied she had already waited long enough and she was ready to be in her wheelchair.

A review of a 24 hour report sheet dated 01/25/15 indicated Resident #31 had a fall with a small skin tear to the right knee.

A review of incident logs for January 2015 revealed there was no documentation of Resident #31's fall on 01/25/15.

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 _____	02/05/2015

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 323	Continued From page 46	F 323		

During an interview on 02/04/15 at 10:59 AM the DON verified the nurse did not fill out an incident report for Resident #31's fall on 01/25/15 so the fall was not investigated. She explained the nurse documented the fall in the nurse's notes and the date of the fall was noted on the care plan but the nurse was supposed to also fill out an incident report so the fall would be investigated. She explained Resident #31 was at risk for falls because she took psychotropic medications and had no safety awareness.

During a follow up interview on 02/04/15 at 12:12 PM the DON explained the nurses were also supposed to complete a Post Fall Assessment/Investigation Form after a resident fall in addition to an incident report and confirmed this Post Fall Assessment/Investigation Form and incident report was not completed after Resident #31's fall.

During an interview on 02/04/15 at 3:13 PM the MDS nurse stated an incident report was supposed to be completed for every resident fall so that it could be brought to the morning meeting or fall committee for investigation.

During a second follow up interview on 02/05/15 at 10:16 AM the DON clarified that it was the nurse's responsibility to answer the questions on the Post Fall Assessment/Investigation Form and then they should give it to the DON for discussion at the morning meeting. She stated all staff who were involved when a resident had a fall had to be interviewed and an investigation done to determine what had happened and to evaluate for fall precautions and initiate new interventions as needed.

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 _____	02/05/2015

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 323	Continued From page 47 During an interview on 02/05/15 at 2:16 PM with the Rehabilitation (Rehab) Director he stated nurses were supposed to generate a document for a therapy screen after a resident fall occurred. He explained they usually did the screen the next day after the fall had occurred to determine if there was a reason for the fall. He confirmed there was no therapy screen submitted by nursing staff after Resident #31's fall so she was not evaluated by therapy staff after her fall on 01/25/15. During an interview on 02/05/15 at 3:34 PM with Nurse #2 she explained she was not assigned to care for Resident #31 on 01/25/15 but she was at the nurse's station when Resident #31's fall happened and went to her room. She stated Resident #31 had slid out of her wheelchair into the floor and was lying on her right side. She explained she assessed Resident #31 and she had a skin tear on her right knee. She further explained she cleaned the skin tear, left the room and reported to the nurse who was assigned to the resident. She stated the nurse assigned to the resident was supposed to complete a post fall assessment and incident report so the fall would be investigated and complete a form for a therapy screen for therapy to evaluate the resident.	F 323		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by:	F 365		3/5/15

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 _____	02/05/2015

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 365	Continued From page 48 Based on observations, record review and staff interviews, the facility failed to provide the correct diet consistency per physician orders for 2 of 2 residents reviewed for food form. Residents #12 and #46 did not receive mechanical soft items as ordered. The findings included: 1. Resident #12 was admitted to the facility on 05/17/13. His diagnosis included dementia and dysphagia. His current diet order, originally established on 06/23/14, included pureed meats, mechanical soft, no added salt, consistent carbohydrate diet with large portions and superfoods at every meal. The Minimum Data Set (MDS), an annual dated 04/21/14, coded him with intact cognition (scoring a 12 out of 15 on the brief interview for mental status (BIMS)) and being able to feed himself independently with set up. The Care Area Assessment dated 04/26/14 for nutrition noted he was at risk of choking related to dysphagia with the provision of mechanically altered consistency with pureed meat. His most recent MDS, a quarterly dated 01/12/15, coded him as having severely impaired cognition (scoring a 4 out of 15 on the BIMS) and being able to feed himself the mechanically altered diet with set up. The current care plan for Resident #12 for having a risk of choking and aspiration was developed 05/01/14 and last reviewed 01/15/15. The interventions included provide diet as ordered and to provide supervision at meal times as needed.	F 365	Corrective action for this alleged deficient practice was accomplished by resident #12 and resident #6 receiving food form as ordered on dinner meal 2/5/2015 with 100% accuracy. To ensure others were not affected by the same alleged deficient practice, an audit of all physician diet orders and printed tray cards was conducted on 2/5/2015. Inservice was conducted with dietary and licensed staff on 2/5/2015, 2/27/2015 and 2/28/2015. The system put in place to ensure compliance is to monitor each meal daily for 5 days. If there are zero errors, then 5 meals weekly for 3 weeks. If no errors are noted 3 times weekly for 2 weeks, then once weekly for 6 months. To be completed by Dietary Manager AND Administrator or designee. Any issues will be corrected immediately and reported to the Administrator. To ensure the system remains in place and effective a report of the findings of all audits will be compiled and presented to the QA&A Committee monthly for 6 months.	

