STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345172	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Center	**707 North Elm Street , High Point, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/11/25 through 08/15/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D30EB-H1.	E0000		09/08/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/11/25 through 08/15/25. The survey team returned to the facility on 08/20/25 to validate the credible allegation of IJ removal. Therefore, the exit date was changed to 08/20/25. The following intakes were investigated. 753442, 754894, 754907, 754899, 754909, 754913, 754915, 754928, 754943, 754949, 754950, 754973, 754986, 754990, 755001, 754983, and 2576726. 4 of the 36 allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity J CFR 483.80 at tag F880 at a scope and severity J The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/21/25 and was removed on 02/26/25 for F689 and started on 08/14/25 and removed on 08/20/25 for F880. An extended survey was conducted.	F0000		09/08/2025
F0561 SS = E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F0561	Resident #22 and Resident #8 dialysis schedules will be reviewed and transportation schedules will be implemented by utilizing outsourced transportation services to and from dialysis appointments by 09/12/2025. A quality review will be completed by the Social Services Director of current interviewable residents receiving dialysis services to ensure transportation services are arranged in order for residents to be picked up from dialysis timely by 09/12/2025.	09/18/2025

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 reverse for further 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.

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

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F0561 SS = E	Continued from page 1 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, residents, and the dialysis center Nurse Manager, the facility failed to provide transportation back to the facility after hemodialysis was completed which caused the residents to wait up to 2 hours to return. The residents requested they be transported back to the facility and not wait, which made one resident late for dinner. This deficient practice affected 2 of 3 residents reviewed for dialysis (Residents #22 and #8). The findings included: 1a. Resident #22 was admitted to the facility on 3/22/25 with the diagnosis of end stage renal disease (ESRD) dependent on hemodialysis. Resident #22's quarterly Minimum Data Set dated 6/29/25 documented the resident had intact cognition. The care plan for Resident #22 dated 7/14/25 documented he had impaired renal function and was at risk for complications of hemodialysis. The interventions were hemodialysis on Monday, Wednesday and Friday and to watch for complications.	F0561	Continued from page 1 An ADHOC Quality Assurance Performance Improvement meeting will be held by 09/10/2025 to formulate and approve a plan of correction for the deficient practice. The Administrator will educate all facility van drivers and the transportation scheduler on residents being picked up from dialysis timely by 09/12/2025. The Administrator or Designee will conduct quality monitoring of all dialysis transportation appointments to ensure residents are picked up timely 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 weeks. The Administrator will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated.	

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F0561 SS = E	Continued from page 2 On 08/12/25 at 9:41 am Resident #22 was interviewed. The resident stated he attends dialysis Monday, Wednesday, and Friday and was usually done at 3:30 pm. Resident #22 indicated at present there was only one van driver to pick up and when she was busy, he could wait up to 2 hours to be picked up to return to the facility and the dialysis center was across the street. Resident #22 stated there used to be two drivers, one for each of the two vans and “When there were two drivers, I never had to wait 2 hours.” The resident stated he has complained to the van driver that he does not want to wait to return to the facility and this problem had been going on for months. The resident commented he was late for dinner, and his tray was sitting on his table and was cold every time he returned late at 6:00 pm. 1b. Resident #8 was admitted to the facility on 7/5/23 with the diagnoses of ESRD and diabetes. The annual Minimum Data Set dated 6/6/25 documented Resident #8 had an intact cognition. Resident #8’s care plan dated 6/18/25 documented she had impaired renal function and was at risk for complication of hemodialysis. The interventions were hemodialysis Monday, Wednesday, and Friday and to watch for complications. On 8/15/25 at 10:25 am Resident #8 was interviewed. Resident #8 stated that her dialysis treatment was completed at about 3:00 pm and she was picked up at 5:00 pm or later and it was a 10-minute return ride back to the facility. The resident stated she had not missed dinner, but it was sitting in her room upon return. The resident commented she has had to wait up to 2 hours for pick up and wants to return after dialysis was completed. Resident #8 indicated the facility provided lunch in an insulated bag. On 8/12/25 at 2:40 pm the Administrator stated that one of the transportation staff that drove the van was absent on extended leave, since about March 2025 and there are two vans but one driver at present.	F0561		

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F0561 SS = E	Continued from page 3 On 08/14/25 at 2:32 pm an interview was conducted with the resident appointment Scheduler. The scheduler stated there was one transportation van driver, and the second driver was absent. The facility was using an outside vendor when there were multiple outside appointments to address. The Scheduler indicated if the facility driver was running late to pick up a resident, the maintenance staff were back up or an outside transport service would be called which would take about 30 to 40 minutes to reach the residents. The Scheduler stated there had not been a report that a resident was waiting for 2 hours to be picked up. On 08/15/25 at 10:17 am an interview was conducted with the dialysis center Nurse Manager. She stated there were three residents from the facility that attended hemodialysis on Monday, Wednesday, and Friday in the afternoon and sometimes the return transportation arrived as late as 6:00 pm. The residents were done with dialysis at approximately 3:30 to 4:00 pm. The Nurse Manager indicated the residents remained in the center with nursing supervision until the van arrived. She stated 6:00 pm was past the dialysis center closure time and the nursing staff had to remain with the residents until they were picked up by the facility transport and the center closed at 4:30 pm when residents were not waiting to be picked up. The Nurse Manager explained the facility was called when the residents were done and ready for pick up. The receptionist and transport person were notified by telephone that the residents were ready for pick up after each dialysis session. The interview further revealed the residents missed dinner, had a diagnosis of diabetes, and this was a concern. The problem of late pickups has gotten more frequent over the past couple of weeks. On 08/15/25 at 10:29 am an interview was conducted with the facility Receptionist. She stated the dialysis center sometimes called the main phone (receptionist) number for the van driver to pick up the residents from the dialysis center and the calls came in close to 4:00 pm. The Receptionist indicated sometimes there was a second request on the same day for pick up when the van driver had not arrived yet. She was not sure how long it was after she received the second call. The Receptionist noted the van driver had a mobile phone and sometimes the dialysis center would call the van driver directly. She was unaware how long the residents were waiting for pick up when there was a delay.	F0561		

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F0561 SS = E	Continued from page 4 On 8/15/25 at 11:17 am the facility transportation Van Driver was interviewed. She stated one of the van drivers had been absent for months and she was the only driver at this time. The Van Driver indicated she had to pick up residents in Greensboro and local (High Point) from dialysis on Monday, Wednesday and Friday. She stated that some days she was late picking up the local dialysis center residents. The Van Driver explained she picked up the Greensboro dialysis center residents from dialysis first. When she was late, the facility Scheduler was notified. The Van Driver stated sometimes an outside vendor was asked to pick up the residents from the local dialysis but there was not always availability and some days the vendor had no availability. She further stated there had been days that she was 2 hours late picking up the local dialysis residents including Residents #22 and Resident #8 when they had completed their dialysis. The Van Driver revealed Resident #8 stated he had not wanted to wait, and the concern was reported to the Scheduler. She further commented that maintenance staff was rarely available to drive the van for resident transportation, and it took 10 minutes to pick up and return the residents from the local dialysis center. On 8/15/25 at 1:05 pm the Maintenance Director was interviewed. He stated one of the van drivers had been out and there was one van driver at present. The Maintenance Director indicated there was limited use of the maintenance staff for driving. Previously, the van driver would review the schedule for resident appointments the day before and request the vendor assist with pick up from dialysis. When the request was made the day before this would ensure the vendor could provide services. The Maintenance Director noted the vendor would mostly likely not be able to provide services within an hour because this was too short notice; they would be booked. On 08/15/25 at 1:53 an interview was conducted with the Administrator. The Administrator stated the van delay to pick up residents from dialysis had been better and was now late again up to two hours occasionally. The Administrator stated he was not aware two residents transported for dialysis had concerns and would prefer to be picked up after treatment was finished and not wait two hours. The Administrator indicated there were two resident transportation vans but only one driver at present.	F0561		
F0636 SS = D	Comprehensive Assessments & Timing	F0636	Resident #190 Minimum Data Set (MDS) admission assessment was completed by the MDS Coordinator on	09/18/2025

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F0636 SS = D	Continued from page 5 CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	F0636	Continued from page 5 08/17/2025. The Director of Nursing will conduct a quality review of all admissions within the previous 30 days to ensure MDS admission assessments were completed timely by 09/16/2025. Any concerns will be addressed as identified. An ADHOC Quality Assurance Performance Improvement meeting will be held by 09/10/2025 to formulate and approve a plan of correction for the deficient practice. The Regional MDS Nurse Consultant will educate the MDS Coordinator on completing an admission Minimum Data Set (MDS) assessment timely by 09/12/2025. Newly hired MDS Nurses will be educated upon hire in orientation. The Director of Nursing or Designee will conduct quality reviews of MDS admission assessments to ensure residents MDS admission assessments are completed timely on 5 random residents 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 weeks. The MDS Coordinator will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated.	

