STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345307	A. BUILDING: _____ B. WING _____	4/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 580	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff and Guardian Social Worker interviews, and record review, the facility failed to provide notification to the legal representative for 1 of 3 residents (Resident #2) reviewed for notification. Findings included: Resident #2 was admitted to the facility on 2/26/2019 and discharged to the hospital on 3/27/2019. Diagnoses included presence of cardiac pacemaker, atrial fibrillation, hypertension, and dementia. Review of the Admission Minimum Data Set (MDS) dated 3/11/2019 revealed that Resident #2 was severely cognitively impaired. Resident #2 required extensive assistance with bed mobility, transfers, and personal hygiene. Resident #2 was incontinent of bowel and bladder.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345307	A. BUILDING: _____ B. WING _____	4/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 580	Continued From Page 1

Review of the active medical record revealed an Order on Petition for Adjudication of Incompetence dated 2/28/2019 which read in part: It is ordered that a guardian be appointed by this court- Guardian of the Person (GOP) Gaston County Department of Health and Human Services. Further review of the active medical record revealed Letters of Appointment Guardian of the Person dated 3/12/2019 which read in part: The guardian of the person is fully authorized and entitled under the laws of North Carolina to have the custody, care and control of the ward, but has no authority to receive, manage or administer the property, estate or business affairs of the ward.

Review of the Admission Record on the active chart dated 2/28/2019 revealed that family was listed as the responsible party and emergency contact.

An interview was completed with the Guardian Social Worker (SW) on 4/17/2019 at 12:29 PM which revealed she was not notified of Resident #2 being transferred to the hospital. The Guardian SW stated the facility had the Guardianship information (which was provided after the guardianship hearing on 2/28/2019) which contained contact numbers, after hour contact numbers, and the guardianship protocols for medical treatment. The Guardian SW further explained that she was contacted by Resident #2's family, several days after Resident #2 had been in the hospital. The Guardian SW expressed that since notification was not made of Resident #2 being transferred to the hospital, the Guardianship department had to report this on to the State Agency (SA).
An interview was completed with Resident #2's family on 4/17/2019 at 1:03 PM. The family stated they recalled when Resident #2 was transferred to the hospital. The family verbalized the facility notified them of Resident #2 being transferred to the hospital. The family explained they notified the Guardian SW but could not recall when they notified her.

An interview was completed with Nurse #1 on 4/17/2019 at 3:28 PM. Nurse #1 stated she was the nurse on duty that transferred Resident #2 to the hospital. Nurse #1 explained Resident #2 complained of pain to her chest and she was aware Resident #2 had a cardiac pace maker. Nurse #1 further explained she assessed Resident #2, made physician notification, and family notification. Nurse #1 stated she did not make notification to the Guardian SW. An observation was completed with Nurse #1 of the active medical record which revealed the family of Resident #2 listed as the responsible party and emergency contact. Nurse #1 reiterated she contacted the responsible party and made notification. Further review of the active medical record with Nurse #1 revealed the Guardianship paperwork with contact information. Nurse #1 was not aware Resident #2 had a Guardian SW in place and notification needed to be made. Nurse #1 stated she relied on the contact information on the active medical record to be current, so that proper notification could be made.

An interview was completed with the Director of Nursing (DON) on 4/17/2019 at 3:59 PM. The DON stated her expectation of nursing staff would be for them to provide notification of any change in condition and / or transfer to the guardian, legal representative, or responsible party.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 On 04/17/19, the Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted an onsite revisit. While some of the deficiencies cited were corrected on 04/01/19, the facility remains out of compliance. The mandatory termination date is 04/25/19	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to maintain the physician ordered rate of oxygen for 1 of 3 residents reviewed for respiratory care. (Resident #5) The findings included: Resident #5 was admitted to the facility on 05/14/18, with diagnoses which included dementia, respiratory failure, asthma and chronic obstructive pulmonary disease (COPD). The most recent quarterly Minimum Data Set (MDS) dated 2/20/19, revealed Resident #5 was moderately cognitively impaired requiring	F 695	Resident #5 orders were reviewed for oxygen and the oxygen flow rate adjusted to 4 LPM by Licensed Nurse on 4/17/19. Resident #5 Oxygen saturation was evaluated by the Nurse Consultant on 4/17/19 to ensure compliance. 2. Resident's receiving oxygen have the potential to be affected by this deficiency that the facility failed to maintain the physician ordered rate of oxygen. A baseline audit was conducted on 4/17/19 by the Director of Nursing for resident receiving oxygen to validate oxygen flow rate per physician order. Any concerns identified were corrected immediately.	4/18/19