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 _____	02/05/2015

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 365	Continued From page 49	F 365		

On 02/04/15 at 8:00 AM Resident #12 was served and he began to feed himself. He was served pureed eggs and pureed sausage. Review of the tray card indicated he was on a pureed meat, mechanical soft diet but the individual items for this meal listed on the tray card noted he was to receive pureed scrambled eggs. He ate 50% of his meal.

On 02/04/15 at 1:01 PM, Resident #12 was served all pureed foods including the chicken parmesan, spaghetti noodles and carrots. At this time Nurse Aide (NA) #4 was asked about the pureed foods and the tray card which indicated he was on a pureed meat, mechanical soft diet. She stated that over the past 3 to 4 months, the kitchen was sending everything out pureed for Resident #12.

On 02/04/14 at 1:04 PM the Dietary Manager (DM) observed Resident #12's pureed meal and was asked about the tray card which indicated that he was on a mechanical soft diet with pureed meats, but the tray indicated that all food should be pureed. DM stated that only the meat should be pureed and that the staff plating the food in the kitchen should have caught that the diet was for pureed meat and other foods served in mechanical soft form.

On 02/05/15 at 8:13 AM Cook #2 stated that the cook generally read the diet card and plated the food. At the end of the serving line, a dietary aide rechecked the plate for accuracy. She stated the diet should have been followed indicating mechanical soft except for pureed meat.

On 02/05/15 at 8:30 AM the Dietary Manager (DM) was interviewed. She stated the tray

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 _____	02/05/2015

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 365	Continued From page 50	F 365		

system was computer generated and automatically printed out all entrees as pureed when the diet was entered with pureed meat first and mechanical soft second. She further stated she expected the cooks to follow the diet listed and provide only the meat in a pureed form and all other food in mechanical soft form. She acknowledged that the tray cards were confusing when all items printed out as being pureed.

During a follow up interview with the DM on 02/05/15 at 9:15 AM, DM stated that she discovered that if the diet entered into the computer started with mechanical soft and then pureed meat was second, the tray cards correctly printed the meats as only pureed and other items printed out as needing to be in mechanical soft form, reducing the risk of error.

During interview on 02/05/15 at 11:46 AM, the Administrator stated she expected dietary staff to read the tray cards and diets and at the point of service, staff were expected to glance over the tray card to double check for accuracy. She further stated their dietary manger was new and still in training.

2. Resident #46 was admitted to the facility on 12/06/03 with diagnoses of dementia and Alzheimer's Disease.

A diet change form dated 07/14/14 changed his diet order from mechanical soft to mechanical soft with pureed meats. This was included in the current physician orders.

The annual Minimum Data Set dated 11/24/14 coded him as having severely impaired cognition (scoring a 6 out of 15 on the brief interview for

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 _____	02/05/2015

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 365	Continued From page 51	F 365		

mental status (BIMS)) and requiring set up and supervision with meals.

On 02/04/15 at 8:02 AM, Resident #46 was observed being served his meal tray. The tray card noted he was on a pureed meat, mechanical soft diet. Resident #46 received pureed scrambled eggs along with pureed meat. The tray card indicated the scrambled eggs were to be pureed.

