

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

PRINTED: 02/06/2019  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>345172</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/02/2019</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>MERIDIAN CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>707 NORTH ELM STREET<br/>HIGH POINT, NC 27262</b>                   |                      |   |
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| F 000  | INITIAL COMMENTS<br><br>A complaint investigation survey was conducted from 12/27/18 through 1/2/19. The surveyor entered and exited the facility on 12/27/18 to conduct the complaint investigation survey. After review of the information, the surveyor conducted additional multiple phone interviews with Guilford County 911 dispatch, the High Point Police Department, Guilford County EMS, and reviewed documents on 12/28/18, 12/29/18, and 12/31/18. The Administrator was made aware of Immediate Jeopardy via a phone call on 12/31/18. The surveyor returned to the facility on 1/2/19 and completed the survey on 1/2/19. Event ID #Y8QV11.<br><br>Immediate Jeopardy was identified at:<br><br>CFR 483.25 at tag F684 at a scope and severity (J)<br><br>The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/5/18 and was removed on 12/31/18. An extended survey was conducted. | F 000   |   |                      |   |
| F 684<br>SS=J  | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.  | F 684   |   | 1/2/19               |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/14/2019

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.

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| F 684  | <p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interviews, police officer interview, dispatch service interviews, record review, and 911 emergency audio recordings, the facility failed to respond to phone calls to the facility and on-site visit by a police officer on 12/5/18 which resulted in a delay in emergency services, including resuscitation, to one of three residents (Resident #1) reviewed for quality of care. Resident #1 was found to be unresponsive, in her room, with the call light on, on 12/5/18 at approximately 10:07 PM and Cardio Pulmonary Resuscitation efforts were unsuccessful and discontinued. The resident was pronounced dead 10:46 PM.</p> <p>Immediate jeopardy began on 12/5/18 when Resident #1 was found to be unresponsive, in her room, with the call light on. The immediate jeopardy continued after the resident was found unresponsive due to the failure of the facility to ensure appropriate and timely response to call lights, answering telephone calls, and responding to visitors at the front door when the magnetic lock was engaged. The immediate jeopardy was removed on 12/31/18 at 8:40 PM when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents. Findings included:</p> <p>Resident #1 was admitted to the facility on 8/15/18 and died on 12/5/18. Resident #1's</p> | F 684   | <p>1. Upon notification on 12/11/18 concerning the incident that occurred on 12/5/18 with Resident #1, the facility conducted an investigation.</p> <p>2. 100% audit completed by the Regional Nurse on 12/31/18, to ensure no other residents have been impacted by a delay in emergency personnel getting into the facility over the last 30 days. This audit included review of Nurses' Notes and documentation of transfers. No other issues were noted. Facility Executive Director developed an ad hoc Quality Assurance and Performance Improvement Plan on 12/28/18 to address the delay in Emergency Personnel getting into the center. Audits were completed over the weekend (total of 11) by the Interdisciplinary Team to ensure compliance. Audits reviewed time to answer doorbell/intercom and time to answer phone calls. All bells and phone calls answered in under 2 minutes. An audit was completed by Nursing Administration (Director of Nursing, Nurse Practice Educator, Registered Nurse Unit Managers) on 12/28/18 to ensure call lights were responded to promptly. No concerns noted. Facility has purchased and put into place additional cordless phones to allow for each hallway to have a cordless phone to facilitate prompt response time to incoming calls. Facility has added a doorbell to the front entrance in addition to the already existing</p> |                      |   |

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| F 684  | <p>Continued From page 2</p> <p>diagnoses included: Acute and chronic respiratory failure, stroke, hemiplegia (weakness of one side of the body), Diabetes, obstructive sleep apnea, asthma, pressure ulcers, lymphedema (swelling of the legs), and tracheostomy.</p> <p>Review of Resident #1's Minimum Data Set (MDS) revealed the most recent assessment was a comprehensive significant change assessment with an Assessment Reference Date (ARD) of 10/1/18. Review of the assessment revealed the resident was coded as having been cognitively intact. The resident was coded as having been able to make herself understood and was able to understand others. The resident was not coded as having had displayed behavioral symptoms during the observation period. The resident was coded as having required extensive or total assistance of two or more people for all activities of daily living (ADLs) except for eating, which the resident was coded as independent with supervision. The resident was not coded as having experienced shortness of breath during the assessment period. The resident was coded as having received suctioning and tracheostomy care during the assessment period.