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F0636 SS = D	Continued from page 6 (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to complete an admission Minimum Data Set (MDS) assessment in the 14-day timeframe for 1 of 33 residents (Resident #190) reviewed for MDS assessments. Findings included: Resident #190 was admitted to the facility on 07/30/25 with diagnoses that included chronic kidney disease, type 2 diabetes, and hypertension. During the record review for Resident #190 it was noted the MDS admission assessment had an assessment reference date of 08/06/25, however it was not complete. An interview was conducted on 08/15/25 at 10:13 am with the MDS Coordinator and she verified Resident #190’s MDS admission assessment was not completed and should have been completed by 08/12/25. She indicated she was “running behind” and would get it done. On 08/15/25 at 12:22 pm an interview was conducted with the Administrator, and he indicated that his expectation was for all MDS assessments to be completed on time.	F0636		

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F0636 SS=D F0640 SS = B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review.	F0636 F0640	Resident #75 Minimum Data Set (MDS) quarterly assessment was transmitted on 08/13/2025 by the MDS Coordinator. The MDS Coordinator will conduct a quality review of all current residents' most recent quarterly MDS assessment to ensure residents quarterly MDS transmitted timely by 09/16/2025. Any concerns will be addressed as identified. An ADHOC Quality Assurance Performance Improvement meeting will be held by 09/10/2025 to formulate and approve a plan of correction for the deficient practice. The Regional MDS Nurse Consultant will educate the MDS Coordinator on submitting quarterly Minimum Data Set (MDS) within the required timeframe by 09/12/2025. Newly hired MDS Nurses will be educated upon hire in orientation. The Director of Nursing or Designee will conduct quality reviews of MDS assessments to ensure MDS assessments are transmitted timely on 5 random residents 3 times per week for 4 weeks, then 2 times per week for 4 weeks then 1 time per week for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated.	09/18/2025

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F0640 SS = B	Continued from page 8 (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews and record review, the facility failed to submit a quarterly Minimum Data Set (MDS) assessment within the required time limit for 1 of 4 residents (Resident #75) reviewed for the Resident Assessment facility task. The findings included: Resident #75 was admitted to the facility on 1/5/24. The resident's electronic medical record (EMR) revealed her history of Minimum Data Set (MDS) assessments included the following, in part: --A quarterly MDS dated 3/11/25 was reported as electronically transmitted to the Centers for Medicare and Medicaid Services (CMS) database and "accepted;" --However, a quarterly MDS dated 6/11/25 was reported only as "completed" in Resident #75's EMR. An interview was conducted on 8/13/25 at 11:02 AM with the facility's MDS Coordinator. During the interview, the nurse reviewed Resident #75's history of MDS submissions. Upon this review, the MDS Coordinator noted the 6/11/25 quarterly MDS completed for Resident #75 should have been sent to CMS but was not. She stated, "That's an error." The MDS Coordinator reported that although the MDS was completed timely, it was not submitted timely. A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility's Administrator and Director of Nursing (DON). During the interview the Administrator reported he would expect MDS assessments to be transmitted timely.	F0640		
F0641 SS = B	Accuracy of Assessments	F0641	Resident #4's admission Minimum Data Set (MDS) assessment was modified and updated to accurately	09/18/2025

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F0641 SS = B	Continued from page 9 CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect whether anticonvulsant and anticoagulant medications were administered for 1 of 36 residents (Resident #4) whose MDS assessment was reviewed. The findings included: Resident #4 was admitted to the facility on 6/4/25. The resident's cumulative diagnoses included diabetes and unspecified convulsions (seizure disorder).	F0641	Continued from page 9 reflect anticonvulsant medication administered on 08/13/2025. The MDS Coordinator will conduct a quality review on all current resident's most recent MDS's in the areas of anticonvulsants and anticoagulants to validate the most recent MDS assessment has been coded to accurately reflect the status of the residents by 09/16/2025. Any concerns will be addressed as identified. An ADHOC Quality Assurance Performance Improvement meeting will be held by 09/10/2025 to formulate and approve a plan of correction for the deficient practice. The Regional MDS Nurse Consultant will educate the MDS Coordinator on the importance of accurate coding on the MDS assessment specifically related to anticonvulsant and anticoagulant medications by 09/12/2025. Newly hired MDS Nurses will be educated upon hire in orientation. The Director of Nursing or Designee will conduct quality reviews of MDS assessments to ensure MDS assessments are coded accurately in the areas related to anticonvulsant and anticoagulants on 5 random residents 3 times per week for 4 weeks, then 2 times per week for 4 weeks then 1 time per week for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated.	

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F0641 SS = B	Continued from page 10 The resident's electronic medical record (EMR) included her Physician's Orders. These orders included, in part: --25 milligrams (mg) lamotrigine (an anticonvulsant medication) given as one tablet by mouth in the evening (Initiated 6/4/25). --75 mg pregabalin (an anticonvulsant medication) to be given as one capsule by mouth two times a day (Initiated 6/4/25). Further review of Resident #4's Physician's Orders and Medication Administration Record (MAR) did not reveal the resident received an anticoagulant at any time during the month of June 2025. The resident's admission Minimum Data Set (MDS) was dated 6/10/25. The medication section of this MDS assessment did not indicate Resident #4 received an anticonvulsant medication. Additionally, the assessment reported that she received an anticoagulant medication during the 7-day look back period. An interview was conducted on 8/13/25 at 11:06 AM with the facility's MDS Coordinator related to Resident #4's admission MDS. At that time, the MDS Coordinator reviewed the resident's admission MDS assessment and electronic medical record (EMR). When asked, the MDS Coordinator confirmed the resident did receive anticonvulsant medications but no anticoagulant medication during the 7-day look back period. The MDS Coordinator stated the MDS was inaccurately coded. A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility's Administrator and Director of Nursing (DON). During the interview the Administrator reported he would expect the MDS assessments to be coded accurately.	F0641		
F0646 SS = E	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews and record review, the	F0646	Residents #39 and #11 Pre-Admission Screening and Resident Reviews (PASRR) were submitted by 08/29/2025 by the Social Worker. Resident #179 no longer resides at the facility. A quality review will be conducted by the Social Services Director on all current residents who had a change in condition indicating significant physical or mental status change within the previous 30 days by 09/16/2025. Any concerns will be addressed as identified.	09/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345172	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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F0646 SS = E	Continued from page 11 facility failed to notify the North Carolina Medicaid Uniform Screening Tool (NC MUST), that is the State Mental Health or Intellectual Disability Authority, when a significant change in condition was identified for a resident with a mental disorder or intellectual disability (Resident #39) and failed to request a Preadmission Screening and Resident Review (PASRR) re-evaluation for PASRR Level II residents identified to have a significant change in his or her physical or mental status (Resident #11 and Resident # 179). This deficient practice affected 3 of 3 residents reviewed who had a significant change in condition. The findings included: 1.Resident #39 was admitted to the facility on 6/25/24. His cumulative diagnoses included a diagnosis of schizoaffective disorder. The resident's electronic medical record (EMR) included information from the North Carolina Medicaid Uniform Screening Tool (NC MUST). This record revealed Resident #39 was evaluated and found to have a PASRR Level I determination with a start date of 6/23/24. The PASRR Level I evaluation assessed the resident for the appropriateness of nursing facility placement and no further PASRR screening was required unless a significant change occurred with the individual's status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. The Level II designation specified there was no end date and no limitation unless the resident had a change in condition. Resident #39's electronic medical record revealed a change of condition progress note dated 1/26/25 which indicated Resident #39 had a change in behavioral symptoms related to agitation and psychosis. The progress note also indicated that the resident was ordered .5 milligrams of Risperdal, an antipsychotic medication, two times a day for agitation. Physician order dated 1/26/25 revealed a new order for Risperdal .5 milligrams to be administered two times a day for agitation. A psychiatric follow up evaluation note dated 1/27/25 indicated that the psychiatric provider was informed by nursing staff that Resident #39 exhibited manic-like behavior with agitation, paranoia, packing and change in sleep pattern. The provider further indicated that a new order of Xanax .5 milligrams every day was ordered for agitation.	F0646	Continued from page 11 An ADHOC Quality Assurance Performance Improvement meeting will be held by 09/10/2025 to formulate and approve a plan of correction for the deficient practice. The Administrator will educate the Social Services Director and the Social Worker on the facility's PASRR policy to include initiating a PASRR level 2 screening for residents with PASRR level 1 and re-evaluating PASRR level 2 screenings for residents with PASRR level 2 when a resident has a significant change in condition by 09/12/2025. The Administrator will conduct quality reviews of resident significant changes in condition to ensure PASRR rescreening or reevaluation are submitted on 5 random residents 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 weeks. The Administrator will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated.	