On 02/05/15 at 8:11 AM Resident #46 received his breakfast tray. Observations revealed the tray contained pureed pancakes. The tray card noted he was on a puree meat, mechanical soft diet and the tray card included that his diet should have pureed pancakes.

On 02/05/15 at 8:13 AM Cook #2 stated that the cook generally read the diet card and plated the food. At the end of the serving line, a dietary aide rechecked the plate for accuracy. She stated the diet should be followed indicating mechanical soft except for pureed meat. She further stated that whenever the facility had pancakes, the tray card indicated they should be pureed.

On 02/05/15 at 8:30 AM the Dietary Manager (DM) was interviewed. She stated the tray system was computer generated and automatically printed out all entrees as pureed when the diet was entered with pureed meat first and mechanical soft second. She further stated she expected the cooks to follow the diet and provide only the meat in a pureed form and all other food in mechanical soft form. She acknowledged that the tray cards were confusing when all items printed out as being pureed.

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 _____	02/05/2015

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 365	Continued From page 52 During a follow up interview with the DM on 02/05/15 at 9:15 AM, DM stated that she discovered that if the diet entered into the computer started with mechanical soft and then pureed meat was second, the tray cards correctly printed the meats as only pureed and other items printed out as needing to be in mechanical soft form, reducing the risk of error. During interview on 02/05/15 at 11:46 AM, the Administrator stated she expected dietary staff to read the tray cards and diets and at the point of service, staff were expected to glance over the tray card to double check for accuracy. She further stated their dietary manger was new and still in training.	F 365		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to 1) use proper hand hygiene when handling clean equipment and 2) air dry food trays and insulated domes before storing and 3) maintain the cleanliness of the exterior door panels of the reach-in refrigerator and freezer.	F 371	Corrective action for this alleged deficient practice was accomplished by counseling Dietary Aide #1 on 2/5/2015 concerning proper hand hygiene, drying and storage methods and cleaning schedules. Cook #1 was counseled concerning proper	3/5/15

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 _____	02/05/2015

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 371	Continued From page 53 The findings included: 1. A continuous observation of Dietary Aide #1 occurred during the initial tour of the kitchen on 02/02/15 from 9:52 AM until 10:09 AM. Dietary Aide #1 completed all the following tasks wearing the same pair of disposable gloves and was not observed washing her hands at any time. The observations were as follows: - At 9:52 Dietary Aide #1 was observed wearing a pair of disposable gloves and wiping food debris into the sink with her right hand. Dietary Aide #1 opened the dishwasher and pushed a rack of dirty food trays into the dishwasher which pushed a rack of clean food trays out. Dietary Aide #1 then removed the clean food trays from the rack on the dish washing line and stacked them on top of each other on an adjacent counter. - At 9:54 AM Dietary Aide #1, opened the dishwasher and pushed a rack of insulated domes into the dishwasher which pushed a rack of food trays out. Dietary Aide #1 removed the clean food trays and stacked them on top of each other on an adjacent counter. - At 9:56 AM Dietary Aide #1 touched the outside of two clean mugs on a rack on the dish washing line and then pushed a rack of silver ware into the dishwasher. Dietary Aide #1 removed the nine clean insulated domes from the rack on the dish line and stacked them on an adjacent counter. She then picked up a dish cloth and wiped food debris off the dishwashing line into the sink. - At 10:00 AM Dietary Aide #1 pulled the trash	F 371	hand hygiene, drying and storage methods, and cleaning schedules. The door of the reach-in refrigerator was cleaned on 2/5/2015. Items that were improperly dried and stored were re-washed, dried correctly and stored properly on 2/5/2015. To ensure others were not affected by the same alleged deficient practice, all dietary staff were inserviced by the Dietary Manager prior to their next shift, and by the Regional Dietary Manager again on 2/27/2015, to include proper hand hygiene, proper drying and storage techniques, cleaning schedules and audit tools; return demonstrations were required by each employee to show knowledge of proper hand hygiene, drying and storage methods, and proper completion of cleaning assignments. The system put in place to ensure this does not occur again is to monitor daily for 5 days, 5 times weekly for 3 weeks, 3 times weekly for 2 weeks and once weekly for 6 months for appropriate hand hygiene, drying and storage methods, and completion of cleaning assignments. Any errors noted will be immediately reported to the Administrator. To ensure the system remains intact and effective, an audit of the monitoring tools will be compiled and a report presented to the QA&A Committee on a monthly basis for review and recommendations for a period of 6 months.	