</p> <p>A review was completed of a Progress Note for Resident #1, documented by the resident's Nurse Practitioner (NP), which was dated 12/4/18. The NP documented the resident was a 51-year-old female who was seen for a routine visit for chronic disease management. The NP documented the resident had been seen for an exacerbation of lymphedema recently and the resident had reported tender areas on her legs. The resident was documented as having been noncompliant with the prescribed treatment for</p> | F 684   | <p>intercom system. The doorbell rings on both nurses' stations on the first floor. Additional key was made and added to the emergency box at the front entrance of the facility for the four emergency exits doors throughout the facility.</p> <p>3. All facility staff were re-educated on 12/31/18 by Nurse Practice Educator and Director of Nursing regarding the process for after hours entry to the facility and prompt response to call bells, as well answering phone calls and carrying the cordless phone on the medication cart during nurse medication pass.</p> <p>4. The Interdisciplinary Team (Administrator, Director of Nursing, Social Workers, Activities Director, Homestead Director, Nurse Practice Educator, Clinical Dietitian, Registered Nurse Unit Manager, Clinical Reimbursement Coordinators, Maintenance Director, Food Service Director, Business Office Manager, Admissions Director, Certified Nursing Assistant, Central Supply, Human Resources, Environmental Services Director, Health Information Manager) will conduct after hours audits of the front door as well as telephone and call bell response times and record the time it takes for staff to respond accordingly to doors, phone calls and call bells. These audits will be conducted daily (including weekends) x 3 weeks, then weekly x 4 weeks and then randomly thereafter, with the Executive Director responsible for monitoring outcomes and compliance. All findings or trends discovered during</p> |                      |   |

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| F 684  | <p>Continued From page 3</p> <p>the lymphedema of the legs, which was wrapping her legs with bandages and refusing the medication for edema (swelling) furosemide. The resident denied any shortness of breath or wheezing. The resident was documented as having had an intermittent cough at baseline secondary to having had a tracheostomy and the resident had complaints her secretions (bodily fluid related to the tracheostomy) had been thicker and she wanted something to help loosen the secretions. The NP ordered guaifenisin 600 milligrams (mg) every 12 hours for secretions.</p> <p>A review of Resident #1's December 2018, Medication Administration Record (MAR) revealed the resident had been administered 7.5 mg of Ipratropium-Albuterol Solution via the resident's tracheostomy at 5:45 PM on 12/5/18. The medication was to be administered to the resident on an as needed basis for shortness of breath, according to the MAR. The medication was documented as having been administered for 20 minutes, the resident's pulse was documented as having been 87, the resident's oxygen saturation was documented as having been 96%, and the medication was administered by Nurse #1.</p> <p>Auditory review of an audio recording from the City of Hight Point 911 dispatch service revealed a call made by Resident #1 dated 12/5/18 and timed 8:50 PM. Resident #1 could be heard stating she could not breathe. Despite multiple attempts by the call taker, the resident was unable to provide detail regarding her location. Review of the documentation associated with the call, City of High Pint Event Report dated 12/5/18 and timed 8:50 PM, revealed the call was made from a cellular phone. Further review of the</p> | F 684   | the audits will be brought to the Quality Assurance and Performance Improvement Committee meeting x 3 months.   |                      |   |

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| F 684  | <p>Continued From page 4</p> <p>associated documentation revealed the ping of the resident's phone was 0.97 miles from a cellular phone tower which would have put the caller near or at the facility. At 8:52 PM documentation attempts were made to call the facility but there was no answer and there was no emergency number on file.</p> <p>A phone interview was conducted with the City of High Point 911 dispatch supervisor on 12/28/18 at 7:09 PM. The supervisor stated he was at the 911 dispatch center the evening the call came in from Resident #1 and had assisted on the call. The supervisor stated he had tried to call the facility at least twice, at approximately 8:52 PM, after the 911 call had come in from Resident #1. The supervisor stated there was no answer at the facility during any of his attempts to call the facility. The supervisor stated the call taker who had initially taken the call, felt like the caller may have been at the facility, but the ping location from the cellular phone was not exact and they did not know if the caller may have been at the facility, at the Emergency Room (ER) across the street, out on the street, or any other location in the area. The supervisor stated he had tried other options, including municipality utility record review, to obtain alternate phone numbers for the facility, but he was unable to obtain any other phone numbers to reach the facility. The supervisor stated due to not knowing the exact location of the caller it was determined to dispatch a police officer to canvas the area.