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 _____	C 03/01/2018

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID # I9GO11.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the	F 565		3/22/18

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

Electronically Signed | 03/22/2018

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F 565	Continued From page 1 families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews, the facility failed to resolve and communicate the facility's efforts to address concerns voiced during Resident Council meetings for 6 consecutive months (September 2017, October 2017, November 2017, December 2017, January 2018, and February 2018). Findings included: The Resident Council minutes for the period September 2017 through February 2018 were reviewed and revealed the following: Resident Council minutes dated 09/22/17 indicated residents had voiced concerns related to food. Resident Council minutes dated 10/18/17 indicated residents had voiced concerns related to food and food menu and nurse aides were not answering call lights on second shift in a timely manner. There was no evidence of the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. Resident Council minutes dated 11/15/17 indicated residents had voiced concerns related to food and not having enough nurse aides to accomplish the amount of help needed in a timely manner. There was no evidence the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed.	F 565	1- A review of the complaint/ grievance process has been conducted noting that Resident Council concerns were inconsistently logged on the complaint/ grievance tracking tool and managed accordingly. The Facility will generate a complaint/ grievance form for each voiced concern during Resident Council meetings; ensuring prompt follow up and communication of the same. Complaints/ grievances will be investigated promptly with resolution communicated and documented. The results of the investigation will be reported back to the resident council at the next meeting under "old business". 2- The facility has reviewed the voiced and documented complaints/ grievances from Resident Council meetings from September 2017 through February 2018. Each complaint/ grievance has been logged onto a complaint/ grievance form, investigated, with resolution noted. These complaints/ grievances received during the resident council meetings from September 2017 through February 2018. Audit findings reflect food concerns related to menu items and/or the preparation of the same and a request for increased staffing. All findings have been investigated and a resolution activated. These complaints/ grievances and resolutions were discussed during the resident council meeting which occurred on 3/21/18 under "old business". Minutes	

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F 565	Continued From page 2 Resident Council minutes dated 12/27/17 indicated residents had voiced concerns related to food and laundry. There was no evidence the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. Resident Council minutes dated 01/24/18 indicated residents had voiced concerns related to food. There was no evidence the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. Resident Council minutes dated 02/21/18 indicated residents had voiced concerns related to food. There was no evidence the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. On 02/28/18 at 2:04 PM an interview was conducted with the Resident Council group including the Resident Council President who stated staff did not address Resident Council concerns. The Resident Council stated they complained of food services each month and received no resolution to their concerns. The Resident Council group stated the Activity Director attended each meeting and wrote down the Resident Council's concerns but they received no feedback regarding on-going concerns. The Resident Council President stated the facility's response to concerns voiced by the Resident Council during previous meetings was not discussed. On 02/28/18 at 3:20 PM an interview was	F 565	from the 3/21/18 resident council meeting confirms this action. 3- A review of the complaint/ grievance process has been conducted. Reinforcement of the process continues. The complaint/ grievance form in use and summary log of those complaints/ grievances shall be maintained reflecting a tracking and trending of the investigative process, resolution, and communication of the findings to complainant in a timely manner. The facility Social Services representative will be responsible for the oversight of this process; ensuring process compliance. All staff, which includes Full Time, Part Time, and Per Diem employees will be in serviced on the complaint/ grievance process for clarity. Complaint/ grievance forms are readily available for all resident, visitors, and staff to complete upon learning of any complaints. 4- The LNHA is responsible for POC implementation and compliance. The Quality Assessment and Assurance (QAA) team and its members will be responsible for the ongoing monitoring of this process through 1)Monday through Friday morning meetings conducted by the facility Social Services representative asking about any received complaints/ grievances since the last morning meeting. The Social Services representative will be responsible for ensuring a complaint/ grievance form has been activated; ensuring the investigation has been activated, concluded, and communicated in accordance with facility policy. 2) Social Services representative will	