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

Electronically Signed | 04/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 695	Continued From page 1 extensive two-person assistance with bed mobility, transfers, dressing and personal hygiene. Resident #5 was coded for requiring supplemental oxygen. Review of physician orders revealed an order dated 05/14/18 which read, "O2 at 4 liters per minute via nasal cannula continuous". Review of the Medication Administration Record (MAR) dated April 2019, revealed Resident #5 was to be on 4 liters per minute (lpm) of oxygen continuously via nasal cannula. The order was initiated on 05/14/18. Further review revealed initialed documentation dated 04/17/19 during the 7 AM to 3 PM shift indicating Resident #5 was receiving 4 lpm of supplemental oxygen. On 04/17/19 at 10:00 AM, Resident #5 was observed sitting in her room in her wheelchair. The oxygen concentrator located behind her wheelchair and in use was observed as set at 3 liters per minute. A large sign was observed over Resident #5's bed indicating the resident needed to be receiving 4 liters of oxygen at all times due to severe COPD. On 04/17/19 at 1:50 PM, Resident #5 was observed in her room in her wheelchair receiving oxygen from an oxygen concentrator which was observed set at 3 lpm. Her family member was also in the room and stated Resident #5's oxygen concentrator was to be set at 4 lpm. An interview with Nurse Aide (NA) #1 who cared for Resident #5 on 04/17/19 was conducted at 2:10 PM. She stated she was not sure why the setting was on 3 lpm as she was aware it needed	F 695	The Director of Nursing or designee will audit the patient MAR monthly x 3 months to ensure compliance is maintained. 3. Director of Nursing re-educated all Licensed Nurses on 4/17/19-4/18/19 regarding following the physician's order for oxygen administration, including the documentation of the flow rate. Education included: all nurses will verify the patient's oxygen rate is accurate on each shift by looking at the patient's oxygen administration set up at eye level to ensure that the rate is at the prescribed order. The nurse will document the oxygen rate in the patient's MAR after physically viewing the rate. In addition, newly hired Licensed Nursing staff will also receive education during subsequent orientation. 4. The Director of Nursing, MDS, or treatment nurse will be responsible for monitoring the residents receiving oxygen for the physician ordered flow rate and Mar's 3x's per week x's 4 weeks and then one (1)x per week x's 2 months starting 4/18/19, to ensure compliance is maintained. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee per Month x's 3 Months presented by the DON and or Designee. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 695	Continued From page 2 to be at 4 lpm. The interview revealed it was the responsibility of the nurse to adjust the resident's oxygen setting. On 04/17/19 at 1:56 PM an interview was conducted with Nurse #1. Nurse #1 stated she was responsible for checking Resident #5's oxygen rate. The interview revealed Nurse #1 had initialed on Resident #5 ' s MAR that she had checked the setting during first shift on 04/17/19 however, had not went into the room to physically look at Resident #5's oxygen concentrator setting. The interview revealed Resident #5 had a physician order to receive 4 liters of continuous supplemental oxygen. Upon entering Resident #5's room during this time Nurse #1 stated the oxygen was to be set at 4 lpm and proceeded to change the gauge on the oxygen concentrator from 3 lpm to 4 lpm. Upon request by the surveyor Nurse #1 obtained Resident #5's oxygen saturation with a result of 95% on 4 lpm of oxygen. On 04/17/19 at 2:20 PM an interview was conducted with the Director of Nursing (DON). The DON stated she expected the oxygen to be administered as ordered by the physician. She stated Resident #5 ' s oxygen concentrator should have been set to 4 lpm. The Administrator stated during interview on 04/17/19 at 2:20 PM that she expected the oxygen to be administered as ordered by the physician.	F 695	compliance. Corrective action will be completed by 4/18/19	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		4/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 801	Continued From page 3 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 801	Continued From page 4 November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to employee a certified dietary manager with required competencies and skills since 03/07/19 through 04/17/19 for 1 of 1 certified dietary manager position.	F 801	No residents were identified as having been affected by the deficient practice. 