</p> <p>A phone interview was conducted on 12/29/18 at 3:51 PM with Police Officer #1 who had been dispatched to canvas the area and look for the 911 caller on 12/5/18 at approximately 9:07 PM. The police officer stated he had went to the</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 5</p> <p>facility at approximately 9:07 PM and knocked on the front door and rang the bell for the intercom system at the front door for several minutes. The officer stated there was no response from the staff inside of the building and no one came to the door of the facility to let the officer in. The officer stated due to lack of response at the door of the facility he left the facility and continued to canvas the area looking for the 911 caller. The officer stated he responded back to the 911 dispatch service at approximately 9:07 PM he was unable to locate the 911 caller, and no one had responded to the door at the facility.</p> <p>An interview was conducted with Nursing Assistant (NA) #1 on 12/27/18 at 4:27 PM. The NA stated Resident #1 had been on her assignment on 12/5/18. The NA stated the resident's family had visited the resident approximately between 5:00 PM and 7:00 PM on 12/5/18 and had brought the resident Chinese food for dinner. The NA stated she had last seen the resident some time in between 8:00 PM and 8:30 PM. The NA stated she had intentions of returning to the resident but there were several other residents requiring care and she was unable to return to the resident. The NA stated she was going to go to Resident #1's room and Resident #1's call light was on, but there was another resident in another room who was hollering very loudly, and the NA stated she provided care for the resident who was hollering. The NA was unable to recall the time she had seen the call light on for Resident #1 when she went to the resident's room who was hollering. The NA stated when was entering the room of the resident who was hollering she had seen the call light was on for Resident #1 but did not check on the resident. NA #1 stated she had not seen</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 6</p> <p>Resident #1's call light on earlier when she was providing care for the other residents. The NA stated the next time she had entered the room was when CPR efforts was being conducted on the resident.</p> <p>Review of the City of High Point Entity Report, dated 12/5/18 and timed 8:50 PM revealed the cellular phone number was registered to Resident #1 and her family, and the address listed was for Thomasville, NC. At approximately 9:12 PM an officer with the Thomasville Police Department was sent to the address listed for Resident #1.</p> <p>A phone interview was conducted with Resident #1's family on 12/27/18 at 6:05 PM. The phone interview revealed a police officer had come to his house after 9:00 PM and had informed him a 911 call had been made from a cellular phone registered to him and Resident #1. The family member further stated the police officer had informed him they were unable to locate Resident #1 and was unaware she was residing at the Meridian Center.</p> <p>A review was completed of the City of High Point Entity Report, dated 12/5/18 and timed 9:40 PM. The report documented Resident #1's family had called the City of High Point 911 dispatch service and informed them Resident #1 was a resident of Meridian Center, he gave the room number, the floor, and the access code to gain entry to the facility. In addition, the resident's family stated he had tried to call the resident's phone and the facility phone number and there was no answer for either phone number.</p> <p>A review was completed of the High Point Police Department Incident/Investigation Report dated</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 7</p> <p>12/5/18 and timed 9:40 PM. Police Officer #2 documented he went to Meridian Center to conduct a welfare check on Resident #1 at approximately 10:07 PM. The officer documented he went to the resident's room and Nurse #1 had asked if he needed assistance when she had seen the officer in the hall. The officer responded a female in room 248 had called in and said she could not breath. The nurse and the officer entered the room and discovered the resident laying on the bed, not breathing, and was unresponsive. The officer documented the resident was discovered to not have a pulse and the resident's legs and torso were still warm. The resident was lowered to the ground Cardio Pulmonary Resuscitation (CPR) was initiated. The officer documented the nursing staff and himself conducted CPR until Emergency Medical Services (EMS) arrived and took over resuscitative efforts. The officer documented after over 30 minutes of life saving efforts, the resident was confirmed as deceased. The officer further documented he called the number which had been the original number belonging to the original 911 call at approximately 8:50 PM and the phone on the resident's bedside table started to ring. The officer documented the phone at the bedside table was the phone the resident had used to originally call 911.</p> <p>Review of the High Point Police Incident/Investigation Report dated 12/5/18 and timed 9:40 PM the Reporting Officer's Narrative documented Officer #3 had interviewed NA #1. The officer documented NA #1 was the last person to have seen Resident #1 alive at approximately 8:00 PM. The NA informed the officer earlier in the day, the resident had complained of having had a hard time breathing,</p> | F 684   |   |                      |   |