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 _____	02/05/2015

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 371	Continued From page 54	F 371		

can over to the sink with her right hand, grasped the removable sink basket which contained food debris and dumped it into the trash can.

- At 10:03 AM Dietary Aide #1 was observed taking a dish cloth out of a small bucket near dish line counter and cleaned the counter top connected to sink.

- At 10:06 AM Dietary Aide #1 moved the rack of clean mugs to an adjacent shelf.

- At 10:08 AM Dietary Aide #1 moved a tray of clean silver ware to an adjacent counter.

- At 10:09 AM Dietary Aide #1 removed her disposable gloves, placed them in a trash can, and washed and dried her hands at a sink in the kitchen.

An interview with the Dietary Manager (DM) on 02/02/15 at 10:11 AM revealed she expected the dietary aides to remove their gloves, wash their hands, and put on a clean pair of gloves anytime they moved from the dirty to the clean area of the dish washing process.

During an interview on 02/02/15 at 10:12 AM Dietary Aide # 1 confirmed she did not change her gloves when she went from the dirty to the clean area of the dish washing process and should have done so.

2. During an initial tour of the kitchen on 02/02/15 at at 9:52 AM Dietary Aide #1 removed clean food trays from a rack on the dish washing line, which were visibly wet on both sides, and stacked them on top of each other on an adjacent counter. At 9:54 AM she removed visibly wet clean food trays

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 _____	02/05/2015

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 371	Continued From page 55	F 371		

from a second rack on the dish line and stacked them on an adjacent counter.

A subsequent observation on 02/02/15 at 9:56 AM revealed Dietary Aide #1 removed nine clean insulated domes from the rack on the dish line, which were visibly wet on both surfaces, and stacked them on top of each other on an adjacent counter.

An interview with the Dietary Manager (DM) on 02/02/15 at 10:11 AM revealed she expected the dietary aides to allow food trays and insulated domes to air dry before stacking them on the counters for tray line.

During an interview on 02/02/15 at 10:12 AM Dietary Aide # 1 stated she was not trained to allow the dishes, food trays, or insulated domes to air dry before stacking them on the counter.

3. Observations of the reach-in refrigerator on 02/02/15 at 10:21 AM and 02/03/15 at 3:59 PM revealed the two door handles and the surface behind the handles were sticky to touch. Light brown particles were noted on the surface behind the door handles that could be scraped off with a fingernail. In addition, white dried spills were noted on the exterior of both door panels.

Observations of the reach-in freezer on 02/02/15 at 10:22 AM and 02/03/15 at 3:59 PM revealed the two door handles and the surface behind the handles were sticky to touch. Light brown particles were noted on the surface behind the door handles that could be scraped off with a fingernail. A large brown dried spill was observed on the left exterior door panel which was sticky to touch and could be smeared with a finger. In

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 _____	02/05/2015

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 371	Continued From page 56	F 371		

addition, white dried spills were noted on the exterior of both door panels.

Observations of the reach-in refrigerator on 02/04/15 at 11:02 AM revealed the two door handles and the surface behind the handles were sticky to touch. Light brown particles were noted on the surface behind the door handles that could be scraped off with a fingernail. In addition, white dried spills were noted on the exterior of both door panels. There were also two quarter-sized areas of dried white matter noted on the right exterior door panel.

Observations of the reach-in freezer on 02/04/15 at 11:03 AM revealed the two door handles and the surface behind the handles were sticky to touch. Light brown particles were noted on the surface behind the door handles that could be scraped off with a fingernail. A large brown dried spill was observed on the left exterior door panel which was sticky to touch and could be smeared with a finger. In addition, white dried spills were noted on the exterior of both door panels.

