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 08/02/2018

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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide the call bell in Resident #112 ' s reach for one of three sampled residents with falls. The findings included: Resident # 112 was re-admitted to the facility on 5/31/18 with diagnosis of a fracture of the first lumbar vertebrae after a fall. Review of the Minimum Data Set (MDS) dated 7/4/18 revealed Resident #112 required extensive assistance with toileting, bed mobility and transfers, had no limitation in the functional ability of his extremities, and was frequently incontinent of bowel and bladder. The MDS indicated the resident had mild impairment with his short- term memory and no impairment with his long- term memory . Review of the care plan dated 7/4/18 included a problem of being at risk for falls due to lack of safety awareness, recent fall with injury and unsteady gait. Two of the listed approaches included for staff to keep the call bell in his reach and encourage the resident to use the call bell when attempting to ambulate or self- transfer.	F 558	1. The call bell was put in reach of the resident #112 on 8/30/2018. 2. The CNE (Center Nurse Executive), ACNE (Assistant Center Nurse Executive) the UM (Unit Manager) completed and audit to ensure all call lights were in reach of the residents. If a resident wanted the call light in a specific area or had a behavior with a call light placement it will be put on the care plan and the kardex, (CNA care instructions). 3.All staff was in serviced by the CNE,ACNE and UM on checking for call light placement to be in reach of the resident when entering the resident room or placing the call where the resident wanted it. 4. CNE, ACNE,UM, Interdisciplinary Team Member and Weekend Manager will audit all residents rooms for call light placement 2 times a day for 6 days to include 1 weekend day for 4 weeks, once daily for 4 weeks then twice weekly for 4 weeks. Any issue from the audit will be corrected immediately and attached to the audit.	8/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/2018

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F 558	Continued From page 1 Observations on the following dates and times revealed: - 07/31/18 at 10:31 AM Resident #112 was in bed and did not have the call bell in reach. It was observed in the floor behind the nightstand. Resident interview at this observation revealed sometimes he had it (call bell) and sometimes not. Interview revealed he used the call bell when he needed assistance. - 07/31/18 at 2:00 PM the call bell for Resident #112 remained out of reach behind his bedside table and he was in his bed. -08/02/18 at 08:30 AM the call bell for Resident #112 remained out of reach behind his bedside table and he was in his bed. Interview on 08/02/18 01:25 PM with Nursing Assistant (NA) #1 revealed he was not aware the resident did not have his call light in reach. Upon entering the resident ' s room, NA #1 moved the call light cord from behind the bedside table to across the resident's bed. Interview with the Nurse #1 on 08/02/18 at 01:36 PM revealed she was not aware the resident did not have his call bell in reach. She explained the resident would "mess with it" at times.	F 558	All findings or trends discovered during the audits will be brought to the monthly QAPI committee for review at the monthly QAPI for three months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		8/24/18

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F 656	Continued From page 2 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to	F 656	1. The call bell was put in reach of the reach of the resident #112 on 8/30/2018 in	

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F 656	Continued From page 3 follow a care planned intervention for fall prevention by not keeping Resident #112 call bell in reach for one of three sampled residents with falls. The findings included: Resident # 112 was re-admitted to the facility on 5/31/18 with diagnosis of a fracture of the first lumbar vertebrae after a fall. Record review revealed the most recent fall occurred on 6/5/18 at 3:45 PM. The nurse ' s note indicated the resident attempted to get up out of the wheelchair and ambulate. He fell on the floor with a skin tear noted to right side of his face above the eye. Review of the Minimum Data Set (MDS) dated 7/4/18 revealed Resident #112 required extensive assistance with toileting, bed mobility and transfers. The MDS indicated the resident had mild impairment with his short- term memory and no impairment with his long- term memory. Review of the care plan dated 7/4/18 included a problem of being at risk for falls due to lack of safety awareness, recent fall with injury and unsteady gait. Two of the listed approaches included for staff to keep the call bell in his reach and encourage the resident to use the call bell when attempting to ambulate or self- transfer. Observations on the following dates and times revealed: - 07/31/18 at 10:31 AM Resident #112 did not have the call bell in reach. It was observed in the floor behind the nightstand. Resident interview at	F 656	accordance with his care panned intervention. 2. The CNE (Center Nurse Executive), ACNE (Assistant Center Nurse Executive) and UM (Unit Manager) completed an audit to ensure call lights were in reach of the residents, per their Care Planned Interventions. If a resident wanted the call light in a specific area or had a behavior with a call light placement it will be put on a care plan and the Kardex, (CNA Care Instructions). 3. All staff was in serviced by CNE, ACNE and UM on checking for call light placement to be in reach of the resident when entering the resident room or placing the call light where the resident wanted it. 4. CNE, ACNE, UM Interdisciplinary Team Member and weekend Manger will audit all the resident rooms for call light placement 2 times a day for 6 days to include 1 weekend day for 4 weeks, once daily for 4 weeks then twice weekly for 4 weeks. Any issues from the audit will be corrected immediately and attached to the audit. All findings or trends discovered during the audits will be brought to the monthly QAPI committee for review at the monthly QAPI for three months. Date of completion 8/23/2018	