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| F 684  | <p>Continued From page 8</p> <p>she had reported it to the nurse, and the nurse had administered a breathing treatment to the resident. The NA stated she had went back to visit the resident later and the resident was observed to have been doing breathing exercises and had reported to the NA she had not felt the breathing treatment was very effective. In addition, the officer interviewed Nurse #1 and the nurse had told the officer she had remembered Resident #1's call light having been on during her medication pass but had not known how long the call light was on and had not checked on the resident. Time of death for the resident was documented as 10:46 PM.</p> <p>A review was completed of the Guilford County EMS incident report pertaining to the EMS call for Resident #1 on 12/5/18. The review revealed Resident #1 was found to be not breathing and did not have a pulse at approximately 10:07 PM. The resident was lowered to the floor and CPR was initiated. EMS was documented to have arrived and at 10:15 PM the resident was documented as having been unresponsive, had a warm core, cool extremities, lips/face purple in color, skin was pale, pupils were dilated and non-responsive, lung sounds were absent, and CPR was in progress. At 10:16 PM CPR was taken over by the High Point Fire Department. The EMS responders contacted the High Point Regional Hospital Emergency Department and updated their physician on the resident's status at 10:46 PM and the physician advised to discontinue all lifesaving efforts. Resuscitation efforts were discontinued at 10:46 PM and the resident was found to not have a pulse or breathing. The narrative portion of the report documented Nurse #1 had seen the call light for Resident #1 was on while she was conducting her</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 9</p> <p>medication pass. The nurse was documented as stating she continued to conduct her medication pass and she did not know how long the resident's call light had been on.</p> <p>Review of the nurses' notes for Resident #1 revealed a nurses' note written by Nurse #1, dated 12/6/18, timed 3:21 PM, and was typed as a "Late Entry." The note described the events which took place the evening of 12/5/18. The note documented the nurse had administered a breathing treatment at 5:45 PM and the resident's oxygen saturation measured 96%, pulse was 87, and the resident's vital signs were stable after the breathing treatment. The nurse documented the resident had been observed to have been sleeping at 7:30 PM. It was then documented at 10:05 PM a High Point Police Department officer was observed in the hallway outside of Resident #1's room. The nurse documented the officer informed the nurse there was a concern regarding the resident's condition and when the two of them entered the resident's room the resident was discovered unresponsive and cool to the touch. The nurse documented the officer radioed for Emergency Medical Services (EMS), "Code Blue" (facility term for an emergency situation) was called over the intercom of the facility, and Cardio Pulmonary Resuscitation (CPR) was initiated at 10:10 PM. It was documented EMS arrived at 10:20 PM and took control of the resuscitative efforts. The nurse documented EMS made multiple attempts to access the resident's intravenous (IV) system to administer medications but was unsuccessful. The nurse documented CPR efforts were continued by EMS until 10:46 PM when the doctor communicating with the EMS personnel from the Emergency Room (ER) communicated</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 10</p> <p>to the EMS personnel to stop resuscitative efforts based on feedback regarding the resident's condition and the time of death was called at 10:46 PM.</p> <p>An interview was conducted with Nurse #1 on 12/27/18 at 3:49 PM. The nurse stated Resident #1 had been on her assignment on 12/5/18. The nurse stated she had given the resident a breathing treatment at approximately 5:45 PM because the resident had had some complaints of shortness of breath. The nurse stated at the end of the breathing treatment the resident's vital signs were stable. The nurse stated the resident had a lot of anxiety and some shortness of breath which was normal for the resident. The nurse stated she had again checked on the resident at 7:30 PM and the resident was resting in bed with her eyes closed. The nurse stated she started her medication pass at about 8:00 PM. The nurse stated she did not recall if Resident #1's call light was on while she was conducting her medication pass. The nurse also stated she did not remember the phone ringing repeatedly or for an exceptionally long time that evening. The nurse stated at approximately 10:00 PM she had come out of a resident's room and she had seen a police officer standing outside the door of Resident #1's room. The nurse stated the officer explained the reason for her being at the facility and the two of them proceeded to enter Resident #1's room. The nurse stated she believed the resident's call light was on at the time she observed the officer outside of the resident's room. The nurse stated when they entered the resident's room the resident was discovered to be unresponsive. It was determined Resident #1 was a full code and with the assistance of the responding police officer and other facility staff</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 11</p> <p>the resident was lowered to the floor and CPR efforts were initiated.