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F0646 SS = E	Continued from page 12 Physician order dated 1/27/25 revealed a new order for .5 milligrams of Xanax every day for agitation. An interview was conducted on 8/13/25 at 1:40 PM with the Social Services Director and Social Worker. They indicated that they did not realize Resident #39 had a significant change in condition related to his behaviors and therefore did not initiate a Level II screening. The Social Workers also indicated that a Level II PASRR screening should have been initiated for Resident #39 due to the change in behavior and treatment. A telephone interview was conducted with the Administrator on 8/15/2025 at 3:49 PM. He indicated that due to Resident #39 having a diagnosis of a serious mental illness with a change in behaviors and treatment he should have been screened for a level II PASRR. 2. Resident #11 was admitted to the facility on 2/9/17. The resident's cumulative diagnoses included schizophrenia and bipolar disorder. A PASRR Level II Determination Notification letter issued for Resident #11 (dated 2/23/17) was reviewed. The letter noted Resident #11 had a PASRR number ending with the letter "B," which was indicative of a PASRR Level II determination with "No end date, No limitation unless change in condition. No specialized services required." The resident's quarterly Minimum Data Set (MDS) assessment dated 5/13/25 reported the resident had moderately impaired cognition with a mood severity score of 9 (indicative of mild depression). No signs / symptoms of a possible swallowing disorder were reported. Resident #11 was not assessed as having experienced a significant weight loss. Resident #11 was discharged to the hospital on 6/3/25 with re-entry to the facility on 6/7/25. The hospital Discharge Summary dated 6/7/25 reported his discharge diagnoses included acute respiratory failure with hypoxia, aspiration pneumonia and dysphagia. The resident's most recent MDS was a significant change in status assessment dated 6/12/25. The MDS reported that Resident #11 was a PASRR Level II resident due to serious mental illness. He had moderately impaired cognition and a mood severity score of 15 (indicative of moderately severe depression). The MDS assessment	F0646		

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F0646 SS = E	Continued from page 13 indicated Resident #11 was experiencing signs / symptoms of possible swallowing disorder (coughing or choking during meals or when swallowing medications). The resident was also identified as having a significant weight loss without being on a physician-prescribed weight-loss regimen. A review of Resident #11's Care Area Assessment (CAA) Worksheet for Functional Abilities (dated 6/25/25) indicated this problem/need was triggered due to the resident's self-care and mobility deficits. Underlying problems were reported to include a diagnosis of pneumonia, mood decline, and nutritional problems. There was no update PASRR Level II referral after the resident's significant change assessment. An interview was conducted on 8/13/25 at 10:58 AM with the facility's MDS Coordinator. During the interview, the MDS Coordinator was asked if a referral was made to the State mental health authority for evaluation of a resident after he or she was identified as having a significant change in condition. At that time, the MDS Coordinator reported the facility's Social Worker assumed responsibility to request a re-evaluation for a PASRR Level II resident having a significant change. The MDS Coordinator confirmed a re-evaluation would need to be done when a significant change in status MDS was completed due to a change in the resident's mental or physical status. An interview was conducted on 8/13/25 at 12:00 PM with the facility's Social Worker (SW) and Social Services Director. The SW and Director reported that up to this point, PASRR Level II residents were not referred to the State mental health authority for re-evaluation when an MDS assessment was initiated for a significant change unless there was a change in a psychiatric diagnosis or behavior. Therefore, a PASRR re-evaluation was not requested for Resident #11 after being identified as having a significant change in status. A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility's Administrator and Director of Nursing (DON). The Administrator reported that he became aware during the survey that a referral for re-evaluation for PASRR Level II residents was not always being made. The Administrator stated he would expect this to be done in accordance with the regulations. 3. Resident #179 was admitted to the facility on 12/14/23 with re-entry to the facility on 1/15/24 from	F0646		

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F0646 SS = E	Continued from page 14 a hospital. His cumulative diagnoses included schizophrenia, bipolar disorder, and adult failure to thrive. A PASRR Level II Determination Notification letter issued for Resident #179 (dated 2/8/24) was reviewed. The letter noted Resident #179 had a PASRR number ending with the letter “B,” which was indicative of a PASRR Level II determination with “No end date, No limitation unless change in condition. No specialized services required.” The resident’s most recent Minimum Data Set (MDS) was a significant change in status assessment dated 4/4/25. The MDS reported that Resident #179 was a PASRR Level II resident due to serious mental illness. The resident was identified as having a significant weight loss without being on a physician-prescribed weight-loss regimen. A review of Resident #179’s Care Area Assessment (CAA) Worksheet for Functional Abilities (dated 4/17/25) indicated the resident was reported to have a declining change in condition related to “adult failure to thrive, multiple other health conditions.” There was no update PASRR Level II referral after the resident’s significant change assessment. An interview was conducted on 8/13/25 at 10:58 AM with the facility’s MDS Coordinator. During the interview, the MDS Coordinator was asked if a referral was made to the State mental health authority for evaluation of a resident after he or she was identified as having a significant change in condition. At that time, the MDS Coordinator reported the facility’s Social Worker assumed responsibility to request a re-evaluation for a PASRR Level II resident having a significant change. The MDS Coordinator confirmed a re-evaluation would need to be done when a significant change in status MDS was completed due to a change in the resident’s mental or physical status. An interview was conducted on 8/13/25 at 12:00 PM with the facility’s Social Worker (SW) and Social Services Director. The SW and Director reported that up to this point, PASRR Level II residents were not referred to the State mental health authority for re-evaluation when an MDS assessment was initiated for a significant change unless there was a change in a psychiatric diagnosis or behavior. Therefore, a PASRR re-evaluation was not requested for Resident #179 after being	F0646		

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F0646 SS = E	Continued from page 15 identified as having a significant change in status. A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility's Administrator and Director of Nursing (DON). The Administrator reported that he became aware during the survey that a referral for re-evaluation for PASRR Level II residents was not always being made. The Administrator stated he would expect this to be done in accordance with the regulations.	F0646		
F0655 SS = A	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b)	F0655		09/08/2025

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F0655 SS = A	Continued from page 16 of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Resident Responsible Party and staff interviews, the facility failed to provide a copy of the baseline care plan to the Responsible Party for 1 of 3 residents reviewed for care plan (Resident # 14). Findings included: Resident #14 admitted to the facility on 5/1/25 with a diagnosis that included chronic obstructive pulmonary disease, hypertensive heart disease and Alzheimer's dementia. A review of the medical record revealed a baseline care plan was completed by Nurse #5 on 5/2/25. A review of the Minimum Data Set (MDS) admission assessment dated 5/7/25 revealed Resident #14 was severely cognitively impaired. A review of the medical record revealed Resident #14 listed a family member as her Responsible Party. A review of the post-admission patient/family conference note dated 5/5/25 indicated Resident #14's baseline care plan was developed with 48 hours and was reviewed at the post-admission patient/family conference and given to the resident and/or resident representative.	F0655		

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F0655 SS = A	Continued from page 17 An interview was conducted with the Homestead Coordinator (coordinator for memory care unit) on 8/14/25 at 12:20 PM. She indicated that the process for reviewing the baseline care plan with the resident and/or responsible party was to be completed at the post-admission patient/family conference. She further revealed that she was responsible for providing the summary to the resident and/or responsible party. She indicated that she did not recall providing a summary of Resident #14's baseline care plan in writing to the Resident or the Responsible Party. An interview was conducted on 8/14/25 at 1:09 PM with the Responsible Party. The Responsible Party indicated he did attend Resident #14's 72-hour post-admission patient/family conference on 5/5/25 by telephone but he did not receive a summary of the baseline care plan. A telephone interview was conducted with the Administrator on 8/15/2025 at 3:49 PM. He indicated the baseline care plan should be completed with 48 hours of admission and a copy of the written summary should be provided to the resident and/or responsible party.	F0655		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 §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).	F0656	Resident #4's care plan was updated to reflect the need for Communication, Functional abilities (Self care and Mobility), Urinary incontinence, Nutritional status, Dehydration / Fluid maintenance, Dental care and Pressure ulcer injury by 09/07/2025. The MDS Coordinator will conduct a quality audit on all current residents verifying that care plans accurately reflect the needs of the residents by 09/16/2025. Any concerns will be addressed as identified. An ADHOC Quality Assurance Performance Improvement meeting will be held by 09/10/2025 to formulate and approve a plan of correction for the deficient practice. The Regional MDS Nurse Consultant will educate the MDS Coordinator and the Director of Nursing on updating care plans to accurately reflect the needs of the resident by 09/12/2025. Newly hired MDS Nurses will be educated upon hire in orientation.	09/18/2025