An interview was conducted with the Dietary Manager (DM) on 02/04/15 at 11:47 AM. During the interview the DM stated the kitchen was cleaned according to the posted daily cleaning schedule. The DM noted the dietary staff were expected to clean the exterior door panels of the reach-in refrigerator and freezer using a sanitizer/water solution on a cleaning cloth when they were assigned these tasks. The cleaning schedule was reviewed during the interview and the DM confirmed that Cook #1 had initialed she had cleaned the reach-in refrigerator on 02/03/15 and Dietary Aide #1 had initialed she had cleaned the reach-freezer on 02/03/15. The DM observed

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 _____	02/05/2015

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 371	Continued From page 57 the exterior door panels of the reach-in refrigerator and freezer during the interview and stated it did not appear the door panels had been cleaned on 02/03/15. During an interview on 02/04/15 at 12:10 PM Cook #1 stated she had wiped down the exterior door panels of the reach-in refrigerator with soap and water on 02/03/15 but did not notice the light brown particles or the dried spills. An interview with Dietary Aide #1 on 02/04/15 at 12:12 PM revealed she wiped down the exterior door panels of the reach-in freezer on 02/03/15 using soap and water on 02/03/15 but did not notice the light brown particles or the dried spills.	F 371		
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	F 441		3/5/15

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 _____	02/05/2015

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 58 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a 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 disinfect a blood glucose meter after use per facility policy for 1 of 1 observation of glucometer disinfection (Resident #42) and failed to follow contact precautions for 1 of 1 resident reviewed for contact precautions (Resident #60). The findings included: 1. A facility policy entitled Deodorizing and Disinfecting Glucometer Machines, blood glucose meter, dated 10/02/13 read in part to use a wipe to remove heavy soil. Thoroughly wet the surface, the treated surface must remain visibly wet for a full 3 minutes. Use additional wipes if needed to assure a 3 minute wet contact time. Let air dry. This must be performed before and after each glucometer use.	F 441	Corrective action for the first of two alleged deficient practice was accomplished by the DON educating nurse #1 regarding proper disinfection of glucose meters. Nurse #1 was advised that the disinfecting agent must remain visibly wet on the meter for a full 3 minutes. To ensure that no one else was affected by the same alleged deficient practice, all licensed staff were inserviced regarding proper glucose meter decontamination procedures on 2/27/2015, 2/28/2016 and 3/1/2016, including return demonstrations. A system was developed to ensure that this alleged deficient practice does not occur again, which includes acquisition of	

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 _____	02/05/2015

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 59 An observation was conducted on 02/04/15 at 11:50 AM of Nurse #1 obtaining a finger stick blood sugar reading. Nurse #1 was observed cleaning the blood glucose meter with a germicidal disinfection wipe at 11:54 AM. The blood glucose meter was visibly wet. At 11:55 AM Nurse #1 covered the visibly wet blood glucose meter with a Kleenex and took it into Resident #42's room. Nurse #1 was observed getting ready to use the blood glucose meter at 11:56 AM on Resident #42 when asked to stop by the surveyor. An interview was conducted on 02/04/15 at 12:02 PM with Nurse #1. She stated it was facility policy to clean the blood glucose machine before and after each use with a germicidal wipe and let the meter remain visibly wet for 3 minutes. She stated she doesn't use a timer or time the 3 minutes with her watch because it took her that long after she cleaned the machine to get her things together to obtain the finger stick blood sugar. Nurse #1 stated she was unaware it had only been 2 minutes from the time she cleaned the blood glucose meter to the time she was ready to use it. She further stated she was unaware she had covered the meter with a Kleenex causing it to dry. An interview was conducted on 02/05/15 at 8:41 AM with the Director of Nursing (DON). She stated it was her expectation for blood glucose meters to be cleaned with a germicidal wipe before and after each use. The DON stated the blood glucose meter should remain visibly wet for 3 minutes after being cleaned. She further stated the 3 minute visibly wet time should be timed with the nurse's watch or a timer to be assured the	F 441	individual glucose meters for each resident requiring daily finger sticks, changing decontamination wipes to a faster-acting wipe which will produce the same results, plastic tubs for storage of individual meters and labeling of meters and tubs for each resident requiring daily glucose monitoring. All licensed staff has been inserviced on the use of the new wipes, cleaning of the glucose meters and proper storage of the meters on 2/27/2015, 2/28/2015 and 3/1/2015. The DON or designee will monitor use and disinfection of the meters by one nurse on each shift daily for 1 week, then one nurse weekly for 30 days, and once monthly thereafter, ongoing. To ensure the system remains in place and effective, blood glucose meter monitoring will be added to the monthly Infection Control audit, and a report will be compiled of all findings to be presented by the DON or designee to the QA&A Committee for review and recommendations monthly, ongoing. Corrective action for the second alleged deficient practice was accomplished by the DON conducting an inventory of the isolation cart for the isolation room, verification that instructions were readily visible for use of PPE, and that appropriate signage was posted on the door of the isolation room. A huddle of staff was conducted to educate the staff present regarding isolation protocols by the DON on 2/4/2015 and inservices were scheduled for all staff.	