</p> <p>A second interview was conducted with Nurse #1 on 12/27/18 at 6:48 PM and Resident #1 body was warm to the touch when she had initially discovered the resident to have been unresponsive on 12/5/18.</p> <p>A third interview was conducted with Nurse #1 via phone on 12/31/18 at 10:01 AM. The nurse stated she did not know if Resident #1's call light was on the whole time (during her med pass) or not, on 12/5/18 from approximately 8:00 PM to the point she had seen the officer outside of the resident's room. The nurse stated she did remember the call light having been on during her med pass, but it could have been turned on, turned off, and then turned back on. The nurse stated the only time she had remembered the call light flashing was when the bed had been moved to transfer the resident out of the bed onto the floor due to the resident having had been on air mattress. The nurse stated the call light has not been pulled out of the wall prior to her and the officer entering the room and discovering the resident to have been unresponsive. The nurse stated she did not remember the time of day when the call light may have been on. The nurse stated she was in and out of other resident rooms conducting her medication pass.</p> <p>Review of the Certificate of Death for Resident #1 revealed the documented immediate cause of death was listed as Cardiopulmonary Arrest.</p> <p>An interview conducted with Nurse #2 on 12/27/18 at 1:58 PM revealed Resident #1 was alert and oriented, able to communicate needs,</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 12 and was able to use the call light.</p> <p>An interview was conducted with Nursing Assistant (NA) #2 on 12/27/18 at 2:09 PM. The NA stated the resident could feed herself, use the phone, use the call light, use her arm, and use the remote control for the television. The NA stated the resident used the call light to let the nursing staff know she needed care. The NA further stated the resident was able to take care of her own tracheostomy care.</p> <p>An observation and interview were conducted with the facility receptionist on 12/27/18 at 6:39 PM. The receptionist stated the front door was locked with a magnetic lock which engaged automatically at either 4:00 PM or 5:00 PM depending on daylight savings time. The receptionist stated there was a code which could be punched into a keypad and there was a keypad located on the inside of building next to the door and on the outside of the building located next to the door. The receptionist stated she would get up and let people in the door if they did not know the code and the door was locked. The receptionist stated she usually left at 5:00 PM and after she left there was an intercom system which rang at the nurses' station and then whoever was at the nurses' station could come and let the individual in.</p> <p>An observation conducted at the front door on 12/27/18 at 6:43 PM revealed two sets of double doors to enter the facility. One set of double doors were on the outside which had no magnetic lock, a small breezeway, and a second set of double doors between the breezeway and the facility, which were locked with a separate magnetic lock on each door. There was an</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 13</p> <p>observed touch pad to disengage the magnetic lock system with numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, *, 0, and # inside the breezeway and inside of the facility. The intercom system observed during the observation was not the same intercom system present when the officer attempted to gain entry the evening of 12/5/18.</p> <p>An interview was conducted with the Director of Nursing (DON) on 12/27/18 at 7:25 PM. The DON stated the current intercom system was installed 2-3 weeks ago, after 12/5/18. The DON stated prior to the current intercom system, there was a button which could be pressed in the breezeway and it would to one South nurses' station. The DON stated the front door was locked in the evenings because of the facility's urban location and proximity to the Emergency Room, which was right across the street. The DON stated they had tried to keep someone at the nurses' station to answer the phone or intercom from the front door, but it was not always possible.</p> <p>An interview was conducted with the Administrator on 12/27/18 at 8:26 PM. The Administrator stated she had interviewed NA #1 and the NA had told her she was on her way to Resident #1's room the evening of 12/5/18 and was aware Resident #1's call light was on, but there was another resident in another room who was screaming and the NA chose to address the resident who was screaming instead of answering the call light. The Administrator stated she had interviewed Nurse #1 and the nurse stated she had seen the call light was on for Resident #1 but had seen the NA go down the hall and she had thought the NA had answered the call light for Resident #1. The Administrator stated she had</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 14</p> <p>determined through her interviews she had determined the resident's call light was on when the