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F0656 SS = D	Continued from page 18 (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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews and record review, the facility failed to develop a comprehensive care plan to address a resident's needs as identified in the admission assessment for 1 of 36 residents (Resident #4) whose care plans were reviewed. The findings included: Resident #4 was admitted to the facility on 6/4/25. The resident's cumulative diagnoses included diabetes and unspecified convulsions (seizure disorder). The resident's most recent Minimum Data Set (MDS) assessment was a comprehensive admission assessment dated 6/10/25. A review of the MDS revealed the resident had intact cognition. She had impairment of range of motion of her upper and lower extremities on both sides of her body and utilized a walker for mobility. The resident required set-up or clean-up assistance for eating and personal hygiene; partial/moderate assistance for bed mobility and sit to	F0656	Continued from page 18 The Director of Nursing or designee will conduct quality reviews of 5 resident care plans to ensure that care plans accurately reflect the needs of the resident 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 months. The Director of Nursing will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated.	

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F0656 SS = D	Continued from page 19 stand; substantial/maximum assistance for bathing and dressing her upper body; and was dependent on staff for toileting and transfers. Resident #4 was assessed as always incontinent of bladder and bowel. She did not receive either a therapeutic diet or mechanically altered diet but was reported to be edentulous (had no natural teeth). Resident #4 was reported to be at risk for developing pressure ulcers/injuries but did not have an unhealed pressure ulcer/injury at the time of the MDS assessment. Resident #4's Care Area Assessments (CAAs) were reviewed and noted the following care areas were triggered: --Communication (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, "Will Communication – Functional Status be addressed in the care plan? Yes." --Functional Abilities (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, "Will Functional Abilities (Self-Care and Mobility) – Functional Status be addressed in the care plan? Yes." --Urinary Incontinence and Indwelling Catheter (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, "Will Urinary Incontinence and Indwelling Catheter - Functional Status be addressed in the care plan? Yes." --Nutritional Status (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, "Will Nutritional Status - Functional Status be addressed in the care plan? Yes." --Dehydration/Fluid Maintenance (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, "Will Dehydration/Fluid Maintenance - Functional Status be addressed in the care plan? Yes." --Dental Care (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, "Will Care - Functional Status be addressed in the care plan? Yes." --Pressure Ulcer/Injury (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, "Will Pressure Ulcer/Injury – Functional Status be addressed in the care plan? Yes." A review of Resident #4's current care plan revealed the areas of focus identified in her comprehensive	F0656		

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F0656 SS = D	Continued from page 20 assessment and in accordance with the information provided by the CAAs were not included. The areas of focus which were not addressed or completed in the resident's current care plan included: Communication, Functional Abilities (Self-Care and Mobility), Urinary Incontinence, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, and Pressure Ulcer/Injury. An interview was conducted on 8/13/25 at 11:06 AM with the facility's MDS Coordinator related to Resident #4's care plan. Upon request, the MDS Coordinator reviewed Resident #4's. When asked, the MDS Coordinator reported the nursing staff typically completed an initial assessment and plan related to the resident's care upon his or her admission, and the MDS nurse would add to the care plan. Upon review of Resident #4's care plan, the MDS Coordinator confirmed the CAAs triggered for this resident indicated there were several areas of focus which still needed to be addressed in the care plan. She further explained by stating that when the CAA indicated a particular area of focus would be included in a care plan, then the comprehensive care plan needed to include it. The MDS Coordinator reported Resident #4's comprehensive care plan should have been completed by 6/24/25. When asked if Resident #4's comprehensive care plan was completed, the MDS Coordinator stated, "No." A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility's Administrator and Director of Nursing (DON). Upon inquiry, the Administrator reported he would expect a comprehensive care plan to be developed in a timely manner.	F0656		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record reviews, and interviews with staff, resident, and the Medical Director, the	F0689	"Past Noncompliance - no plan of correction required"	09/08/2025

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F0689 SS = SQC-J	Continued from page 21 facility failed to ensure safe securement per manufacturer recommendations of a resident during a van transport. On 2/21/25, Resident #8 was being transferred to dialysis in the facility's transportation van. When Transportation Driver #1 made a left turn, Resident #8 and the wheelchair she was seated in tipped over onto the floor of the van. The Transportation Driver called 911. Resident #8 complained of pain to the right side of her neck and face and was transported to the hospital via Emergency Medical Services (EMS). Resident #8 was receiving a blood thinner which increased her risk of bleeding. While at the hospital, Resident #8 was found to not have sustained any injuries but was admitted for one day to receive her missed dialysis treatment before returning to the facility. This practice had a high likelihood of causing a serious adverse outcome, including death or serious injury. This deficient practice was for 1 of 7 residents reviewed for accidents (Resident #8). Findings included: Review of the manufacturer's operating instructions dated 2014 for the facility's securement system used in the transportation van showed the following instructions for the use of the 4-Point Wheelchair Securement System: "1. Center wheelchair facing forward in Securement Zone and lock wheelchair brakes (or power off electric chair). 2. Attach four retractors into Floor Anchorage points and lock them in place, with an approximate distance of 48" to 54" between the front and rear retractors. 3. Completely pull out each webbing and attach J-hooks to compliant WC19 (a WC19 is a term used to describe a standard wheelchair designed to be used in vehicles) Chair Securement Points near seat level (or solid frame members) at an approximate 45-degree side angle. 4. Move wheelchair forward and back to remove webbing slack or manually tension webbing with retractor knobs. Resident #8 was admitted to the facility on 10/15/19 with diagnoses which included End-Stage Renal Disease	F0689		

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F0689 SS = SQC-J	Continued from page 22 (ESRD), congestive heart failure and atrial fibrillation. The physician's order dated 12/8/23 and the current medication administration records revealed Resident #8 received 2.5mg (milligrams) apixaban two times per day. Apixaban is an anticoagulant medication (blood thinner). The quarterly minimum Data Set (MDS) assessment dated 1/23/25 indicated Resident #8 was cognitively intact, received anticoagulant medication, had no falls, and received dialysis therapy. The review of the Incident Report prepared by Unit Manager #1 and the Interdisciplinary Team Review completed by Nurse #6, both dated 2/21/25 documented that as Resident #8 was transported to the dialysis center in the facility's transportation van, the resident's wheelchair turned over, onto its side. The Resident was assessed and transported to the Emergency Department for further evaluation. The Resident was unable to give a description of what had happened. There were no witnesses. There were no injuries observed at the time of the incident. Review of the Emergency Medical Services (EMS) Report dated 2/21/25 documented that upon EMS arrival on the scene, Resident #8 was observed on the floor of the transport van with a wheelchair turned on its' side and underneath the resident. The Resident was alert, speaking full sentences. Transportation Driver #1 informed EMS that he was transporting the Resident in her wheelchair in the van to the dialysis center and when the van turned a corner the Resident and her wheelchair overturned. The Resident complained of pain to the right side of her face and the right side of her neck. EMS freed the wheelchair from the safety straps and removed the wheelchair from under the resident. A cervical collar was placed on the Resident, and she was transferred to a stretcher and in the EMS unit where assessment and interview were completed. The Resident denied loss of consciousness, chest pain, shortness of breath, nausea and vomiting. The Resident revealed she was enroute to the dialysis center and her last dialysis treatment was on Wednesday, 2/19/25. The Resident denied any other injuries and was able to move lower extremities with no pain to pelvis/hips and had equal hand grip. The duration of head and neck pain was ten minutes. The Resident was transferred to the	F0689		