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 _____	02/05/2015

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 60 meter was disinfected according to policy. 2. Review of the facility Contact Isolation Policy created 02/2007 revealed contact isolation would be implemented for multiple resistant organisms - MRSA (until 3 negative cultures 24 hours apart, 72 hours after discontinuance of anti-microbial). Gloves are necessary when touching infective secretions/materials and items likely to be contaminated by them. Gowns are necessary if soiling of clothing with infectious material is likely. Review of physician orders dated 01/26/15 revealed Resident #60 was to be placed on contact isolation for methicillin resistant staphylococcus aureus (MRSA), a multiple drug resistant organism in the urine and the nares. Physician order dated 01/29/15 revealed Resident #60 was to continue strict isolation precautions for vancomycin resistant enterococci (VRE), a multiple drug resistant bacteria in the urine. An observation was made on 02/03/15 at 2:00 PM of Resident #60's room with a contact precaution sign on the door and a cart with gowns and gloves located outside of the room. An observation made on 02/03/15 at 2:01 PM revealed nurse aide (NA) #1 entered Resident #60's room with gloves on but no gown and checked Resident #60's blood pressure. NA #1 leaned against Resident #60's bed when she checked her blood pressure. NA #1 then discarded her gloves, threw them in the trash can in Resident #60's room. NA #1 exited Resident #60's room, placed the blood pressure cuff in the isolation cart outside the room, cleaned the stethoscope with an antibacterial wipe and used	F 441	To ensure others are not affected by the same alleged deficient practice, the DON conducted inservice training for all staff on 2/27/2015, 2/28/2015, 3/1/2015 and 3/2/2015. The inservice training included instruction on types of isolation, PPE required for each type of isolation, the proper use of PPE, proper disposal of used PPE and proper hand hygiene. Instruction was additionally given to the housekeeping department regarding the proper cleaning and disinfecting of an isolation room. A system was put in place to ensure that this alleged deficient practice does not occur again, which includes monitoring of any isolation/contaminated rooms for adherence to facility protocols, policies and procedures. These monitoring tools are to be completed by the DON or designee for 5 days when the next isolation incident occurs; the facility currently does not have anyone on isolation. Additionally skills validation via interview and return demonstration for isolation procedures will be conducted. To ensure the system remains effective, an audit of all monitoring tools will be compiled by the DON or designee and presented to the QA&A Committee for review and recommendations on a monthly basis, ongoing.	

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 _____	02/05/2015

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 61	F 441		

hand sanitizer to clean her hands.

An observation made on 02/04/15 at 12:30 PM revealed NA #1 took Resident #60's lunch tray into her room and placed it on the over bed table and removed the insulated dome cover without gloves or a gown on. NA #1 exited Resident #60's room at 12:31 PM and donned a gown and gloves and at 12:32 PM went back into the room and finished the lunch tray set up.