police arrived inside the facility and the police officer and Nurse #1 discovered Resident #1 to be unresponsive. The Administrator stated she had never received any concerns regarding a problem for anyone getting into the facility. The Administrator stated she had not received concerns from the police department or EMS regarding them not being able to get into the building at night. The Administrator further stated the front door to the facility was locked in the evening for security reasons, the facility was in the inner city, and the hospital ER is right across the street. The Administrator stated if a police officer came to the facility and could not get into the facility there were several options for the police officer to gain entry to the facility. Some of the options the Administrator explained were the police officer could call the facility, knock on the door, or call the police department because the police department had the Administrator's cellular phone number. The Administrator stated each phone at all 5 nurses' stations rang when someone would call the facility.</p> <p>A second interview was conducted over the phone with the DON on 12/28/18 at 10:35 AM. The DON stated there was a brown box located outside of the facility which the Fire Department had access to. Inside of the brown box was information (a code to disengage the magnetic lock) and keys to access the facility. The DON stated during emergency situations in the past EMS, the police department, and the fire department would all be called to respond to the facility. The DON stated if the fire department had been called to respond to the emergency situation or any other emergency situation they</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 15<br/>would have been able to gain entry to the facility.</p> <p>The Administrator was informed of Immediate Jeopardy on 12/31/18 at 11:13 AM.</p> <p>On 12/31/18 at 8:40 PM, the facility provided the following Credible Allegation of Immediate Jeopardy Removal:</p> <p><b>ALLEGATION OF IMMEDIATE JEOPARDY REMOVAL</b><br/>Facility respectfully submits the below allegation of compliance for F684 Quality of Care, Professional Standards of Practice: Identify and provide care and services to include Emergency Services.</p> <p>1. Police Officer came to center and knocked on door at front entrance, Facility staff did not hear or respond to this. He then rang bell and called center, without a response from the center. Police Officer then left the center. Facility staff failed to answer the front door, answer outside call and call bell, in response to resident # 1 Emergency needs. Facility staff were responding to call bells on the unit as they were able. Facility staff did not hear a phone call come in during this time frame. Resident # 1 with diagnoses of Chronic Respiratory Failure, Acute Kidney Failure, hemiplegia, morbid obesity with alveolar hypoventilation, obstructive sleep apnea, Diabetes, tracheostomy, hypothyroidism and asthma, who was a full code, was found unresponsive when police officer and facility charge nurse entered room together at approximately 10:05 p.m. on 12/05/18. CPR was initiated by facility staff and police officer. EMS arrived on site at approximately 10:15 and the</p> | F 684   |   |                      |   |



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| F 684  | <p>Continued From page 16</p> <p>EMS team assumed responsibility for continuation of CPR and AED, until hospital physician called the code at 10:46 pm. Body was released to funeral home. Facility was later informed on 12/11/18, by an external source that a police man had arrived at the center earlier, and was unable to enter the center or get the center on the telephone. Upon receipt of this external report, the facility Administrator initiated an immediate investigation on 12/11/18 and developed an action plan which was completed on 12/28/18.</p> <p>Staff that were on during the 3-11 shift on 12/05/18 have been questioned through the investigation process and re-educated regarding the process for afterhours entry to facility and prompt response to call bells, as well as answering call bells.</p> <p>2. Education initiated by Nurse Practice Educator and Director of Nursing on 12/27/18 for all staff in all departments regarding process for emergency personnel getting in the center after hours, this includes: that staff will answer the intercom system and/or doorbell promptly which ring on both nurses stations. This system is audible throughout the units. Education also included answering of call bells and incoming calls timely. As of 12/31/18 at 12:34 p.m. over 99 % of the staff have completed the education via phone or in person by the Nurse Practice Educator, Center Nurse Executive and Center Executive. The remaining staff shall not work until they have completed this education, this will be ensured by the Executive Director. The Executive Director or Center Nurse Executive will personally be at the facility on the next scheduled shift for the remaining staff members to ensure that they receive the education prior to starting</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 17</p> <p>their shift, if they have not returned phone call for education prior to that time.</p> <p>3. 