STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The complaint investigation was initiated on 1/5/17 with an unannounced late entry. The on-site survey continued on 1/6/17 and observations and record reviews were conducted. Due to adverse weather which started the afternoon of 1/6/17, and remained in effect through 1/9/17, not all the required interviews were completed before leaving the facility on 1/6/17. The remaining interviews were conducted off-site. The Hospital Discharge Summary was initially requested from the hospital on 1/6/17 and with two follow-up requests had not yet been received as of 1/18/17. Telephone interviews were completed on 1/18/17 and 1/19/17 and the exit was conducted via telephone on 1/19/17. The Hospital Discharge Record was received from the hospital on 1/24/17.	F 000		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review; and staff, Nurse Practitioner and Physician interview, the facility failed to transcribe a medication order written by a Nurse Practitioner on a diagnostic test report and failed to include the intended duration of an antibiotic medication in the antibiotic medication order for 1 of 3 sampled residents (Resident #3). The findings included:	F 281	1. Resident #3 was sent to the hospital on 11-9-16, and did not return to the facility. 2. The facility will complete 100% care plan audits for residents with CHF and/or diuretics by the DNS, ADNS and Unit Managers by 2/9/17. Audit will be	2/10/17

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

Electronically Signed | 02/07/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

(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 281	Continued From page 1 1a. Resident #3 was admitted 10/25/16 with diagnoses including chronic diastolic heart failure (CHF), hypertension, emphysema, obstructive sleep apnea, diabetes, simple chronic bronchitis and degenerative joint disease. The Admission Minimum Data Set (MDS) dated 11/1/16 revealed Resident #3 was cognitively intact. The Care Plan dated 10/26/16 revealed review of the care plan reveled there was not a plan of care for diastolic heart failure or use of a diuretic medication. Review of the Physician ' s Orders revealed an order dated 10/25/16 for Lasix (a diuretic), 40 mg (milligrams) once a day for edema. A 10/27/16 Physician Order revealed an order for a chest x-ray to rule out pneumonia. Review of the Radiology Report for the chest x-ray dated 10/27/16 revealed the following conclusion: cardiomegaly (an enlarged heart) and CHF (Congestive Heart Failure). Further review of the 10/27/16 Radiology Report revealed the following hand written order dated 10/28/16: Add Lasix by mouth every bedtime x 5 days. The order was signed by the Nurse Practitioner. Review of the Physician ' s Orders and Medication Administration Record (MAR) for the duration of the resident ' s stay in the facility (10/25/16 - 11/9/16) revealed the order for an added dose of Lasix every bedtime for 5 days was not present in the Physicians Orders or on the Medication Administration Record. Resident #3 was transferred to the hospital on 11/9/16 due to complaints of severe abdominal pain and admitted on 11/10/16. Telephone interview with Nurse #1 on 1/18/17 at 11:45 AM revealed that she recalled Resident #3 but not the specific details regarding orders. She	F 281	completed of lab reports and X Rays for the past three months for residents with diuretics and CHF diagnosis by the DNS, ADNS and unit managers by 2-9-17. Residents with orders for antibiotics were audited by unit managers, ADNS, and DNS on 2/9/17. If any deficiencies are found during the audits they will be corrected by 2-9-17.All new admissions/readmission charts will be brought to the daily stand up meeting and reviewed by the Unit Manager/DNS/ADNS beginning on 2/6/2017. 3. DNS/ADNS/Unit Managers will monitor each resident upon admission or readmission for diuretics orders and/or CHF diagnosis -if diuretics are present, it will be added to care plan under either CHF or hydration problem list. DNS/ADNS/Unit Manager will monitor upon admission or readmission for antibiotic from the Discharge Summary from the hospital for the Stop date or duration of. If duration of antibiotic is not specified , the nurse will contact the MD/NP for stop date. The licensed nurses will be in-serviced on admission/readmission verification of orders, including antibiotics start and stop dates by NPE/Unit Manager on 2/7/17. The 11-7 nurses will check the Admissions/Re admissions orders against hospital discharge summary and discharge medication list for accuracy and antibiotic start and stop dates. The nurse will initial on the Discharge medication list after verifying. MD/NP were in serviced on 2/7/2017 on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