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F0689 SS = SQC-J	Continued from page 23 Emergency Department of the hospital, answering questions appropriately. Transportation Driver #1 was not available for interview during the survey. Review of the hospital Emergency Department assessment and plan dated 2/21/25 revealed Resident #8 was evaluated for right-sided head/neck pain due to resident stating her head and neck were injured by striking something inside the transport van on her way to the dialysis center. The result of the computed tomography (CT) scan of the resident's head and neck showed no acute intracranial pathology or cervical spine pathology. The Emergency Department physician contacted the resident's outpatient nephrologist and it was decided that it was too late in the day for the Resident to go to the dialysis center this day. Also, there was no indication that the Resident would be able to be transported from the nursing home to the dialysis center on 2/22/25 (Saturday). Because the Resident's next scheduled dialysis appointment would not be until 2/24/25 (Monday), the recommendation was for Resident #8 to be evaluated for admission to the hospital and receive her dialysis treatment on this night of 2/21/25. The hospital discharge summary dated 2/22/25 revealed Resident #8 also reported right hip pain and the right hip x-ray showed no acute fracture or abnormality. The pain was mild and managed conservatively. The resident received her normal treatment of dialysis on Friday night (2/21/25) and would continue on her Mondays, Wednesdays, and Fridays schedule. There were no new physician orders made during this hospitalization. The summary indicated the Resident's condition was good at discharge and that she returned to the facility. During an interview on 8/12/2025 at 10:21 a.m., Resident #8 revealed that in February 2025 she had a fall in the facility's transportation van enroute to the dialysis center. She recalled that as the transportation van driver was making a left turn, her wheelchair fell sideways to the right in the van causing her to hit her neck and face. The resident did not recall what she hit her neck and face on. She stated she was hospitalized overnight. The Resident indicated the accident did not result in any fractures, but she had constant back pain since the accident.	F0689		

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F0689 SS = SQC-J	Continued from page 24 A second interview was conducted with Resident #8 while awaiting transport to the dialysis center on 8/13/25 at 10:23 a.m. The Resident was observed sitting upright in a wheelchair The Resident recalled that the February accident occurred at approximately 12:30 p.m. when Transportation Driver #1 made a left turn onto another street. She revealed she was the only passenger in the van. She stated that Transportation Driver #1 did not attempt to move or reposition her after the fall. The Resident stated EMS arrived and applied a neck brace and transported her to the hospital. She stated she believed Transportation Driver #1 must have turned the van too fast causing her wheelchair to turn over on its side. A telephone interview was conducted with the facility's Medical Director on 8/13/25 at 3:10 p.m. The Medical Director recalled being notified by the Administrator and the Director of Nursing of Resident #8's accident in the van the same day. She stated she reviewed the incident records, the hospital reports, including the x-rays which showed the Resident had no injuries as a result of the accident. The Medical Director indicated Resident #8 receiving blood thinner medication did not place her at risk of serious injury or death as a result of the minor accident. The Medical Director concluded the resident was sent to the hospital as a precaution following the accident. An interview was conducted with the Administrator on 8/12/25 at 3:45 p.m. He stated Transportation Driver #1 notified him of the accident and his call for EMS on 2/21/25 via telephone. The Administrator stated when he arrived on the scene of the accident, EMS was on-site. He revealed he observed Resident #8 in the facility's van, in her wheelchair, alert and verbal. He stated he interviewed Transportation Driver #1 at the scene of the accident and on return to the facility and Transportation Driver #1's account of the accident remained the same. The Transportation Driver #1 informed him (Administrator) that he was transporting Resident #8 to the dialysis center in the van and when he made a left turn onto another street, the Resident's wheelchair tilted over. Transportation Driver #1 reported he stopped the van and telephoned EMS then the facility. The Administrator stated Transportation Driver #1 insisted he had "double checked the immobility of the Resident's wheelchair in the van to ensure no movement." The Administrator revealed Transportation Driver #1 was originally hired in June 2024 as the Maintenance Assistant but in January 2025	F0689		

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F0689 SS = SQC-J	Continued from page 25 became one of two facility transportation drivers. The Administrator added Transportation Driver #1 was trained by the former Maintenance Director. The Administrator provided documentation of Transportation Driver #1's facility transportation training dated 1/13/25 and signed by Transportation Driver #1. This signed training documentation included: Vehicle Safety: Tips for Safely Transporting Patients in Wheelchairs; Authorized Driver Checklist; Vehicle Safety Competency; The Wheelchair tie down and Occupant Restraint System; Mobile Device Use Agreement for Drivers of Company Vehicles; and Procedures to Follow after a Vehicle Accident. The former Maintenance Director was interviewed on 8/15/25 at 11:03 a.m. and explained he was the Maintenance Director at the facility during the time of the accident involving the wheelchair turning over in the facility's van during transport. He revealed the van was purchased by the facility in January 2025 and after a complete inspection, he replaced the ratchets and straps before the van was used by the facility because they were old and loose. He stated that he inspected the facility's two transportation vans including the wheelchair securement systems, yearly. He stated that within twenty-four hours of the accident in February 2025, he inspected the van including having Transportation Driver #1 re-enact the securing method of the Resident's wheelchair in the van, as he did on the day of the accident. He stated that the demonstration concluded Transportation Driver #1 securely strapped Resident #8's wheelchair to the floor of the van; and inspection of the van identified no defective equipment. On 8/13//25 at 5:13 p.m., the Administrator was notified of immediate jeopardy. The facility implemented the following corrective action plan: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Root cause analysis has revealed that on 02/21/2025 at approximately 11:57am, resident #8 sustained a fall while being transported to dialysis in the facility van. The facility Van driver stated as he was turning	F0689		

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F0689 SS = SQC-J	Continued from page 26 onto Meadow Pl at 6 miles per hour the wheelchair tipped over due to the ratchet system used to secure residents in place not properly adjusted to ensure that Resident #8 wheelchair was secured inside the facility van. Resident #8 (BIMS - 15) did not provide details regarding the incident as she only stated that she was having current back and neck pain. At the time of the incident, the van driver called Emergency Services. EMS and Fire Department arrived at the scene of the incident at 12:11pm. The incident occurred at the intersection of Ferndale Boulevard and Meadow Place. The resident was safely transported to the hospital by Emergency Medical Services at 12:25pm. Administrator, Resource Operator and Registered Nurse arrived at the scene of the incident at 12:11pm. It was observed by the facility's Administrator and Registered Nurse that resident #8 was strapped in her wheelchair via a facility van lapbelt. Resident #8's wheelchair was latched via the floor track ratcheting system x1 strap from the rear of the wheelchair to the left sided frame and x1 strap from the rear of the wheelchair to the right sided frame. Additionally, the wheelchair was latched by utilizing the floor ratcheting system x1 strap to the front frame of the right side of the wheelchair and x1 strap to the front frame of the left side of the wheelchair. Resident #8 was transported to hospital for evaluation on 02/21/2025 by Emergency Medical Services. The resident was assessed at the hospital. According to the hospital records, a CT of Resident #8's head and C-Spine. CT scan from hospital dated 02/21/2025 at 2:30 pm revealed no fractures to head or spine. Resident #8 was discharged from the hospital on 02/22/2025 back to the facility. Upon her return, the Licensed Nurse assessed resident #8. A new order from the hospital for zofran 4MG was prescribed every 6 hours for nausea and vomiting. The facility van driver was interviewed by the facility Administrator at the facility. The van driver's statement revealed, Resident #8 was loaded into the van at 11:55am by the van driver. The facility van driver secured the wheelchair via 4 straps on the floor track ratcheting system and placed and secured the van's lapbelt on the resident. The van driver checked to ensure the wheelchair was secure prior to departing from the facility. The van driver departed from the facility heading to Kidney Center. Facility Van driver stated as he was turning onto Meadow Pl at 6 miles per	F0689		