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F 656	Continued From page 4 this observation revealed sometimes he had it (call bell) and sometimes not. Interview revealed he used the call bell when he needed assistance. - 07/31/18 at 2:00 PM the call bell for Resident #112 remained out of reach behind his bedside table and he was in his bed. -08/02/18 at 08:30 AM the call bell for Resident #112 remained out of reach behind his bedside table and he was in his bed. Interview on 08/02/18 01:25 PM with Nursing Assistant (NA) #1revealed he was not aware the resident did not have his call light in reach. Upon entering the resident ' s room, NA #1 moved the call light cord from behind the bedside table to across the resident's bed. Interview with the Nurse #1 on 08/02/18 at 01:36 PM revealed she was not aware the resident did not have his call bell in reach. She explained the resident would "mess with it" at times.	F 656		
F 812 SS=F	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	F 812		8/24/18

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F 812	Continued From page 5 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 and staff interviews, the facility failed to ensure the plate lid covers were stacked dry in 1 of 4 dining rooms; and to ensure food items stored in 3 of 4 nourishment refrigerators were labeled, dated and were only for use by the facility's residents. Findings included: During the food service observation in the first floor South Dining Room on 8/1/18 at 1:20 p.m., 18-plate lid covers were stacked wet on the steamtable line in preparation for use to cover plated meals transported to residents' rooms. On 8/1/18 at 12:06 p.m., the nourishment refrigerator in the Behavior Unit's dining room contained 4-uncooked shelled eggs in a carton dated "best by May 06" and a resealed jar of homemade peach preserves without a label of named resident or date. During an observation of the first floor South Nourishment Room on 8/2/18 at 4:15 p.m., the refrigerator contained an unlabeled insulated lunch bag. Staff Nurse #1 revealed the lunch bag belonged to her and she had temporarily placed the lunch bag in the residents' refrigerator while she giving report to the next shift's nurse on duty.	F 812	1. 1st Floor South Dining Room had 18 plate lid covers that were rewashed and stacked properly by the Food Service Director (FSD), on 8/1/2018. the Homestead Unit had 4 uncooked shelled eggs and homemade peach preserves in the refrigerator that had no resident name or date on them and were thrown away by the Homestead Director, on 8/1/2018. The 1st Floor South Nourishment room had an unlabeled lunch bag in it and the Staff Nurse removed it on 8/1/2018. The First Floor North Nourishment room had 3 containers of frozen liquid and 1-sealed plastic bowl of a food item were thrown away by the Registered Dietician (RD). 2. The Director of Dining Services(DDS and Executive Chef (EC) in serviced the dietary staff the week on 8/20/2018 on properly storing the plate lids to prevent wet nesting. Center Nurse Executive (CNE), Assistant Center Nurse Executive (CNE), Unit Manager (UM)will in service all staff on not putting personal food items in Resident Nourishment rooms. 3. DDS and EC will complete a kitchen audit on the proper drying of the plate lids to prevent wet nesting, 2 times per week	

