STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		2/6/18

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

Electronically Signed | 02/05/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and Nurse Practitioner interviews, the facility failed to notify the Nurse Practitioner of a resident fall for 1 of 3 (Resident # 1) sampled for falls. Findings included: The resident was admitted to the facility on 4/10/16 with diagnosis including: Frontotemporal Dementia, Picks Disease and Degenerative Disc Disease. A review of the most recent Quarterly Minimum Data Set (MDS) assessment dated 1/9/18 revealed the resident required extensive assistance with 2 people for bed mobility and extensive assistance assist of one person for transfers. The resident was ambulatory with a walker. A review of the medical record on 1/23/18 at 10:30 AM revealed a nurses note on 1/11/18 at 2300, the resident was lowered to the floor with the assistance of the nursing assistant when his legs became weak. The responsible party was notified. A further review of the medical record did not indicate that the Nurse Practitioner had been	F 580	Facility failed to notify Nurse Practitioner of a resident fall. It was an oversight/human error that the nurse forgot to call the NP about a residents fall. 1. Nursing staff failed to inform Physician or NP of fall in timely manner. Medical Director and NP have been made aware of resident #1 having had a fall. A 100% audit of all falls in the last 30 days was completed by the Center Nurse Executive to ensure MD/NP/responsible party notification is completed and documented. The CNE or Assistant Center Nurse Executive will complete training for licensed nurses on notifying the MD/NP for all events/changes of conditions in a timely manner. Handbooks will be placed at all nurses' stations for quick references for events and changes of conditions. All events will be reviewed 5 times per week in the clinical morning meeting/stand up to ensure notification of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 notified. A phone interview on 1/23/18 at 10:25 AM revealed she was on duty on the 11th and was going to change the residents' bed because it was wet. She asked the resident to stand and his legs became weak so she assisted him to the floor. She stated she called for assistance, notified the nurse and got the residents blood pressure. An interview with the Nurse Practitioner on 1/23/18 at 11:45 AM revealed she was not notified of the incident on 1/11/18 where the resident was lowered to the floor. She further revealed she would have expected to be notified due to the resident's history and his previous fall on 1/8/18 with fractures of T11 and L1. A phone interview on 1/23/18 at 12:56 PM with the Nurse #1, who was on duty on 1/11/18 when the incident occurred, revealed the nursing assistant called her to the room and she entered to find the resident sitting on the floor. She revealed the nursing assistant told her the residents' legs became weak and she assisted him to the floor. The nurse revealed she did not notify the Nurse Practitioner because she didn't consider the incident a fall. She revealed she notified the responsible party and added the incident to the change of condition that was already in the system from the fall on 1/8/18. An interview with the Director of Nursing on 1/24/18 at 8:44 AM revealed a fall is any change from one surface to another, including sliding out of a bed or a wheelchair or being assisted to the floor. She revealed she did consider the incident on 1/11 with this resident to be a fall and would	F 580	MD/NP/RP was completed and documented. Results of these audits will be brought to the monthly Quality Assurance and Performance Improvement Committee for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN CENTER	**707 NORTH ELM STREET HIGH POINT, NC 27262**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 have expected the nurse to assess the resident, call the physician or Nurse Practitioner on duty, complete a change of condition and notify the responsible party. She stated that the facility has conducted inservicing following this incident on what was considered a fall and what actions to take.	F 580		