(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 281	Continued From page 2 stated that she did not recall seeing any orders written on a Radiology Report but if she had the process would be to call or text the Nurse Practitioner for a verbal telephone order and then transcribe to the Physician ' s Orders in the electronic medical record which would place the order on the MAR. She said she would have also faxed the order to the pharmacy. Telephone interview with the Physician on 1/19/17 at 11:09 AM revealed that the ordering process was being changed. Orders would no longer be written on diagnostic reports and would instead be written on a Physician Order Sheet and flagged for transcription and processing. He added that he did not think the Lasix would have ultimately been helpful to Resident #3 as she progressed to renal failure which he indicted could be caused by her CHF and other underlying factors. He acknoledged that it was his expectstion that orders were written in the correct location, transcribed and implemented and that in other circumstnces omission of an order for additional Lasix could have adverse effects. Telephone interview with the Nurse Practitioner (NP) on 1/19/17 at 3:12 PM revealed he recalled the x-ray result indicating Resident #3 had CHF and writing an order for additional Lasix for a limited period on the Radiology Report. He stated that he had not been aware that the order had not been transcribed or implemented. The added that the ordering process had been changed recently and that orders would be written on a Physician Order Sheet and flagged for transcription and processing. 1b. Review of the Augmentin Manufacturer ' s Data Sheet, Version 5, and dated 4/29/13 reveled: "To minimize the potential gastrointestinal intolerance, administer at the start	F 281	the Physician Communication Book and not to write orders on the results of labs or X ray. The results of labs/X-Rays will be placed in the MD notebook in sleeve marked "Reviewed and signed by MD/NP". The 11-7 nurse will review the book to ensure all orders are carried out and the nurse will initial the lab , X ray or order, nurses were in serviced on 2/7/2017. 4. The DNS, ADNS, Unit Managers will review all orders upon admission, readmission, and review orders daily for new orders of antibiotic with duration date and order for labs and X Ray. New admissions Care plans will be audited with in 72 hours for congestive heart failure diagnosis and diuretic use by DNS, ADNS and Unit managers. Any finding from the review will be brought to the PI meeting each month. This will be a continued Best Practice .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

(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 281	Continued From page 3	F 281		

of a meal for optimal absorption of Augmentin. Duration of therapy should be appropriate to the indication and should not exceed 14 days without review. "

Resident #3 was admitted 10/25/16 with diagnoses including chronic diastolic heart failure, hypertension, emphysema, obstructive sleep apnea, diabetes, simple chronic bronchitis and degenerative joint disease.
The Admission Minimum Data Set (MDS) dated 11/1/16 revealed Resident #3 was cognitively intact.
Review of the 10/25/16 Hospital Discharge Summary revealed an order to continue taking Augmentin (an antibiotic) 825-125 mg (milligrams) 1 tablet twice a day. No duration was specified. There were no notes indicating the duration had been verified with the sending facility or the physician.
The Care Plan dated 10/26/16 revealed review of the care plan reveled a plan of care for Chronic Obstructive Pulmonary Disease and Clinical Management Chronic Bronchitis. The goal for this focus area was " The patients pulse ox (oxygen saturation percent) will be 90% or greater x 90 days. " The interventions listed were obtain pulse ox every shift and as needed and notify physician if less than 90% and to administer oxygen as ordered. Antibiotic therapy was not mentioned in the care plan.
Review of the Physician ' s Orders revealed an order dated 10/25/16 and started on 10/26/16 for Augmentin Tablet 875-125, 1 tablet two times a day for infection. No duration was specified.
Review of the Nursing Notes from 10/25/16 - 11/6/16 revealed multiple entries stating no adverse reaction to antibiotics in the Nursing Notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

(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 281	Continued From page 4	F 281		

Review of the Medication Administration Record revealed no Augmentin was given after 9:00 AM on 11/6/16. Resident #3 refused the 11/6/16 5:00 PM dose.
Review of the Nursing Notes dated 11/7/16 revealed the Augmentin tablets had run out and could not be refilled. The note further indicated " will check for stop date. "
The Physician Orders for 11/7/16 revealed the Augmentin was discontinued.
Telephone interview with the Physician on 1/19/17 at 11:09 AM revealed that Resident #3 had been on Augmentin for Bronchitis. He stated that Antibiotic orders should have appropriate stop and start dates upon ordering. He added that while 14 days was a typical durtion for augmentin, hospital discharge instructions should specify the number of days to continue the antibiotic in the facility. The Physician also acknoledged that if the duration was not specified in the Hospital Discharge Orderd the durstion should be clarifified but that Pharmacy would likely automatically stop it after 14 days.
Telephone interview with the Nurse Practitioner on 1/9/17 at 3:12 PM revealed that in the absence of adverse reactions to antibiotics, a duration of longer than 14 days could be given if needed.
During telephone interview with the Director of Nursing (DON) on 1/19/17 at 4:43 PM she stated that a Physician verifies all Admission Orders, so if the Physician did not add a stop date, she did not feel Nursing Staff needed to ask for a clarification. In regards to Standards of Practice for medication orders she indicated that it was appropriate to rewrite the orders as written on the Hospital Discharge Summary even if duration was not specified for an antibiotic. When asked about the responsibility of nursing staff to clarify the duration of the antibiotic order for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

(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 281	Continued From page 5 #3, given that the Resident may already have received doses in the hospital before arriving at the facility; The DON did not comment.	F 281		