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F 812	Continued From page 6 The observation of the first floor North Nourishment Room on 8/2/18 at 4:29 p.m., revealed 3-containers of frozen liquids and 1-sealed plastic bowl of a food item. There were no names or dates on any of these containers. During an interview on 8/2/18 at 4:45 p.m., the Food Service Director and the Registered Dietician indicated the nourishment refrigerators were for the residents' use, only. The resident's name and storage date were required on any personal food items stored in the refrigerators.	F 812	for 6 days to include 1 weekend day for 4 weeks, once daily for 4 weeks, then twice weekly for 4 weeks. Any issues will be corrected immediately and attached to the audit. The CNE, ACNE, UM, Weekend Manager on Duty will audit the residents nourishment refrigerator 2 times a day for 6 days to include 1 weekend day for 4 weeks, once daily for 4 weeks, then twice weekly for 4 weeks. Any issues will be corrected immediately and attached to the audit sheet. 4. All findings or trends discovered during the audits and monitoring will be brought for review at the monthly QAPI for three months.	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure 1 of 1 trash compactor properly contained disposable waste and offending odors; and ensure the surrounding area was free of open-ended containers filled with standing water. Findings included: During the initial tour of the facility on 7/30/18 at 4:00 p.m., the large trash compactor was located approximately 10-feet from the delivery dock at the back of the facility. On the ground, beneath	F 814	1. The ground beneath the trash compactor had a thick/green muddy substance which was power washed on 7/30/2018 and on 8/2/2018 by the Maintenance Director (MD).The uncovered hand truck that contained a shovel, a plastic bag dirt and several inches of water was cleaned by the Maintenance Director on 7/30/2018 and put in the storage shed. 2.The new compactor has been ordered and is scheduled to be at the facility for installment on 8/22/2018. The area under	8/24/18

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F 814	Continued From page 7 the trash compactor was a thick green/brown muddy substance which covered the length and width of the compactor. There was a strong, unpleasant odor emitting from the trash compactor. Also, a large uncovered, plastic utility hand truck was observed next to the trash compactor. The uncovered hand truck contained a shovel, a plastic bag, dirt and was filled with several inches of standing water (it had rained earlier that day). During an interview on 7/30/18 at 4:10 p.m., the Food Service Director and the Registered Dietician (RD) acknowledged the condition of the area surrounding the trash compactor was unacceptable. Both indicated they were unsure who was responsible for keeping the area free or debris and odors. The RD stated the hand truck belonged to the housekeeping department. During a second observation on 8/1/18 at 12:15 p.m., the thick green/brown muddy substance remained on the ground beneath and along the sides of the trash compactor and continued to emit a strong pungent odor. During an interview on 8/1/18 at 12:18 p.m., the Food Service Director indicated the dietary department was responsible for keeping the area surrounding the trash compactor clean and free from debris. On 8/2/18 at 9:12 a.m., the Maintenance Director revealed that when he began working at the facility in January 2018, he noticed some small leakage from the trash compactor. He stated that he notified the supplier of the trash compactor and the rubber seal on the door of the trash compactor was replaced; but the leakage	F 814	the compactor was power washed before the installation of the new trash compactor on 8/22/2018. 3. The Maintenance Director, the Maintenance Assistant and the Weekend Manager will audit the trash compactor for any leakage and report it to the company as it will be under warranty. The audit will also include monitoring for open ended containers and debris. The Audit will be completed 6 days a week to include one weekend day for 4 weeks, then 2 times a week 4 weeks and then 1 time a week for 4 weeks. 4. All findings or trends discovered during audits and monitoring to QAPI committee for review at the monthly QAPI for three months.	

