STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345307	A. BUILDING: _____ B. WING _____	1/20/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

§483.10(g) Information and Communication.
(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.

(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -

(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345307	A. BUILDING: _____ B. WING _____	1/20/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345307	A. BUILDING: _____ B. WING _____	1/20/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 2

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews, the facility failed to keep residents informed of the location of the contact information for the State Agency and local Regional Long Term Care Ombudsman and inform residents of what the Ombudsman's positon was.

The findings included:

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345307	A. BUILDING: _____ B. WING _____	1/20/2017

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 3

An interview was conducted with the Resident Council Representative, Resident #35, on 01/18/17 at 11:15 AM. She stated she was unaware of who or what the Ombudsman did for the facility and was unaware of how to contact her. She further stated she was unaware she was able to contact the State Agency with complaints or the location of the contact information for the state agency.

Interviews conducted with Resident #41 on 01/20/17 at 9:30 AM and Resident #39 on 01/20/17 at 9:45 AM, who attended Resident Council Meetings on a regular basis stated they did not know who or what the Ombudsman did or how to contact them and did not know they were able to contact the State Agency with complaints or where the contact information was located. They further stated they had not been informed of this information during resident council meetings.

An interview conducted on 01/19/17 at 8:47 AM with the Activity Director (AD) revealed she had worked at the facility since 12/2016 and had facilitated the resident council meetings in 12/2016 and 01/2017. The AD stated she had not and was not aware she should have informed residents at the meetings about who the Ombudsman was or what they did and how to contact the State Agency with concerns/complaints. She stated she would add those things and resident rights to future resident council meetings.

An interview conducted on 01/20/17 at 1:10 PM with the Administrator revealed the contact information for the Ombudsman and state agency was posted in facility. He stated residents should be informed of their right to contact the State Agency and the Ombudsman and where the contact information was located.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to implement a physician's order for double portions for 1 of 4 residents reviewed for nutrition (Resident #47). The findings included: Resident #47 was admitted on 01/04/17 with diagnoses including a history of adult failure to thrive (FTT). Review of a dietary assessment completed by the Registered Dietitian (RD) on 01/06/17 revealed Resident #47's current diet order was for a regular diet and a high protein, high calorie nutrition drink at bedtime. The RD noted Resident #47's current weight was 131 pounds and he did not trigger for nutritional status related to his body mass index but was at risk for skin break down due to immobility and had a history of adult FTT. The plan was to discontinue the order for the high protein, high calorie nutrition drink at bedtime, continue the regular diet, and add double portion entree at every meal for nutritional support. Review of the medical record revealed an order dated 01/06/17 written by the RD and signed by	F 281	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility. Such liability is specifically hereby denied. The submission of the plan does not constitute an agreement of the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. Corrective action for the alleged deficient practice was accomplished by resident #47's order was immediately changed to double portions with every meal. To ensure that others are not affected by the same alleged practice, a licensed nurse and the Dietary Manager will review all diet orders for all residents in the facility. We will reconcile any discrepancies in the orders. The licensed nurse is responsible for making sure all changes regarding diet are followed. The	2/14/17