2.The facility as of 4/18/19 has hired a full-time (30hrs per week to 40hrs per	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 801	Continued From page 5 The findings included: On 04/17/19 at 10:02 AM an interview was conducted with the facility's designated dietary manager. The manager explained that she had worked in the facility for years as a cook and was asked by the Administrator to take over the role as Dietary Manager "around the first of April." The designated dietary manager explained that she was not a certified dietary manager but had registered and started an 8-week on-line training course on 04/15/19. The designated dietary manager reported she thought a certified dietary manager had been hired but then ended up not taking the position which left the vacancy. She stated the facility had been without a certified dietary manager since the previous survey. On 04/17/19 at 1:55 PM the Registered Dietitian (RD) was interviewed on the telephone and explained she was a consultant RD and came to the facility once a month. She explained her focus was clinical. On 04/17/19 at 3:23 PM the Administrator was interviewed and reported that the facility had made attempts to hire a certified dietary manager without success and decided to promote the designated dietary manager into the role. She stated that the designated dietary manager was SERV Safe Certified and had started her on-line training to be a certified dietary manager. The Administrator she felt that satisfied the regulatory requirement for a certified dietary manager.	F 801	week) Certified Dietary Manager who will start on 4/20/19.The RD currently works 8 hrs. per month and will be working a additional 4 hours per Month beginning 4/23/19. The Certified Dietary Manger will oversee the dietary department day to day operations. 3. The Corporate Administrator re-educated the Administrator on 4/18/19 on ensuring that a qualified dietitian or other clinically qualified and or a certified dietary Manager is employ full-time to manage the Dietary department. 4. Monitoring to ensure compliance the HR director or Designee will sign off 1 x per Month for four (4) Months that Dietary staffing Compliance for a Certified Dietary Manager and or a Certified food service Manager is achieved starting 4/20/19. Data will be summarized and presented to the facility Quality Assurance Committee per Month x's 4 Months presented by the HR Director and or Designee. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. Corrective action will be completed by 4/20/19.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy.	F 803		4/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 803	Continued From page 6 Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to follow a recipe for the lunch meal entrée by omitting ground beef. This practice had the potential to affect all residents served baked ziti. The findings included: On 04/17/19 at 11:41 AM the lunch meal service was observed. The lunch's menu main entrée was baked ziti. Observations of the baked ziti revealed the entrée consisted of pasta, tomato	F 803	No residents were identified as having been affected by the deficient practice. 2.On 4/17/19 The Administrator has printed off and placed in the Dietary Department all of the recipes for the residents' menus from the optima system and created a binder containing all of the resident's meals, so that the dietary cooks will be able to follow the established recipes for the resident meals.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 803	Continued From page 7 sauce and shredded cheese. On 04/17/19 at 12:02 PM the cook was interviewed and stated the baked ziti included noodles, sauce and cheese that she had prepared that same day. The cook reported that she relied on the menu to tell her what was being served for lunch. The cook was unaware if there were recipes and added that she relied on the posted menu to know what to cook and that baked ziti did not specify meat, so she did not include meat in the entrée. The cook also stated that no other protein was being provided for the lunch meal. On 04/17/19 at 12:10 PM the Dietary Manager (DM) was asked for the recipe for baked ziti. The DM explained that she wasn't familiar with the recipes because she was new in her role. And she stated she did not know how to print the recipe and would have to request the recipe from the Administrator. She added that she had not used recipes and prior to being the DM she was a cook for the facility and had been told by the former Dietary Manager to make baked ziti using noodles, sauce and cheese. On 04/17/19 at 12:30 PM the Dietary Manager provided a copy of the recipe for baked ziti that was named "Baked Beef Ziti" and called for 16 pounds of ground beef to be used. The DM stated she had no idea the recipe called for ground beef. On 04/17/19 at 1:55 PM the Registered Dietitian (RD) was interviewed on the telephone and explained that she had reviewed the menu system with the new Dietary Manager and shown her how to access menus and recipes during a	F 803	3. Education was provided by the Administrator on 4/17/19 and 4/18/19 with the dietary Cooks regarding the Recipe Book and preparing meals in advance by prepping the meals for each shift in order to ensure that the correct amount of protein is given and the recipes are followed. The Administrator will also review the above education with the Dietary Manager on 4/20/19. In addition, newly hired dietary staff will also receive education during subsequent orientation. 4. Monitoring to ensure that the problem does not recur, the Administrator or Designees (Certified Dietary Manager and or RD) will check the meals with the cooks to ensure that recipes are followed when cooking meals 5 x's per week lunch and Dinner for 8 weeks starting 4/18/19. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee per Month x's 2 Months presented by the Dietary manager and or Designee. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. Corrective action will be completed by 4/20/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 803	Continued From page 8 recent visit to the facility. The RD stated that the ground beef was important to the overall daily protein needs of the residents because the menus were developed to meet the needs of residents for a whole day and that if a recipe called for beef, then it should be provided. On 04/17/19 at 12:45 PM the Administrator was interviewed and provided the food purchase order and ground beef was listed as "temporarily out of stock." The Administrator explained that she ordered all the food and if the DM had told her she needed ground beef, she would have taken money and bought the ground beef herself for the recipe.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		4/18/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 812	Continued From page 9 by: Based on observations, staff interviews and record review, the facility failed to serve milk within safe temperature range and failed to keep hair covered when serving food for 1 of 1 lunch meal observations. The practice of not covering hair had the potential to affect food being served to residents. The findings included: 1. On 04/17/19 at 11:41 AM observations were made of the kitchen during the lunch meal preparation with the Dietary Manager (DM). During the observations, a dietary aide was noted to be preparing meal trays for the lunch service by placing condiments and beverages on the trays. Individual milk cartons were on a cart with other beverages such as iced tea and water. The beverages were not being chilled and stored open to air. The ice inside the tea was noted to be partially melted. On 04/17/19 at 11:54 AM the dietary aide was noted to place milk cartons on residents' meal trays. There were 9 milk cartons placed on meal trays. The meal trays were stored on an open-air rack. The dietary aide reported that she used the tray tickers to "count" how many milks, teas and waters she needed for the meal trays. On 04/17/19 at 12:02 the cook proceeded to use a digital thermometer to measure the internal temperature of hot food items. The cook was interviewed and asked about measuring the temperature of milk and reported that she did not measure the temperature of milk because she relied on the "milk box's" (reach in cooler for milk cartons) thermometer for the temperature of milk.	F 812	No residents were identified as being affected by the deficient practice. 2.The Administrator conducted a audit on 4/17/-4/18/19 in the Dietary Department on the food temperatures and hair nets in order to ensure food safety compliance. 3. Education regarding the food temperature policy, the food serving policy, and the infection control policy which includes wearing a hairnet in order to ensure compliance in the dietary department with the dietary staff were conducted on 4/18/19 by the Administrator. 4. Monitoring performance to make sure that solutions are sustained in the Dietary Department the Dietary manager and or Designee will randomly audit five residents trays for serving temperatures on drinks and meals 3 x's per week x's two(2) month and 2 x's per week x's one (1)month starting 4/18/19. Hairnets will be monitored 3x's per week x's two (2) months and 2 x's per week x's one (1) month starting 4/18/19 on all three shifts by the Dietary manager and or Designee. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee per Month x's 3 Months presented by the Dietary Manager and or Designee. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 812	Continued From page 10 The cook was asked to measure the temperature of one of the milk cartons out for the lunch meal service. She used the digital thermometer to measure the internal temperature of a milk carton and the thermometer read 61 degrees Fahrenheit. The cook proceeded to remove a carton of milk from the "milk box" and measure the internal temperature of the milk carton at 40 degrees Fahrenheit and stated, "see we go by that reading." The 9 cartons of milk that had been unrefrigerated remained in use for the lunch meal service and were served to residents. On 04/17/19 at 12:20 PM the DM provided the temperature logs for meal service, review of the logs revealed the "cold beverages" temperature was measured daily to be 40 degrees Fahrenheit. The DM was interviewed about the cold beverages' temperature and reported that the temperature was the internal thermometer's temperature and not the milk's actual temperature. Observations were made of the "milk box" that contained an internal thermometer that read 40 degrees Fahrenheit. Inside the milk box was a cardboard box of individual milk carts. The outside of the cardboard milk box was stamped with instructions that read, "Keep Refrigerated between 34 - 40 degrees." On 04/17/19 at 1:55 PM the Registered Dietitian (RD) was interviewed on the telephone and explained she was responsible for the clinical aspects but was helping the DM with some basic kitchen operations since the DM was new in her role. The RD stated that milk was expected to be kept cold and should not have been served to residents at 61 degrees Fahrenheit.	F 812	and the plan will be revised to ensure continued compliance. Corrective action will be completed by 4/18/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 04/17/2019