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F 565	Continued From page 3 conducted with the Administrator who stated he did not have a system in place that provided feed back to the Resident Council regarding old business and concerns from the prior meeting. The Administrator stated old business was not discussed during each meeting and concerns voiced by the Resident Council during previous meetings were not reviewed during the meeting. On 03/01/18 at 1:51 PM an interview was conducted with Activity Director (AD) who stated she facilitated all Resident Council meetings and recorded the meeting minutes for the period September 2017 through February 2018. The AD stated she provided a copy of the minutes to each department head and the administrator. The AD stated she did not discuss old business with the Resident Council and had no system in place to determine if prior concerns of the Resident Council were resolved. The AD acknowledged the facilities efforts to address the concerns voiced by the residents during previous meetings were not reviewed or discussed during the next Resident council meeting. The AD stated she did not know that she was supposed to discuss old business and prior concerns with the Resident Council. On 03/01/18 at 2:15 PM an interview was conducted with the Administrator who stated his expectation was that the Activity Director would have addressed concerns during the previous month's Resident Council meeting with the members to determine if old business had been resolved. The Administrator stated a system was not in place to address the previous month's Resident Council meeting concerns to determine if they had been resolved. The Administrator stated his expectation going forward was that the AD would discuss as old business the results of	F 565	conduct a complaint/ grievance form and log review monthly, ensuring all complaints/ grievances are to be logged, evaluated, resolution achieved, and results communicated. All findings will be promptly addressed with responsive action and reported to the QAA team during routine meetings. After three (3) months, the QAA Coordinator and LNHA will determine the frequency of ongoing audits and processes, but will not occur less than quarterly for one (1) year. Date of compliance: 3/29/18	

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F 565	Continued From page 4 the investigation regarding Resident Council concerns during the next Resident council meeting.	F 565		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, policy and record review, and resident and staff interviews, the facility failed to follow their abuse policy and procedure in the area of reporting for 1 of 1 sampled resident (Resident #27) who had a bruise of unknown origin to the left cheek along the nasolabial fold (smile line). Findings included: A review of the facility policy and procedure titled "Abuse, Neglect, Misappropriation, Mistreatment" dated February 2017 read in part: Procedure: An injury of unknown source exists when the source of the injury was not observed by any person or could not be explained by resident and the injury is suspicious because of	F 607	1- Resident #27 remains at baseline and her facial bruise has resolved. A review of the facility's abuse investigation and decision regarding reporting of an injury of unknown origin (e.g. bruising) was not in accordance with the facility policy. No revisions to the policy is needed at this time. The process is being strengthened by the initiation of education and auditing. 2- The facility has conducted a review of incident reports and progress notes generated over the last thirty (30) days along with observation rounds of current residents to determine possible injuries of unknown origin; confirming compliance with facility policy specific to reporting. The audit was completed, identifying two (2) residents with small bruises. Both	3/22/18

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F 607	Continued From page 5 the extent of the injury or the location of the injury (area not generally vulnerable to trauma). Reporting: The facility will ensure all allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility or the Abuse Coordinator and to the State Agency (SA) immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The results of the investigation must be reported in accordance with state law within 5 working days after the incident. Resident #27 was admitted to the facility on 12/04/17 with diagnoses that included rectal bleeding, acute blood loss anemia, history of deep vein thrombosis (blood clot of a vein deep inside the body), and late onset Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) dated 01/15/18 indicated Resident #27 had moderate impairment in cognition and required extensive to total staff assistance with all activities of daily living except for eating. The MDS revealed Resident #27 had impairment on one side of the upper extremity and both sides of the lower extremities. Review of the incident report dated 02/22/18 revealed Resident #27 was observed by Nurse #1 to have bruising to the left side of the cheek. Review of the facility's post fall assessment/investigation form completed by	F 607	residents are alert and oriented and confirm the absence of abuse or rough handling. Care plans are present identifying the potential for bruising for both residents. 3- A review of the facility's abuse policies which includes reporting suspicion of a crime policies have been reviewed. No revisions are needed at this time. No revisions are needed at this time. All staff, which includes Full Time, Part Time, and Per Diem employees will be in serviced on reporting suspicion of a crime within two (2) hours and completing facility reported incidents processes remains the responsibility of the NHA. 4- The LNHA is responsible for POC implementation and compliance. The Quality Assessment and Assurance (QAA) team and its members will be responsible for the ongoing monitoring of this process through 1) daily review of the 24 hour report by the Director of Nursing (DON) and/ or charge nurse where injuries of unknown origin are documented will be conducted; resulting in prompt reporting and investigation of injuries of unknown origin in accordance to facility policy. 2) Review of weekly skin checklists by the DON and/or charge nurse to identify, promptly report, and investigate injuries of unknown origin. All findings will be promptly addressed with responsive action and reported to the QAA team during routine meetings. After three (3) months, the QAA Coordinator and LNHA will determine the frequency of ongoing audits and processes, but will occur not less than quarterly for one (1) year.	