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F0689 SS = SQC-J	Continued from page 27 hour the wheelchair tipped over. The facility Van driver stated he immediately called Emergency Services. The van driver stated that he was unaware of what caused the incident as he believed that he secured the resident's chair per the manufacturer's recommendation for the ratcheting system. The van driver stated that as he was making a left turn he heard the wheelchair tilt and immediately stopped the facility van. The facility van driver was placed on administrative leave pending investigation on 02/21/2025. A formal investigation was initiated by the Administrator on 02/21/2025. As a result of the investigation, it was determined that the ratchet system used to secure residents in the facility van was not properly used by the van driver per manufacturers recommendations on 2/21/25. On 02/21/2025, the Administrator reviewed the restraint manufacturer's instructions for how to secure a wheelchair and person to the facility van. The Administrator re-educated the Maintenance Director to include competency checks on 2 facility van drivers who transport facility residents on the center's Authorized Driver Checklist, Vehicle Safety Competency, Vehicle Safety Policy (SH413), Vehicle Safety: Tips for Safely Transporting Patients in Wheelchairs prior to the beginning of his next scheduled shift. From 02/22/2025 - 02/24/2025, an outsource transportation company was utilized to transport residents to medical appointments. The Maintenance Director re-educated to include competency checks on 2 facility van drivers who transport facility residents on the center's Authorized Driver Checklist, Vehicle Safety Competency, Vehicle Safety Policy (SH413), Vehicle Safety: Tips for Safely Transporting Patients in Wheelchairs prior to beginning their next scheduled shifts. The Medical Director and the Resident #8 responsible party were notified of the incident by the Administrator. The wheelchair for Resident #8 was inspected by the Maintenance and Therapy department to ensure proper functioning. No issues identified during either inspection. Following Resident #8 readmission from the hospital, Resident #8 was transported via facility van to medical appointments in a standard wheelchair.	F0689		

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F0689 SS = SQC-J	Continued from page 28 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 2/21/25, the Administrator reviewed a list of residents who have been transported by facility staff and all outsourced transportation companies in the last 30 days to ensure no other residents sustained an injury during transportation. No additional incidents were identified as a result of the audit. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 02/21/2025, an audit was conducted by the Administrator to ensure all facility van drivers were current on van safety education and skills competencies were up to date. No negative findings as a result of the audit. Education consisted of the center's Authorized Driver Checklist, Vehicle Safety Competency, Vehicle Safety Policy (SH413), Vehicle Safety: Tips for Safely Transporting Patients in Wheelchairs. On 02/21/2025, the Administrator and Maintenance Director inspected the ratcheting system and all seat belts in the facility van. All ratchet straps and seatbelts were in proper working order. The Administrator re-educated the Maintenance Director to include competency checks on 2 facility van drivers who transport facility residents on the center's Authorized Driver Checklist, Vehicle Safety Competency, Vehicle Safety Policy (SH413), Vehicle Safety: Tips for Safely Transporting Patients in Wheelchairs prior to the beginning of his next scheduled shift. Beginning 02/25/2025, the Administrator and Maintenance Director re-educated 2 facility van drivers on the center's Authorized Driver Checklist, Vehicle Safety Competency, Vehicle Safety Policy (SH413), Vehicle Safety: Tips for Safely Transporting Patients in Wheelchairs. The safety tips are comparable to the restraint manufacturer's instructions. Return demonstration was conducted by 2 van drivers to ensure proper methods are used while securing residents / wheelchairs in the van via the ratcheting system. Any van driver that was not educated will receive education prior to their next scheduled shift. Newly hired drivers will be trained upon hire in orientation by the Maintenance Director.	F0689		

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F0689 SS = SQC-J	Continued from page 29 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 02/21/2025, the Administrator will audit resident transportations on 10 residents 2 times per week for 4 weeks, then 1 time per week for 8 weeks utilizing a monitoring tool to ensure residents are transported without incident regardless of the transportation organization and that all facility van drivers remain educated on facility van safety policies to include restraint manufacturer's instructions. On 02/21/2025, an ADHOC Quality Assurance Performance Improvement meeting was conducted by the Administrator with the interdisciplinary team members to review the root cause of the incident, discuss immediate measures to ensure all other residents are safe, education required for facility licensed van drives and how the center will ensure quality monitoring going forward to ensure no other residents are not safely transported regardless of the transportation organization. The Administrator will report the results of the monitoring to the QAPI committee to review audits and make recommendations to ensure compliance is maintained ongoing. The QAPI Committee will determine the need for further intervention and auditing beyond three months to assure compliance is sustained ongoing. Alleged date of Immediate Jeopardy Removal: 02/26/25 The deficiency correction date is alleged to be 02/26/25. The facility's corrective action plan was validated by the following on 8/15/25: The facility provided audits of residents in wheelchairs who were interviewed if they felt safe with the wheelchair securing methods used in the transportation vans and if they felt safe with the driving of the transportation van drivers. Only 1 of the 2 facility van drivers were currently working at the facility. Transportation Driver #1 was currently on leave. The Maintenance Director also worked as a transportation van driver, documentation specified Transportation Driver #1, Transportation Driver #2, and	F0689		

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F0689 SS = SQC-J	Continued from page 30 the Maintenance Director received the training on the restraint system's manufacturer's instructions. The facility provided documentation of the restraint system's manufacturer's video of correct application of the use of the 4-Point Wheelchair Securement System in transport vans. This training included checklists, observations and audits that included return demonstration on securing a resident in their wheelchair inside the transportation van, and of and on loading of residents into the vans. Interviews with Transportation Driver #2 and the Maintenance Director verified they received the training with return demonstration of wheelchair securement system in the transportation van according to the restraint system's manufacturer instructions. The monitoring of all residents using the transport van was conducted and presented in the facility's QA meeting. An observation was conducted on 8/15/25 at 10:02 a.m. of Transportation Driver #2 as she secured three residents according to the restraint system's instructions. After securing the wheels of wheelchair to the floor of the transportation van and strapping Transportation Driver #2 tested the immobility of the wheels and the handles of each resident's wheelchair after with positive results of wheelchair immobility. Transportation Driver #2 stated she always tested both areas (top and bottom) of each wheelchair to ensure safety. The facility's IJ removal date and compliance date for the corrective action plan of 2/26/25 was validated.	F0689		
F0812 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	F0812	The ice machine was cleaned by the Maintenance Director on 08/11/2025. The 3 large mixing bowls were removed from the drying rack and rewashed and properly air dried by the dietary staff on 08/12/2025. The Maintenance Director will conduct a review of all facility ice machines to ensure they are free of debris by 09/10/2025. Any concerns will be addressed as identified. The Assistant Dietary Manager will conduct an audit of all metalware in the kitchen to ensure they are fully dry before being stacked together by 09/10/2025. Any concerns will be addressed as identified. An ADHOC Quality Assurance Performance Improvement meeting will be held by 09/10/2025 to formulate and approve a plan of correction for the deficient	09/18/2025

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F0812 SS = E	Continued from page 31 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 and staff interviews, the facility failed to ensure 1 of 2 kitchen icemakers was free from black and gray debris and wet mixing bowls were not stacked together before they were fully dry. This had the potential to affect all residents who received ice and/or food that came into contact with the mixing bowls. An observation completed on 08/11/25 at 9:38 AM revealed 1 of the facility's 2 icemakers in the kitchen had black and gray debris running down the ice divider inside of the ice maker and then along the top ridge of the icemaker where the door opened and closed. The black and gray debris was wet in nature and appeared to be running down the divider and potentially dripping onto the ice. Additional observations at this time revealed 3 large metal mixing bowls that had recently been washed, nested together on a storage shelf. When pulled apart visible liquid drained from each of the bowls and onto the floor. An interview with the Dietary Manager on 08/11/25 at 9:46 AM revealed the ice maker was scheduled to be cleaned monthly by the maintenance department. The Dietary Manager stated he believed it was scheduled to be cleaned later that week. He also reported he did not know the ice machine was dirty and indicated he did not know what the black and gray substance was on the ice machine's divider and that he would not want that substance dripping into ice he was going to use. The Dietary Manager also reported that he tries to keep metalware separated until fully dry but insisted that there was not a lot of space to store the wet dishes. The Dietary Manager reported that the ice machine should be free from dirt and debris and that metalware should not be nested while still wet and should be fully dry before being stacked. An interview with the Maintenance Director on 08/12/25 at 1:02 PM revealed he was the staff member responsible for the routine maintenance and cleaning of the ice	F0812	Continued from page 31 practice. The Senior Maintenance Director will educate the Maintenance Director and Maintenance Assistant on the facility's process of cleaning ice machines to include removing the ice divider to ensure it is free of debris by 09/12/2025. The District Dietary Manager will educate all dietary staff on the facility's policy for warewashing to include drying metalware fully prior to stacking them together by 09/12/2025. The Administrator will conduct quality monitoring of all facility ice machines to ensure they are clean and free of debris 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 weeks. The Administrator will conduct monitoring of all kitchen metalware to ensure metalware is dried properly 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 weeks. The Administrator will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345172	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