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 812	Continued From page 11	F 812		

On 04/17/19 at 2:13 PM the dietary aide was interviewed and stated she had worked in the facility for 5 years and never thought about the milk getting hot by placing it on the trays prior to the start of tray line. The dietary aide was asked and did not recall when she took the milk cartons out of the "milk box."

During the lunch meal observation, the kitchen was noted to have an air condition window unit in use and set to 62 degrees Fahrenheit. In addition, the kitchen ' s back door was open and a screen door was in use. The cook stated that the screen door was to help cool off the kitchen because it was so hot inside.

On 04/17/19 at 2:18 PM a follow-up interview was conducted with the DM and she reported that was the first time she had ever had a milk carton ' s temperature measured because the milk cartons were pulled directly for use from the "milk box." She added that she relied on the temperature of the "milk box" to be the same temperature as the milk cartons. The DM was aware the milk cartons had been left out and one measured recorded 61 degrees Fahrenheit. The DM stated that the milk cartons should have been thrown away and not used for meal service and cold milk should have been served to the residents. She added that she also expected the dietary aides to pull from the "milk box" as needed to keep the milk cold.

On 04/17/19 at 2:46 PM the Administrator was interviewed and stated her expectations were the same as the RD's.

2. On 04/17/19 at 12:15 PM observations of 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 _____	C 04/17/2019

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 812	Continued From page 12	F 812		

lunch meal service were made that revealed the cook was noted to have a hairnet secured on the top of head, leaving the bottom half of her hair exposed. The cook was serving food from the tray line during the observation.

On 04/17/19 at 2:20 PM the cook was interviewed and reported that she usually had to wear two hairnets to cover all her hair and offered no explanation why her hair was not fully covered during the lunch meal service because, "she was fixing to clock out and go home."

On 04/17/19 at 2:22PM the Dietary Manager was interviewed and explained that there had been no training on hairnets, but all staff were expected to wear them to cover all the hair on their head.

On 04/17/19 at 2:46 PM the Administrator was interviewed and reported that she expected staff to keep all their hair covered when working in the kitchen.

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 _____	R-C 04/17/2019

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 On 04/17/19, the Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted an onsite revisit. While some of the deficiencies cited were corrected on 04/01/19, the facility remains out of compliance. The mandatory termination date is 04/25/19.	F 000		
{F 801} SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.	{F 801}		4/20/19

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

Electronically Signed | 04/19/2019

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 _____	R-C 04/17/2019

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 801}	Continued From page 1 (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service	{F 801}		