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F 607	Continued From page 6	F 607	Date of compliance: 3/29/18	

Nurse #1 and attached to the incident report read in part, resident lying in bed when discovered, no witnessed fall, call bell in reach.

Review of the investigation completed by the Director of Nursing (DON) related to Resident #27's injury of unknown origin revealed the following:

Nurse Aide (NA) #1 statement dated 02/22/18 at 2:00 PM read in part, "went in to check on resident, noticed a bruise on the left cheek." Activity Director (AD) statement dated 02/22/18 at 3:30 PM read in part, "on 02/21/18 during activities, around 2:30 PM, I was sitting beside Resident #27 reading a book and noticed a very light discoloration on her left side of face near her mouth. I asked Resident #27 what happened to her face, she said she did not know anything was there. I believed nursing already knew this."

An observation of Resident #27 on 02/26/18 at 12:00 PM revealed her sitting up in the geri-chair leaning toward the right side. She had a dark purple bruise to the left cheek along the nasolabial fold approximately 3 inches long and quarter inch wide from the tip of the nose to chin.

During an interview on 02/27/18 at 8:56 AM Resident #27 was unaware of the bruising to her left cheek and unable to recall how it had occurred.

Telephone attempts to contact Nurse #1 on 03/01/18 at 10:07 AM and 1:49 PM for an interview were unsuccessful.

During an interview on 03/01/18 at 2:30 PM the DON stated she expected staff to notify her of a

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F 607	Continued From page 7	F 607		

resident's injuries or bruises of unknown origin as soon as they were identified. She confirmed she was notified of the bruising to Resident #27's left cheek on 02/22/18 and an investigation was conducted. She added the bruise on Resident #27's cheek was not an area normally susceptible to trauma. She stated they were unable to determine what caused the bruise to Resident #27's cheek and explained the bruising could be related to Resident #27's diagnoses or due to an injury sustained during routine personal care, "that is why we don't know." The DON stated she felt the bruise was an injury of unknown origin and had recommended to the Administrator that he report it to the State Agency (SA). The DON confirmed the Administrator was responsible for submitting all 24-hour and 5-day reports to the SA.

Telephone attempt to contact NA #1 on 03/01/18 at 3:18 PM for an interview was unsuccessful.

During an interview on 03/01/18 at 3:52 PM the Administrator confirmed he did not submit a 24-hour or 5-day report to the SA related to Resident #27's injury of unknown origin. The Administrator stated Resident #27's bruising was "explainable" due to her "anemia and plethora of other diagnoses." He added he did not feel it was reportable because the location of the bruising was in an area that was susceptible to trauma during routine personal care.

During an interview on 03/01/18 at 4:07 PM the AD recalled on 02/21/18 she had noticed a "light but noticeable mark" on Resident #27's left cheek. The AD stated she had assumed nursing was aware and confirmed she had not reported the bruising to anyone at that time.