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F 814	Continued From page 8 continued. In March 2018, the supplier sent a welder who patched a hole in the floor of the trash compactor, but the leakage continued. The Maintenance Director stated he emailed the facility's corporate office on 6/18/18 concerning the leakage and the unsuccessful attempts to repair the trash compactor. The Vice President of the supply company of the trash compactor came to the facility to observe the compactor in mid-July 2018 and promised to replace the trash compactor, but did not give a timeline. The Maintenance Director stated throughout this time period, he pressure washed the area surrounding the trash compactor several times, but because of the continued leakage the odor and debris continued to build-up. The Maintenance Director stated that on the morning of 8/2/18, the facility's corporate office received an email from the supplier of the trash compactor indicating a replacement compactor would be delivered to the facility in 14 days.	F 814		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 865		8/24/18

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F 865	Continued From page 9 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 6/22/17 complaint and recertification survey. This was for a recited deficiency in the areas of Food Procurement, Store/Prepare/Serve - Sanitation (F-812) and Develop/Implement Comprehensive Care Plan. The deficiencies were cited again on the current complaint and recertification survey on 8/2/2018. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings include: This tag is cross referenced to: F-812 - Food Procurement, Store/Prepare/Serve - Sanitation: Based on observations and staff interviews, the facility failed to ensure the plate lid covers were stacked dry in 1 of 4 dining rooms; and to ensure food items stored in 3 of 4 nourishment refrigerators were labeled, dated and were only for use by the facility's residents. During the complaint and recertification survey of 6/22/2017 the facility failed to maintain the temperature of foods stored in the walk-in cooler at / below 41 degrees F, failed to ensure dishes were sanitized and in good repair, failed to store	F 865	1. Facility failed to maintain a effective Quality Assurance and Performance Improvement Committee to ensure in compliance with Care Plan implementation (F656) and Kitchen Sanitation (F812), Which resulted in repeat deficient practice in these areas. 2. All resident have to be effected. F 656: The CNE (Center Nurse Executive), ACNE (Assistant Center Nurse Executive) and the UM (Unit Manager) completed and audit to ensure call lights were in reach of the residents, per their Care Planned interventions. If a resident wanted the call in a specific area or had a behavior with a call light placement it will be put on a care plan and the Kardex (C.N.A, Care Instructions), on 8/21/2018. F 812: The Director of Dining Services (DDS) and Executive Chef (EC) in serviced the dietary staff the week on 8/20/2018, on properly storing the plate lids to prevent wet nesting. Center Nurse Executive (CNE), Assistant Center Nurse Executive (ACNE) Unit Manager (UM) will in-service all staff on not putting personal food times in the Resident Nourishment rooms. 3. Education provided to the Center	

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F 865	Continued From page 10 foods in sealed, labeled and dated containers, failed to maintain clean kitchen equipment, failed to maintain the holding temperature of a cold salad at / below 41 degrees F and failed to reheat a casserole to a minimum of 165 degrees F. F-656 - Develop/Implement Comprehensive Care Plan: Based on observations, resident and staff interviews and record review the facility failed to follow a care planned intervention for fall prevention by not keeping Resident #112 call bell in reach for one of three sampled residents with falls. During the complaint and recertification survey of 6/22/2017 the facility failed to update the Care Plans for 1 of 1 sampled resident receiving dialysis who was self-administering medication, and was no longer on fluid restrictions (Resident #166); and for 1 of 1 sampled resident who was noncompliant with requesting assistance with ADL (activities of daily living) care (Resident #251). The facility also failed to invite a resident to participate in their care plan meetings for 1 of 2 (Resident # 205) who were reviewed for notification of participation in care plan meetings. An Interview was conducted with the facility's administrator on 8/2/18 at 5:39 PM. When asked who attends the meeting she stated that the Administrator and Director of Nursing led the meetings, the medical director attended, as well as all of the department heads. The meetings were held every month, and the committee reviewed medication errors, pressure ulcers, trends in infection control, falls, weight loss, and any other areas that needed attention. When asked what expectations the facility's	F 865	Interdisciplinary Team on Quality Assurance and Performance Improvement by the Quality Advisor through ALLIANT Quality (Quality Improvement Organization: QIO)on 8/24/2018 4. All findings or trends discovered during audits and monitoring to QAPI committee for review at the monthly QAPI for three months, with oversight by Quality Advisor and the Genesis Regional Nurse.	

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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 865	Continued From page 11 administration had for preventing reoccurring problems, specifically previous citations in the kitchen and care plans, she stated that the expectation was that staff follow all protocols and procedure guidelines provided to them by the facility.	F 865		