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F0812 SS = E	Continued from page 32 machines located in the kitchen. He reported he completed a deep cleaning of the ice machine once every 6 months and if requested through the maintenance service request system the facility utilized. He reported he believed it was the responsibility of the Dietary Manager and his staff to ensure that the ice machine was clean on a daily basis. The Maintenance Director reported he had most recently deep cleaned the ice machine approximately 3 weeks ago but stated be must have missed pulling out the divider panel and stated it had not been cleaned. An interview with the Administrator on 08/12/25 at 1:20 PM revealed he expected the ice machine to be cleaned as needed and to be free from dirt and debris. He also reported that metalware should be fully dry before being stacked or nested together.	F0812		
F0880 SS = J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	Resident #135 was not affected related to the shared blood glucose meter not being cleaned and disinfected according to manufacturer's instructions in between residents. On 08/14/2025, the Infection Preventionist re-educated the licensed nurse on shared blood glucose meters that can be contaminated with blood and must be cleaned and disinfected after each use with an approved EPA product and procedure in accordance with the manufacturer's instructions to prevent potentially exposing residents to the spread of blood borne infections with return demonstration. All residents requiring blood glucose monitoring have the potential to be affected by the deficient practice. A list of residents that have orders for blood glucose monitoring was obtained from Electronic Medical Record by the Director of Nursing on 08/18/2025 to identify residents who require blood glucose monitoring to observe infection control practices related to cleaning and disinfecting the blood glucose meter according the manufacturer instructions for the EPA - registered disinfectant. 55 residents were identified with orders to obtain blood glucose monitoring. Individual glucometers were purchased for all 55 residents with orders to obtain blood glucose monitoring. An ADHOC Quality Assurance Performance Improvement meeting will be held by 09/10/2025 to formulate and approve a plan of correction for the deficient practice.	09/18/2025

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F0880 SS = J	Continued from page 33 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff and Medical Director interviews, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents in accordance with the instructions provided by the manufacturer of the disinfectant wipes used for 1 of 2 residents whose blood glucose levels were checked (Residents #135). This occurred while	F0880	Continued from page 33 The Director of Nursing or the Infection Preventionist will educate licensed nurses and Medication Aides to include agency licensed nurses and medication aides on cleaning and disinfecting of blood glucose meters after use per manufacturer instructions to prevent contamination and potential to spread blood borne pathogens with validation of understanding by 09/12/2025. Newly hired licensed nurses and medication aides to include newly hired agency licensed nurses and medication aides will be educated on cleaning and disinfecting of blood glucose meters upon hire by the Director of Nursing or Infection Preventionist. The Director of Nursing or the Infection Preventionist completed skilled competency check off through observation for Licensed Nurses and Medication Aides on the use of blood glucose meters to include cleaning and disinfecting according to manufacturer instructions on 08/18/2025 - 08/19/2025. The Director of Nursing or Infection Preventionist will conduct a skilled competency check off for newly hired staff to include newly hired agency staff on the use of blood glucose meters to include cleaning and disinfecting according to manufacturer instructions. 4. The Director of Nursing or Infection Preventionist will conduct quality monitoring of 5 nurses to ensure cleaning and disinfecting of blood glucose meters after use per manufacturer instructions to prevent contamination and potential to spread blood borne pathogens 3 times per week for 4 weeks, then 2 times per week for 4 weeks, then 1 time per week for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated.	

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F0880 SS = J	Continued from page 34 there was at least one resident with a known bloodborne pathogen in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer potentially exposes residents to the spread of blood borne infections. Care must also be taken by personnel handling glucometers to protect the glucometers against cross-contamination via contact with other surfaces. Immediate Jeopardy began on 8/14/25 when Nurse #1 was observed performing blood glucose checks on residents using a shared glucometer without disinfecting per manufacturer's instructions. Immediate Jeopardy was removed on 8/20/25 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: The facility's document entitled, "Procedure: Fingerstick Glucose Measurement" (Reviewed and Revised on 7/15/25) outlined the following process, in part: Step #22 (of 27): "Clean and disinfect the blood glucose meter [glucometer] after use with EPA approved disinfectant, following manufacturer's instructions." Upon request, additional documents were provided by the facility in lieu of a Policy / Procedure for glucometer disinfection: ---A "Glucometer Cleaning & Disinfection Observation" described the purpose of the observation as: "Bloodborne pathogens such as Hep B [hepatitis B], Hep C [hepatitis C], and HIV [human immunodeficiency virus] can be transmitted to other patients if glucometers are not cleaned & disinfected. Such transmission has occurred in the past in LTC [long term care] facilities that do not use a cleaning & disinfecting procedure." The requirements of the observation included, in part: -"…The glucometer is cleaned and disinfected after each use. If the nurse is unsure whether the glucometer is clean, it should be cleaned and disinfected before use. -The glucometer is wiped down with the product specified for use by the manufacturer. Products	F0880		

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F0880 SS = J	Continued from page 35 approved for the [brand name] meter include: [4 brands of disinfectant wipes, including the facility's disinfectant] -Staff clean & disinfect surfaces that come into contact with the glucometer (e.g., overbed tables, med [medication] carts, etc.). -The glucometer remains wet for the time specified in the directions on the cleaning and disinfecting product…" ---"Clinical Competency Validation Fingerstick Glucose Measurement" included step #19 (of 23): "Cleans and disinfects the blood glucose meter after use with EPA approved disinfectant, following manufacturer's instructions." A "Healthcare Professional Operator's Manual & In-Service Guide" (Dated 2023) from the manufacturer of the facility's glucometer included a section on "Cleaning and Disinfecting your [brand name of the glucometer]." It noted the following information, in part: "Cleaning and disinfecting the meter and lancing device is very important in the prevention of infectious disease. Cleaning is the removal of dust and dirt from the meter and lancing device surface so no dust or dirt gets inside. Cleaning also allows for subsequent disinfection to ensure germs and disease causing agents are destroyed on the meter and lancing device surface." The products listed as having been validated for disinfecting the facility's glucometer included the brand of disinfectant wipes available for use at the facility. The manufacturer instructions for the glucometer used at the facility indicated the cleaning and disinfection procedure required the following step: #4 (of 6). To disinfect the meter, clean the meter with one of the validated disinfecting wipes…Wipe all external areas of the meter including both front and back surfaces until visibly clean. Avoid wetting the meter test strip port. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. The manufacturer's labeling of the brand of disinfectant wipes used at the facility was reviewed and read, in part: "Kills HIV-1 [human immunodeficiency virus], HBV [hepatitis B virus], and HCV [hepatitis C virus] on precleaned environmental surfaces/objects previously soiled with blood/body fluids in health care settings or other settings in which there is an	F0880		

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F0880 SS = J	Continued from page 36 expected likelihood of soiling of inanimate surfaces/objects with blood/body fluids and in which the surfaces/objects likely to be soiled with blood/body fluids can be associated with the potential for transmission of HIV-1 (associated with AIDS), HBV, and HCV." The directions for use of the disinfectant wipes addressed the required contact time for disinfection. The manufacturer instructed that surface(s) should remain "visibly wet" for 30 seconds to kill the bacteria and viruses (as individually listed on the label), except a 1 minute contact time is required to kill Candida albicans (a fungus) and Trichophyton interdigitale (a fungus); a 2 minute contact time is required to kill Candida auris (a fungus); and a 3 minute contact time is required to kill Clostridium difficile spores (a resistant, dormant structure produced by C. diff bacterium). An observation of blood glucose monitoring was initiated on 8/14/25 at 11:25 AM with Nurse #1. The observation began as Nurse #1 prepared to conduct a blood glucose check for Resident #7. The nurse removed a (brand name) glucometer stored inside a plastic bag from the top right drawer of the medication cart and placed the glucometer on top of the medication cart. It could not be determined by observation whether the surface of the medication cart had been previously disinfected. Nurse #1 then collected additional supplies for monitoring, including alcohol wipes, a glucose strip, and a single-use lancet. At 11:26 AM, the Nurse was observed to insert the glucose strip into the meter. Immediately afterwards, she placed the meter back on top of the medication cart, donned gloves, picked up the glucometer and supplies, then entered Resident #7's room. Nurse #1 used the lancet to obtain a blood sample from the Resident, then placed the meter (with the glucose strip inserted) on top of Resident #7's bedside tray table while she wiped the remaining blood from the resident's finger. The resident's blood glucose result was 137. At 11:28 AM, Nurse #1 was observed as she removed her gloves while still in the resident's room, picked up the used glucometer, and returned to the medication cart. The Nurse obtained a (brand name) disinfectant wipe from the bottom drawer of the medication cart and wiped the glucometer with the disinfectant wipe for a count of 5 seconds. She then placed the glucometer on a paper towel on top of her medication cart. Upon inspection of the meter placed on the paper towel, the meter appeared to be completely dry and had no signs of being visibly wet. The nurse returned to Resident #7's room, washed her hands, then came back to the medication cart to prepare an "as needed" medication requested by the resident.	F0880		