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to submit a 24-hour and 5-day report to the State Agency for 1 of 1 sampled resident (Resident #27) who had a bruise of unknown origin to the left cheek along the nasolabial fold (smile line).	F 609	1- Resident #27 remains at baseline and her facial bruise has resolved. A review of the facility's abuse investigation and decision regarding reporting of an injury of unknown origin (e.g. bruising) was not in accordance with the facility policy. No revisions to the policy are needed at this	3/22/18

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F 609	Continued From page 9 Findings included: Resident #27 was admitted to the facility on 12/04/17 with diagnoses that included rectal bleeding, acute blood loss anemia, history of deep vein thrombosis (blood clot of a vein deep inside the body), and late onset Alzheimer's disease. Review of the quarterly Minimum Data Set (MDS) dated 01/15/18 indicated Resident #27 had moderate impairment in cognition and required extensive to total staff assistance with all Activities of Daily Living (ADL) except for eating. The MDS revealed Resident #27 had impairment on one side of the upper extremity and both sides of the lower extremities. Review of the incident report dated 02/22/18 revealed Resident #27 was observed by Nurse #1 to have bruising to the left cheek. Review of the facility's post fall assessment/investigation form completed by Nurse #1 and attached to the incident report read in part, resident lying in bed when discovered, no witnessed fall, call bell in reach. Review of the investigation completed by the Director of Nursing (DON) related to Resident #27's injury of unknown origin revealed the following: Nurse Aide (NA) #1 statement dated 02/22/18 at 2:00 PM read in part, "went in to check on resident, noticed a bruise on the left cheek." Activity Director (AD) statement dated 02/22/18 at 3:30 PM read in part, "on 02/21/18 during activities, around 2:30 PM, I was sitting beside Resident #27 reading a book and noticed a very	F 609	time. The process is being strengthened by the initiation of education and auditing. 2- The facility has conducted a review of incident reports and progress notes generated over the last thirty (30) days along with observation rounds of current residents to determine possible injuries of unknown origin; confirming compliance with facility policy specific to reporting. The audit was completed identifying two (2) residents with small bruises. Both residents are alert and oriented and confirm the absence of abuse or rough handling. Care plans are present identifying the potential for bruising for both residents. 3- A review of the facility's abuse policies which include reporting of injuries of unknown origin as a facility reporting incident within 24 hours along with a five(5) day report to the State Agency have been reviewed. The Administrator will be re in serviced on the above policy and regulation. 4- The LNHA is responsible for POC compliance. The Quality Assessment and Assurance (QAA) team and its members will be responsible for the ongoing monitoring of this process through 1) Daily review of the 24 hour report by the Director of Nursing (DON) and/or charge nurse where injuries of unknown origin are documented will be conducted; resulting in prompt reporting of injuries of unknown origin in accordance to facility policy. 2) Monthly for three (3) months a review by the Director of Nursing of FRI's submitted confirming compliance with facility policy; and 3) after three (3)	

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F 609	Continued From page 10 light discoloration on her left side of face near her mouth. I asked Resident #27 what happened to her face, she said she did not know anything was there. I believed nursing already knew this." An observation of Resident #27 on 02/26/18 at 12:00 PM revealed her sitting up in the geri-chair leaning toward the right side. She had a dark purple bruise to the left cheek along the nasolabial fold approximately 3 inches long and quarter inch wide from the tip of the nose to chin. During an interview on 02/27/18 at 8:56 AM Resident #27 was unaware of the bruising to her left cheek and unable to recall how it had occurred. During an interview on 02/28/18 at 12:20 PM NA #2 stated Resident #27 required extensive staff assistance with most ADL and was unable to transfer without the assistance of 2 staff members using a mechanical lift. NA #2 added Resident #27 tended to lean toward the right side when sitting up in bed or the geri-chair and was unable to independently reposition self. NA #2 indicated she noticed the bruising to Resident #27's check when she returned to work at the beginning of the week. NA #2 added she reported the bruising to the Nurse and was informed it had already been addressed. Telephone attempts to contact Nurse #1 on 03/01/18 at 10:07 AM and 1:49 PM for an interview were unsuccessful. During an interview on 03/01/18 at 2:30 PM the DON stated she expected staff to notify her of a resident's injuries or bruises of unknown origin as soon as they were identified. She confirmed she	F 609	months, the QAA Coordinator an LNHA will determine the frequency of ongoing audits and processes, but will occur not less than quarterly for one (1) year. Date of compliance: 3/29/18.	