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 _____	R-C 04/17/2019

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 801}	Continued From page 2 managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to employee a certified dietary manager with required competencies and skills since 03/07/19 through 04/17/19 for 1 of 1 certified dietary manager positions. The findings included: On 04/17/19 at 10:02 AM an interview was conducted with the facility's designated dietary manager. The manager explained that she had worked in the facility for years as a cook and was asked by the Administrator to take over the role as Dietary Manager "around the first of April." The designated dietary manager explained that she was not a certified dietary manager but had registered and started an 8-week on-line training course on 04/15/19. The designated dietary manager reported she thought a certified dietary manager had been hired but then ended up not taking the position which left the vacancy. She stated the facility had been without a certified dietary manager since the previous survey. On 04/17/19 at 1:55 PM the Registered Dietitian (RD) was interviewed on the telephone and explained she was a consultant RD and came to the facility once a month. She explained her focus was clinical. On 04/17/19 at 3:23 PM the Administrator was interviewed and reported that the facility had made attempts to hire a certified dietary manager	{F 801}	No residents were identified as having been affected by the deficient practice. 2.The facility as of 4/18/19 has hired a full-time (30hrs per week to 40hrs per week) Certified Dietary Manager who will start on 4/20/19.The RD currently works 8 hrs. per month and will be working a additional 4 hours per Month beginning 4/23/19. The Certified Dietary Manger will oversee the dietary department day to day operations. 3. The Corporate Administrator re-educated the Administrator on 4/18/19 on ensuring that a qualified dietitian or other clinically qualified and or a certified dietary Manager is employ full-time to manage the Dietary department. 4. Monitoring to ensure compliance the HR director or Designee will sign off 1 x per Month for four (4) Months that Dietary staffing Compliance for a Certified Dietary Manager and or a Certified food service Manager is achieved starting 4/20/19. Data will be summarized and presented to the facility Quality Assurance Committee per Month x's 4 Months presented by the HR Director and or Designee. Any issues or trends identified will be addressed by	

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 _____	R-C 04/17/2019

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 801}	Continued From page 3 without success and decided to promote the designated dietary manager into the role. She stated that the designated dietary manager was SERV Safe Certified and had started her on-line training to be a certified dietary manager. The Administrator she felt that satisfied the regulatory requirement for a certified dietary manager.	{F 801}	the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. Corrective action will be completed by 4/20/19.	
{F 812} SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to serve milk within safe temperature range and failed to keep hair covered when serving food for 1 of 1 lunch meal observations. The practice of not covering hair had the potential to affect food being served to residents.	{F 812}	No residents were identified as being affected by the deficient practice. 2.The Administrator conducted a audit on 4/17/-4/18/19 in the Dietary Department on the food temperatures and hair nets in order to ensure food safety compliance.	4/18/19

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 _____	R-C 04/17/2019

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 812}	Continued From page 4 The findings included: 1. On 04/17/19 at 11:41 AM observations were made of the kitchen during the lunch meal preparation with the Dietary Manager (DM). During the observations, a dietary aide was noted to be preparing meal trays for the lunch service by placing condiments and beverages on the trays. Individual milk cartons were on a cart with other beverages such as iced tea and water. The beverages were not being chilled and stored open to air. The ice inside the tea was noted to be partially melted. On 04/17/19 at 11:54 AM the dietary aide was noted to place milk cartons on residents' meal trays. There were 9 milk cartons placed on meal trays. The meal trays were stored on an open-air rack. The dietary aide reported that she used the tray tickers to "count" how many milks, teas and waters she needed for the meal trays. On 04/17/19 at 12:02 the cook proceeded to use a digital thermometer to measure the internal temperature of hot food items. The cook was interviewed and asked about measuring the temperature of milk and reported that she did not measure the temperature of milk because she relied on the "milk box's" (reach in cooler for milk cartons) thermometer for the temperature of milk. The cook was asked to measure the temperature of one of the milk cartons out for the lunch meal service. She used the digital thermometer to measure the internal temperature of a milk carton and the thermometer read 61 degrees Fahrenheit. The cook proceeded to remove a carton of milk from the "milk box" and measure the internal temperature of the milk carton at 40	{F 812}	3. Education regarding the food temperature policy, the food serving policy, and the infection control policy which includes wearing a hairnet in order to ensure compliance in the dietary department with the dietary staff were conducted on 4/18/19 by the Administrator. 4. Monitoring performance to make sure that solutions are sustained in the Dietary Department the Dietary manager and or Designee will randomly audit five residents trays for serving temperatures on drinks and meals 3 x's per week x's two(2) month and 2 x's per week x's one (1)month starting 4/18/19. Hairnets will be monitored 3x's per week x's two (2) months and 2 x's per week x's one (1) month starting 4/18/19 on all three shifts by the Dietary manager and or Designee. Data will be summarized and presented to the facility Quality Assurance Performance Improvement Committee per Month x's 3 Months presented by the Dietary Manager and or Designee. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. Corrective action will be completed by 4/18/19	

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 _____	R-C 04/17/2019

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 812}	Continued From page 5	{F 812}		

degrees Fahrenheit and stated, "see we go by that reading." The 9 cartons of milk that had been unrefrigerated remained in use for the lunch meal service and were served to residents.