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

Electronically Signed | 02/09/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 1 the physician to discontinue the high protein, high calorie nutrition drink and add double portion entree at every meal. Observations of Resident #47's lunch tray card 01/18/17 at 12:22 PM revealed he received a regular diet tray. There was no notation of the double portion entree on the tray card and the serving of lasagna on his plate did not appear to be a double serving. During an interview on 01/19/17 at 8:19 AM the Dietary Manager (DM) stated the RD came to the facility once a week and wrote orders for diets and supplements directly in the resident's medial record. The DM explained a carbon copy of dietary orders were placed in her box by the nursing staff and then she entered the orders into meal tracker (dietary computer system). On 01/19/17 at 11:21 AM the DM pulled up a list of all the residents' current diet orders for review. The list noted the residents' diet orders and there was also a column for special instructions including dislikes, double portions, and thickened liquids. Review of the list revealed Resident #47 was ordered a regular diet with no instructions for double portion entree at all meals. The DM confirmed the information from the diet order list printed out on the meal tray cards which the cooks and dietary aides reviewed while preparing residents' meal trays. The interview further revealed the DM was not aware of the order written by the RD on 01/06/17 for Resident #47 to receive double portion entree at all meals. During a follow up interview on 01/19/17 at 11:53 AM the DM stated she reviewed Resident #47's medical record and was not sure what happened	F 281	nurse will document this starting 2/6/17, and do so for 6 weeks, and it will be reported on during our next three QA meetings, involving the Administrator, Director of Nursing, MDS Coordinator, Infection Control Specialist, Treatment Nurse, Business Office Manager, Director of Social Services, Director of Health Information, Activities Director, Director of Rehab, Medical Director, and our Consultant Pharmacist. The system put in place is the Registered Dietician is to make an extra copy of her recommendation, and give the original order to the admitting nurse, and the copy directly to the Dietary Manager and attending Physician. The Corrective action will be monitored to ensure the alleged deficient practice will not reoccur. The Administrator will bring results of the licensed nurse's documentation to the monthly QA meeting for the next three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 2 with the order for double portions. The DM stated the nursing staff usually put the yellow copy of the order in her box and it was not his medical record. An interview with the RD on 01/20/17 at 9:30 AM revealed when she wrote an order the nurses typically signed off on the order and took it to the DM. The RD further stated when she wrote an order she expected it to be carried out. An interview was conducted with the Director of Nursing (DON) on 01/20/17 at 11:54 AM. The DON stated there was a nurse who worked Monday through Thursday responsible for signing off and transcribing orders and she and the nurse managers were responsible on Friday. The nurse supervisor was assigned this task on the weekends. The DON further stated the order for Resident #47 to receive a double portion entree at every meal written by the RD on 01/06/17 should have been signed, transcribed, and sent to the DM. The DON indicated she did not know where the breakdown had occurred or how the order had been missed.	F 281		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making	F 328		2/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 3	F 328		

appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 4 and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to administer oxygen at the physician ordered liters per minute rate and also administered oxygen to a resident without a physician order for 2 of 4 residents reviewed for oxygen therapy (Residents #39 and #25). The findings included: 1. Resident #39 was admitted on 05/14/15 with diagnoses including chronic obstructive pulmonary disease. Review of a care plan initiated on 05/25/16 revealed Resident #39 required assistance with an activities of daily living due to dementia, limited mobility, and osteoarthritis. Interventions included: Oxygen worn at 3 liters per minute during the night. Set up as needed. Will remove and apply ad lib (as desired). Review of the quarterly Minimum Data Set (MDS) dated 10/24/16 revealed Resident #39 was cognitively intact. Review of Resident #39's Physician's orders for January 2017 revealed an order initiated on 05/28/15 for oxygen at 3 liters per minute to be applied every night. Review of Resident #39's January 2017 Medication Administration Record (MAR) from	F 328	Corrective action for the alleged deficient practice was accomplished by resident #39's oxygen is being checked every 3-11 shift by a licensed nurse, starting on 2/6/17. We will continue to check her oxygen every 3-11 shift for 6 weeks. The nurse doing the checks will initial that the oxygen setting is correct. Regarding resident #25, we obtained an order for continuous Oxygen at 2L and are currently following it. All residents with an order for Oxygen have the potential to be effected. To ensure that others are not effected by the same alleged practice, a licensed nurse will check and document the Oxygen Liters for all residents on Oxygen daily, starting 2/6/17, for 6 weeks. The system put in place is a licensed nurse, weekly for the next six weeks (starting 2/6/17), will check and document that all Oxygen orders are correct, for all residents on Oxygen. The corrective action will be monitored to ensure the alleged deficient practice will not reoccur by the Administrator bringing results of weekly checks to the monthly QA meeting for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 5	F 328		

01/01/17 through 01/19/17 revealed nurses initialed the MAR during the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM next to physician's order for oxygen at 3 liters per minute to be applied every night.