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F 609	Continued From page 11	F 609		

was notified of the bruising to Resident #27's left cheek on 02/22/18 and an investigation was conducted. She added the bruise on Resident #27's cheek was not an area normally susceptible to trauma. She stated they were unable to determine what caused the bruise to Resident #27's cheek and explained the bruising could be related to Resident #27's diagnoses or due to an injury sustained during routine personal care, "that is why we don't know." The DON stated she felt the bruise was an injury of unknown origin and had recommended to the Administrator that he report it to the State Agency (SA). The DON confirmed the Administrator was responsible for submitting all 24-hour and 5-day reports to the SA.

An observation of Resident #27 on 03/01/18 at 2:44 PM revealed her sitting back in the geri-chair leaning toward the right side. Resident #27 was unable to move her right arm and could slowly move her left hand to her face but not with enough force to cause bruising.

Telephone attempt to contact NA #1 on 03/01/18 at 3:18 PM for an interview was unsuccessful.

During an interview on 03/01/18 at 3:52 PM the Administrator confirmed he did not submit a 24-hour or 5-day report to the SA related to Resident #27's injury of unknown origin. The Administrator stated Resident #27's bruising was "explainable" due to her "anemia and plethora of other diagnoses." He added he did not feel it was reportable because the location of the bruising was in an area that was susceptible to trauma during routine personal care.

During an interview on 03/01/18 at 4:07 PM the

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F 609	Continued From page 12 AD recalled on 02/21/18 she had noticed a "light but noticeable mark" on Resident #27's left cheek. The AD stated she had assumed nursing was aware and confirmed she had not reported the bruising to anyone at that time.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code 1 of 5 sampled residents reviewed for accidents utilizing the Minimum Data Set (MDS) to reflect bed and chair alarm (Resident #38). Findings included: Resident #38 was admitted to the facility on 05/21/15 with diagnoses of dementia. A review of the fall care plan that was initiated on 06/03/15 indicated Resident #38 required a sensor alarm at all times to alert staff of unsafe movements. A review of the physician's monthly orders for January 2018 that were signed by the physician indicated Resident #38 was to have a sensor alarm to his bed and wheelchair for fall risk. A review of physician's monthly orders for February 2018 that were signed by the physician indicated Resident #38 was to have a sensor alarm to his bed and wheelchair for fall risk.	F 641	1- A correction to Resident #38's Minimum Data Set assessment (MDS) with an Assessment Reference Date (ARD) of 2/5/18 to Section P noting the use of a bed and chair alarm has been completed and submitted by 2/27/18. The facility's MDS policy and RAI manual guidance and the nurse's observation and MDS coding were reviewed noting inconsistent practices related to the use of personal safety alarms on the MDS. No revisions to the policy are needed. The process is being strengthened by the initiation of education and auditing. 2- A facility wide review of the most recent MDS for current residents has been conducted; ensuring accurate coding of personal safety alarms in section P of the MDS. The audit confirms that section P related to personal safety alarm use was accurately coded on all current residents during his/her most recent MDS. 3- A review of the facility's MDS policy has been reviewed. No revisions are needed. The facility has the most current RAI	3/22/18