An observation made on 02/05/15 at 2:46 PM revealed a resident propelled herself in her wheelchair into Resident #60's room and sit at the doorway. At 2:47 PM NA #1 saw the resident sitting in Resident #60's room and pushed her out into the hallway and asked her if she had touched anything then left her in the hallway. At 2:48 PM the resident propelled herself back into Resident #60's room and touched items on the sink and turned the water on, she propelled herself back into the hallway at 2:49 PM.

An interview was conducted on 02/03/15 at 2:07 PM with NA #1. She stated when a resident is on contact precautions gowns were worn for incontinence care and bathing only. She stated she didn't wear a gown to check Resident #60's blood pressure because she didn't touch anything but her arm.

An interview was conducted on 02/03/15 at 2:37 PM with the facility Nurse Practitioner (NP). She stated she expected strict contact precautions be used with Resident #60 to prevent the spread of infection to staff and other residents. The NP stated her expectation of strict contact precautions was for staff and visitors to wear gloves and gowns when entering Resident #60's

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 _____	02/05/2015

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 62 room for any reason. An interview was conducted on 02/05/15 at 8:41 AM with the Director of Nursing (DON). She stated it was her expectation for staff and visitors to wear a gown and gloves any time they entered Resident #60's room. She stated she was unaware staff had not been following contact precautions as ordered and was unaware other residents had been entering Resident #60's room.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		3/5/15

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 _____	02/05/2015

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 520	Continued From page 63 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in October 2013. This was for one recited deficiency which was originally cited in October 2013 on a Recertification survey and subsequently recited in February 2015 on the current recertification survey. The deficiency was in the area of infection control. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F 441 Infection Control: Based on observations, record review and staff interviews the facility failed to disinfect a blood glucose meter after use per facility policy for 1 of 1 observation of glucometer disinfection (Resident #42). During the recertification survey of 10/03/13 the facility was cited for failure to provide training to nursing staff to ensure blood glucose meters were disinfected/sanitized by the manufacturer's recommendations. On the current recertification survey F 441 was again recited for failure to disinfect a blood glucose meter after use per facility policy. During an interview on 02/05/15 at 8:41 AM the	F 520	Corrective action for this alleged deficient practice was accomplished by adding disinfection of blood glucose meter monitoring to the DON's Infection Control Reporting List for presentation to the QA&A Committee monthly. To ensure no other areas are affected by the same alleged deficient practice, the Administrator or designee will ensure that Infection Control Monitoring remains on the QA&A Agenda indefinitely and ongoing. In addition, an audit of all monitoring tools resulting from the 2013 Survey was completed on 3/2/2015 by the Administrator and DON. A system has been developed to ensure that this alleged deficient practice does not recur, which includes the creation of a Master Agenda for monthly and quarterly QA&A Committee meetings. The Master Agenda will encompass all monitoring and audit reviews, reports and PIP reports for active PIP teams. To ensure the system remains effective, no items may be removed from the Master Agenda without the express permission of the Administrator, DON and Medical Director. The date on which an item is removed, as well as the reason for removal, will be noted in the QA&A Committee meeting minutes. This practice will be ongoing indefinitely.	

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 _____	02/05/2015

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 520	Continued From page 64 Director of Nursing (DON) stated it was her expectation for blood glucose meters to be cleaned with a germicidal wipe before and after each use. The DON stated the blood glucose meter should remain visibly wet for 3 minutes after being cleaned. She further stated the 3 minute visibly wet time should be timed with the nurse's watch or a timer to be assured the meter was disinfected according to policy. During an interview on 02/05/15 at 4:44 PM the Administrator stated the Quality Assessment and Assurance Committee met on a quarterly basis and they also utilized teams which met monthly to resolve issues. She explained past deficiencies were not always monitored on an ongoing basis but they were monitored for a certain period of time as documented on the plan of correction. She verified disinfection of blood glucose meters was monitored for a period of time after the last survey but somewhere along the way it went back out of compliance. She stated it was her expectation for staff in-services to be done with return demonstrations of disinfection of blood glucose meters and monitoring should be included on the monthly checklist of infection control items they reviewed. She further stated disinfection of blood glucose meters should also be added to the Quality Assessment and Assurance Committee agenda for review to monitor compliance.	F 520		