Observations of Resident #39 revealed the following:
- On 01/18/17 at 8:38 AM Resident #39 was resting in bed with her eyes closed with oxygen in use via a nasal cannula. The flow meter on the oxygen concentrator was set at 1.5 liters per minute.
- On 01/19/17 at 8:29 AM Resident #39 was awake in bed with oxygen in use via a nasal cannula. The flow meter on the oxygen concentrator was set at 1.0 liters per minute. Resident #39 stated she only used the oxygen at night and proceeded to remove the nasal cannula and start eating her breakfast.
- On 01/20/17 at 7:58 AM Resident #39 was awake in bed without her oxygen in use.

During an interview on 01/20/17 at 11:53 AM the Director of Nursing (DON) stated Resident #39's oxygen flow meter should be set at 3 liters per minute during the night. The DON further stated she expected the nurses to verify Resident #39's flow meter was set at 3 liters per minute during the night.

Attempts to contact the nurse who care for Resident #39 during the 11:00 PM (01/19/17) to 7:00 AM (01/20/17) were not successful.

2. Resident #25 was admitted to the facility on 05/08/14 with diagnoses including chronic obstructive pulmonary disease and readmitted on 01/05/17 following a hospitalization due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 6	F 328		

bronchitis.

Review of the quarterly Minimum Data Set dated 11/28/16 revealed Resident #25 was cognitively intact and required oxygen therapy.

Review of Resident #25's medical record and Physician's orders for January 2017 revealed no orders for oxygen administration.