100% audit completed by the Regional Nurse, to ensure no other residents have been impacted by a delay in emergency personnel getting into the facility over the last 30 days. This audit included review of Nurses Notes, and documentation of transfers. No other issues were noted. Audit was completed on 12/31/18. Facility Executive Director developed an ADHOC QAPI Plan on 12/28/18 to address the delay in Emergency Personnel getting into center. Audits were completed over the weekend (total of 11) by the Interdisciplinary Team to ensure compliance. Audits reviewed time to answer doorbell/intercom and time to answer phone calls. All bells and phone calls answered in under 2 minutes. An Audit was completed by Nursing Administration on 12/28/18 to ensure call lights responded to promptly. No concerns noted.</p> <p>Facility has purchased and put into place additional cordless phones to allow for each hallway to have a cordless phone to facilitate prompt response time to incoming calls. These were put in use on 12/28/18 with phone lines for these additional lines have been implemented.</p> <p>Facility has added a door bell to the front entrance in addition to the already existing intercom system, on 12/14/18. Both the door bell and intercom system have been set up to ring at both nurses stations, where in the past the intercom system only rang on one unit. Door Bell system is audible throughout the units.</p> <p>Executive Director requested that the Fire Marshall visit the center on 12/28/18 to ensure</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 18</p> <p>that center had all necessary information to enter the facility in the emergency box in the front entry to ensure emergency personnel have access. Fire Marshall had no concerns upon his exit.</p> <p>The above will be monitored through the daily audits described in number 4 below. There is no ability to record missed calls or call bell response time at this center.</p> <p>4. The Interdisciplinary Team will conduct after hour's audits of front door and telephone and call bell response times and record the time it takes for staff to respond accordingly to doors, phone calls and call bells. The audits will be conducted by team members making phone calls, ringing bell at front entrance and testing call bell response times. These audits will be conducted daily (including weekends) X 3 weeks, then weekly x 4 weeks, and then randomly thereafter, with the Executive Director responsible for monitoring outcomes and compliance. The Center Nurse Executive or Assistant Director of Nursing will review all EMS transfers for the next 30 days to ensure prompt/timely response to resident change of condition and EMS arrival and entry to center.</p> <p>It is the policy of the Fire Department not to give a key to the lock box at the center entry. (the lock box at the facility entry is provided by the local fire department so that they can get in in the event of a fire emergency). Facility has contacted the Police Chief regarding this policy and have provided the code to the front door. This was completed on 12/31/18 at 3:35 p.m.</p> <p>The Quality Assurance and Performance Improvement Committee met on 12/28/18 to</p> | F 684   |   |                      |   |

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| F 684  | <p>Continued From page 19</p> <p>discuss the findings identified by the external report and by the surveyor and the action plan. The Quality Assurance and Performance Improvement Committee will review and discuss monthly.</p> <p>5. Allegation of compliance 12/31/18 at 8:40 pm. Center Executive Director is responsible for the implementation of this plan.</p> <p>The credible allegation was verified on 1/2/18 at 3:00 PM as evidenced by staff interviews and an observation of call lights being answered timely, and observation with demonstration of the new intercom system from the front door to the two first floor nurses' stations. The intercom system was demonstrated to facilitate communication between a visitor in the breezeway and either of the first-floor nurses' stations. Staff education was initiated on 12/27/18 regarding the process for emergency personnel getting in the center after hours, which included: that staff will answer the intercom system and/or doorbell promptly which ring on both nurses' stations. This system is audible throughout the first-floor units. Education also included answering of call bells and incoming calls timely. All staff interviewed (nursing staff and administrative staff) stated they were aware of the importance of responding to the intercom system at the two first floor nurses' stations, or to an individual who was knocking at the front door when the magnetic lock was engaged. In addition, the interviewed staff stated the importance of answering incoming phone call and answering call lights in a timely manner. Verification of education for staff regarding the education regarding answering call lights, responding to the intercom or visitors knocking at the front door, and answering the telephone was</p> | F 684   |   |                      |   |

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FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>345172</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>01/02/2019</b> |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MERIDIAN CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>707 NORTH ELM STREET</b><br><b>HIGH POINT, NC 27262</b>             |                      |   |
| (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 684  | Continued From page 20 completed on 1/2/18.  | F 684   |   |                      |   |