On 04/17/19 at 12:20 PM the DM provided the temperature logs for meal service, review of the logs revealed the "cold beverages" temperature was measured daily to be 40 degrees Fahrenheit. The DM was interviewed about the cold beverages ' temperature and reported that the temperature was the internal thermometer's temperature and not the milk's actual temperature.

Observations were made of the "milk box" that contained an internal thermometer that read 40 degrees Fahrenheit. Inside the milk box was a cardboard box of individual milk carts. The outside of the cardboard milk box was stamped with instructions that read, "Keep Refrigerated between 34 - 40 degrees."

On 04/17/19 at 1:55 PM the Registered Dietitian (RD) was interviewed on the telephone and explained she was responsible for the clinical aspects but was helping the DM with some basic kitchen operations since the DM was new in her role. The RD stated that milk was expected to be kept cold and should not have been served to residents at 61 degrees Fahrenheit.

On 04/17/19 at 2:13 PM the dietary aide was interviewed and stated she had worked in the facility for 5 years and never thought about the milk getting hot by placing it on the trays prior to the start of tray line. The dietary aide was asked and did not recall when she took the milk cartons out of the "milk box."

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 _____	R-C 04/17/2019

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 812}	Continued From page 6	{F 812}		

During the lunch meal observation, the kitchen was noted to have an air condition window unit in use and set to 62 degrees Fahrenheit. In addition, the kitchen's back door was open and a screen door was in use. The cook stated that the screen door was to help cool off the kitchen because it was so hot inside.

On 04/17/19 at 2:18 PM a follow-up interview was conducted with the DM and she reported that was the first time she had ever had a milk carton's temperature measured because the milk cartons were pulled directly for use from the "milk box." She added that she relied on the temperature of the "milk box" to be the same temperature as the milk cartons. The DM was aware the milk cartons had been left out and one measured recorded 61 degrees Fahrenheit. The DM stated that the milk cartons should have been thrown away and not used for meal service and cold milk should have been served to the residents. She added that she also expected the dietary aides to pull from the "milk box" as needed to keep the milk cold.

On 04/17/19 at 2:46 PM the Administrator was interviewed and stated her expectations were the same as the RD's.

2. On 04/17/19 at 12:15 PM observations of the lunch meal service were made that revealed the cook was noted to have a hairnet secured on the top of head, leaving the bottom half of her hair exposed. The cook was serving food from the tray line during the observation.

On 04/17/19 at 2:20 PM the cook was interviewed and reported that she usually had to wear two

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 _____	R-C 04/17/2019

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 812}	Continued From page 7 hairnets to cover all her hair and offered no explanation why her hair was not fully covered during the lunch meal service because, "she was fixing to clock out and go home." On 04/17/19 at 2:22PM the Dietary Manager was interviewed and explained that there had been no training on hairnets, but all staff were expected to wear them to cover all the hair on their head. On 04/17/19 at 2:46 PM the Administrator was interviewed and reported that she expected staff to keep all their hair covered when working in the kitchen.	{F 812}		

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 _____	R-C 04/17/2019

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 On 04/17/19, the Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted an onsite revisit. While some of the deficiencies cited were corrected on 04/01/19, the facility remains out of compliance. The mandatory termination date is 04/25/19.	F 000		

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

Electronically Signed | 04/29/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	R-C 04/17/2019

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 On 04/17/19, the Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted an onsite revisit. While some of the deficiencies cited were corrected on 04/01/19, the facility remains out of compliance. The mandatory termination date is 04/25/19.	F 000		

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

Electronically Signed | 04/29/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	R-C 04/17/2019

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 On 04/17/19, the Division of Health Service Regulation, Nursing Home Licensure and Certification Section conducted an onsite revisit. While some of the deficiencies cited were corrected on 04/01/19, the facility remains out of compliance. The mandatory termination date is 04/25/19.	F 000		

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

Electronically Signed | 04/29/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.