Observations of Resident #25 revealed the following:
- On 01/18/17 at 11:30 AM Resident #25 was observed resting in bed with oxygen in use via a nasal cannula. The flow meter on her oxygen concentrator was set at 2.5 liters.
- On 01/18/17 at 3:02 PM Resident #25 was observed in bed during a dressing change with oxygen in use via a nasal cannula. The flow meter on her oxygen concentrator was set at 2.5 liters.
- On 01/19/17 at 8:16 AM Resident #25 was observed in the dining room eating breakfast with oxygen in use via a nasal cannula. The oxygen tubing was attached to a portable oxygen tank on the back of her wheelchair with the flow meter set at 2 liters per minute.
- On 01/19/17 at 10:42 AM Resident #25 was observed resting in bed with oxygen in use via a nasal cannula. The flow meter on her oxygen concentrator was set between 2.0 and 2.5 liters.
- On 01/19/17 at 3:59 PM Resident #25 was observed resting in bed with oxygen in use via a nasal cannula. The flow meter on her oxygen concentrator was set between 2.0 and 2.5 liters.
- On 01/20/17 at 10:45 AM Resident #25 was observed resting in bed with oxygen in use via a nasal cannula.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 7 During an interview on 01/20/17 at 1:53 PM the Director of Nursing (DON) stated Resident #25 should have a Physician's order for her oxygen and did not know how this was missed when she was readmitted from the hospital on 01/05/17.	F 328		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to use proper hand hygiene before handling clean plastic cups, insulated coffee mugs, and insulated dome covers during observations of	F 371	Corrective action for the alleged deficient practice was accomplished by the Dietary Manager is to re-educate all Dietary Aides on proper hand washing policy. Any	2/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 8 dishwashing. The findings included: 1. A continuous observation of Dietary Aide #1 occurred during the initial tour of the kitchen on 01/17/17 from 9:23 AM until 9:33 AM and revealed the following: - On 01/17/17 at 9:23 AM Dietary Aide #1 was observed removing breakfast trays from a tray cart and rinsing food debris off the dishes, cups, silverware, and trays into the sink. She placed the rinsed dishes on a rack in front of the dishwashing machine. - On 01/17/17 at 9:27 AM Dietary Aide #1 was observed touching a full rack of inverted clear plastic cups with both hands to knock some of the water off bottom of the cups. The clear plastic cups had come out of the dishwashing machine a short time before. She also removed 3 insulated coffee mugs from another rack that had recently come out of the dishwashing machine and placed them on an adjacent shelf to dry. Dietary aide #1 did not wash her hands prior to touching the clean cups or mugs. - On 01/17/17 at 9:28 AM the Dietary Manager (DM) approached Dietary Aide #1 and spoke to her. Dietary Aide #1 went to the sink and washed her hands. - On 01/17/17 at 9:30 AM Dietary Aide #1 was observed removing breakfast trays from a tray cart and rinsing food debris off the dishes, cups, silverware, and trays into the sink. - On 01/17/17 at 9:33 AM Dietary Aide #1 was	F 371	dietary aide non-conforming will be disciplines up to and including termination. All residents have the potential to be effected. To ensure that others are not effected by the same alleged deficient practice, the Dietary Manager will hold weekly in-service on hand washing, starting week of 2/6/17, lasting 6 weeks. All dietary employees are to sign-in, at beginning of in-service. The system put in place is Dietary Manager will monitor the dish line daily (5 days per week) for 6 weeks, with a check-off list beginning 2/6/17. The corrective action will be monitored to ensure the alleged deficient practice will not reoccur by the dietary manager will bring results of audits to the monthly QA meeting for the next 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 9 observed touching 7 insulated dome covers from a rack that had come out of the dishwashing machine a short time before and placed them on an adjacent shelf to dry. Dietary Aide #1 did not wash her hands prior to touching the insulated dome covers. - On 01/17/17 at 9:33 AM Dietary Aide #1 went to the sink and washed her hands. During an interview on 01/17/17 at 9:45 AM Dietary Aide #1 stated she knew she was supposed to wash her hands before touching clean dishes and was not paying attention that morning. An interview with the DM on 01/17/17 at 9:48 AM revealed she expected the dietary aides to wash their hands before handling clean dishes and to wash their hands anytime they moved from the dirty to the clean area of the dish washing process.	F 371		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the	F 520		2/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 10 administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November 2015. This was for a recited deficiency which was originally cited in November 2015 on a recertification survey. The deficiency was in the area of food storage and sanitation. The continued failure during two federal surveys of record show a pattern of the facility's inability to	F 520	Corrective action for the alleged deficient practice was accomplished by the Dietary Manager re-educating all dietary aides on proper hand washing policy. Any Dietary Aide non-conforming will be disciplined up to and including termination. All residents have the potential to be effected. The Dietary manager is to hold weekly in-service on hand washing, starting week of 2/6/17, and lasting 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWWOOD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 11 sustain an effective Quality Assurance Program. The findings included: This tag was cross referred to: · F371 Food storage and Sanitation: The facility was recited for F371 for failure to use proper hand hygiene before handling clean plastic cups, insulated coffee mugs and insulated dome covers during observations of dishwashing. · F371 was originally cited during a recertification and complaint survey on 11/19/15 for failure to prevent the walk in cooler floor from developing rust, keep the kitchen floor free from dirt build-up and repair cracked tiles in the kitchen floor. During an interview conducted on 01/20/17 at 1:10 pm The Administrator stated he had only come to work at the facility in 01/2017. He stated he planned to have monthly Quality Assessment and Assurance committee meetings and they will focus on any new and prior citations to make sure the facility stay's in compliance with the regulations.	F 520	weeks. All dietary employees are to sign-in, at beginning of in-service. Dietary manager to monitor the dish line daily (5 days per week), for 6 weeks, with a check-off list. This will start on 2/6/17. To ensure that others are not affected by the same alleged practice, the Administrator will meet weekly with the Dietary Manager, to discuss the results of the in-services/ line audits for 6 weeks, starting the week of 2/6/17. The Administrator will meet weekly with the Dietary Manager and Regional Dietary manager, to discuss the results of the in-services/ line audits for six weeks (as well as any other issues) starting the week of 2/6/17. The corrective action will be monitored to ensure the alleged deficient practice will not reoccur by the Administrator reporting the results of these meetings during monthly QA meetings for the next 3 months.	