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F0880 SS = J	Continued from page 37 A continuous observation of the medication cart and glucometer was conducted. On 8/14/25 at 11:35 AM, Nurse #1 moved the medication cart directly in front of another room to conduct a blood glucose check for Resident #135. The medication cart was positioned so that the nurse was at the doorway of the resident's room. At that time, Nurse #1 reported that she had to wait three (3) minutes before she could use the glucometer for another resident after having disinfected the meter. When asked to clarify, the nurse stated the shared glucometer needed to dry for 3 minutes before being used for another resident. Meanwhile, she collected the additional supplies needed for the blood glucose check, including alcohol wipes, a glucose strip, and a single-use lancet. Then, Nurse #1 picked up the shared glucometer and began to insert a glucose strip into the meter. The nurse was already directly in front of the doorway of Resident #135's room, therefore she was asked to stop at that time and review the labeling on the canister containing the disinfectant wipes used on the shared glucometer. When the canister was again pulled out of the medication cart, the directions for disinfection were read. While reviewing the manufacturer's directions on disinfectant wipes, Unit Manager #1 walked by the medication cart. At that time, the disinfection of the shared glucometer was discussed with the Unit Manager. When asked, the Unit Manager reported she herself typically wrapped a wet disinfectant wipe around the glucometer to meet the requirement of a 3-minute contact time. When asked to clarify, she confirmed the 3-minute contact time was the amount of time the shared glucometer remained in contact with a wet disinfectant wipe (not the drying time). An interview was conducted on 8/14/25 at 1:02 PM with the facility's Infection Preventionist (IP). The IP provided a copy of the facility's "Procedure: Fingerstick Glucose Measurement" (Reviewed and Revised on 7/15/25). During the interview, the IP detailed the steps outlined in the document and reported the education provided to the licensed nurses was based on that information. The IP stated she would expect the nurse to make sure a surface barrier was in place for the glucometer so the meter was not placed directly on a medication cart that may not be clean. She also reported that the glucometer should not be placed on "resident property" such as a bedside tray table inside a resident's room (because it's "dirty") and that a used glucometer should be wrapped in paper towels prior to leaving the room. Additionally, the IP noted a glucometer should be "cleaned" according to the	F0880		

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F0880 SS = J	Continued from page 38 directions on the disinfectant wipes being used. The IP stated the “contact time” meant the time the glucometer was wet. She added that the nurse should wait until the glucometer was completely dry before using that glucometer again. When asked, the IP stated a glucometer should be disinfected between residents and after being used for the last resident having his or her blood glucose checked before replacing it into the storage bag kept on the medication cart. A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility’s Administrator and DON. During the interview, concerns encountered during the survey were addressed. When the observation of blood glucose monitoring and disinfection of a shared glucometer was discussed, the DON reported she would expect the nurses to wipe and disinfect the glucometer according to the instructions provided by the manufacturer of the disinfectant wipes. Upon further inquiry, the DON stated the “contact time” noted on the disinfectant wipes’ canister referred to the actual contact time with a wet disinfectant wipe, not the drying time of the glucometer. Upon request, the facility provided a Diagnosis Report for its current residents on 8/18/25. The Diagnosis Report indicated 8 residents were identified as having at least one bloodborne pathogen, which included hepatitis C and HIV. A telephone interview was conducted on 8/19/25 at 10:55 AM with the facility’s Medical Director. During the telephone interview, the Medical Director was asked what her thoughts were related to the observation of the failure to disinfect a shared glucometer in accordance with the manufacturer’s instructions. The Medical Director stated she did not agree that this was an immediate jeopardy situation and declined to make any additional comments. The facility's Resource Operator of the Southeast Market was informed of the immediate jeopardy (IJ) by telephone on 8/18/25 at 1:45 PM (in the absence of the Administrator who was on leave). The facility provided the following plan for IJ removal: How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	F0880		

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F0880 SS = J	Continued from page 39 Resident #135 was not affected related to the shared blood glucose meter not being cleaned and disinfected according to manufacturer's instructions in between residents. The facility licensed nurse did not clean and disinfect the blood glucose meter per manufacturer recommendations prior to entering Resident # 135's room. The licensed nurse cleaned the glucometer for a time frame less than the manufacturer's instructions. The shared blood glucose meter for Resident #135 was not used to obtain a blood sugar check. The surveyor observing at the time the blood sugar was being obtained, the surveyor intervened and stopped the licensed nurse from using the blood glucose meter. Prior to the deficient practice, the facility licensed nurse was last educated on 2/10/25 on manufacturer instructions related to cleaning and disinfecting blood glucose meters. On 8/14/25, the Infection Preventionist re-educated the licensed nurse on shared blood glucose meters that can be contaminated with blood and must be cleaned and disinfected after each use with an approved EPA product and procedure in accordance with the manufacturer's instructions to prevent potentially exposing residents to the spread of blood borne infections with return demonstration. The EPA registered disinfectant manufacturer's instructions included the following: 3 minute contact time for Sporicidal, 2 minute contact time for Fungicidal, 1 minute contact time for Fungicidal and 30 second contact time for Virucidal and Bactericidal. A root cause analysis was conducted and based on the findings, the facility licensed nurse failed to follow the manufacturer instructions to clean and disinfect shared blood glucose meters prior to inserting a blood test strip. The facility licensed nurse was being observed by the surveyor to ensure infection control practices were being followed and the facility licensed nurse became anxious and nervous during the observation to perform blood sugar check. The Medical Director was immediately notified on 08/14/25 by the Director of Nursing via telephone of the facility Licensed Nurse failing to follow the contact time for cleaning and disinfecting blood glucose meters and inserting a blood test strip in the meter prior to full contact time. On 08/19/25, the Director of Nursing notified the local department via telephone of the facility Licensed Nurse failing to follow the manufacturer instructions to disinfect a shared blood glucose meter potentially exposing residents to the spread of blood borne pathogens.	F0880		

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F0880 SS = J	Continued from page 40 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. All residents requiring blood glucose monitoring have the potential to be affected by the deficient practice. A list of residents that have orders for blood glucose monitoring was obtained from Electronic Medical Record by the Director of Nursing on 8/18/25 to identify residents who require blood glucose monitoring to observe infection control practices related to cleaning and disinfecting the blood glucose meter according the manufacturer instructions for the EPA- registered disinfectant. 55 residents were identified with orders to obtain blood glucose monitoring. The Director of Nursing or the Infection Preventionist educated licensed nurses and medication aides to include agency licensed nurses and medication aides on cleaning and disinfecting of blood glucose meters after use per manufacturer instructions to prevent contamination and potential to spread blood borne pathogens and outcomes if the facility licensed nurse failed to do so on 08/18/25 - 08/19/25 in person with validation of understanding. Newly hired licensed nurses and medication aides to include newly hired agency licensed nurses and medication aides will be educated on cleaning and disinfecting of blood glucose meters upon hire by the Director of Nursing or Infection Preventionist. The Director of Nursing or the Infection Preventionist completed skilled competency check off through observation for licensed nurses and medication aides on the use of blood glucose meters to include cleaning and disinfecting according to manufacturer instructions on 08/18/25 - 08/19/25. The Director of Nursing or Infection Preventionist will conduct a skilled competency check off for newly hired staff to include newly hired agency staff on the use of blood glucose meters to include cleaning and disinfecting according to manufacturer instructions. On 8/18/25, individual glucometers were ordered by the Director of Nursing for each resident requiring blood glucose testing. An ADHOC Quality Assurance Performance Improvement Committee was held on 08/18/25 to formulate and approve a credible allegation of immediate jeopardy for removal of the deficient practice.	F0880		

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F0880 SS = J	Continued from page 41 Date of Removal of Immediate Jeopardy 8/20/25 The facility's credible allegation of immediate jeopardy removal was validated on 8/20/25. A review was conducted of the education for glucometer disinfection procedures provided by the Director of Nursing and Infection Preventionist dated 8/18/25-8/19/25 for licensed nursing staff. Observations were conducted on 8/20/25 as three licensed nurses performed glucose blood checks for four residents. No infection control concerns were identified. Staff interviewed were able to verbalize the education and training provided in reference to the glucometer disinfection and the required disinfectant wet contact times for the glucometer. The immediate jeopardy removal date of 8/20/25 was validated.	F0880		