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F 641	Continued From page 13 A review of the quarterly MDS assessment dated 02/05/18 indicated under Section P0200. Alarms (an alarm was any physical or electronic device that monitored resident movement and alerted the staff when movement was detected) that Resident #38 was not coded as using a bed and chair alarm daily. On 02/27/18 at 1:39 PM an interview was conducted with the MDS Coordinator who stated she coded Section P0200 Alarms on Resident #38's quarterly MDS assessment dated 02/05/18. The MDS Coordinator stated Resident #38 should have been coded under Section P to indicate a bed and chair alarm was used daily and was missed for coding. The MDS Coordinator stated she would have to submit a modification to the quarterly MDS assessment dated 02/05/18 to reflect under Section P that Resident #38 used a bed and chair alarm daily. On 02/27/18 at 2:31 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the quarterly MDS assessment dated 02/05/18 would have been accurately coded under Section P to reflect Resident #38 used a bed and chair alarm daily. The DON stated it was her expectation that the MDS Coordinator would submit a modification to the quarterly MDS assessment dated 02/05/18 to indicate Resident #38 used a bed and chair alarm daily. On 02/27/18 at 2:34 PM an interview was conducted with the Administrator who stated his expectation was that the quarterly MDS assessment dated 02/05/18 would have been accurately coded under Section P to reflect	F 641	manual at its disposal. The MDS nurse responsible for completing section P was re-educated on the appropriate coding for section P; confirming understanding. 4- The LNHA is responsible for POC implementation and compliance. The Quality Assessment and Assurance (QAA) team and its members will be responsible for the ongoing monitoring of this process through the 1) MDS nurse will review physician orders, care plans related to safety, and Medication Administration Records (MARs)for personal safety alarms in use for the residents prior to completing and submitting the MDS'. 3) The Director of Nursing (DON) or charge nurse will review up to 30% of section P on completed MDS prior to submission; confirming accuracy of section P specific to the coding of personal safety alarms monthly for three (3) months. All findings will be promptly addressed with corrections or modifications allowed in accordance with the RAI manual with findings reported to the QAA team during routine meetings. After three (3) months, the QAA Coordinator and LNHA will determine the frequency of ongoing audits, but will occur not less than quarterly for one (1) year. Date of compliance: 3/29/18	

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F 641	Continued From page 14 Resident #38 used a bed and chair alarm daily. The Administrator stated it was his expectation that the MDS Coordinator would submit a modification to the quarterly MDS assessment dated 02/05/18 to indicate Resident #38 used a bed and chair alarm daily.	F 641		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 review and staff interviews, the facility failed to obtain a physician's order for the use of a chair alarm for 1 of 2 sampled residents (Resident #13) observed with a personal alarm, failed to obtain a physician's order to discontinue the use of a chair and bed alarm for 1 of 2 sampled residents (Resident #27) with orders for a personal alarm, and failed to transcribe an order for contact isolation precautions for 1 of 1 sampled resident (Resident #189) reviewed for infection. Finding included: 1. Resident #13 was admitted to the facility on 01/08/16 with diagnoses that included dementia, psychosis, unspecified visual loss, anxiety, and hallucinations. Review of the annual Minimum Data Set (MDS) dated 12/11/17 coded Resident #13 with moderate impairment in cognition and required	F 658	1- Resident #13's personal safety alarm was removed from the wheel chair. An order to discontinue Resident #27's personal safety alarm was secured. Resident #27's MAR and care plan were amended noting the removal of personal safety alarms as a safety intervention. A physician's order was obtained to support the initiation of contact precautions on 3/1/18 for Resident #189. Resident's antibiotic course has concluded resulting in an order for the discontinuation of contact precautions on 3/11/18. Facility processes and related practices for processing physician orders and care plan revisions with the use and discontinuation of safety alarms and contact precautions were inconsistently followed by the licensed nurse(s). Facility policies need no revisions. The process is being strengthened by the initiation of education and auditing.	3/22/18

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F 658	Continued From page 15 extensive staff assistance with all Activities of Daily Living (ADL). The MDS indicated Resident #13 had one fall with no injury during the 7-day assessment period. Further review revealed bed or chair alarms were not used. Review of Resident #13's medical record revealed no physician's order for the use of a chair or bed alarm. An observation of Resident #13 on 02/28/18 at 2:12 PM revealed a chair alarm on the back of the wheelchair with the cord clipped to the back of her shirt. During an interview on 02/28/18 at 12:20 PM Nurse Aide (NA) #2 stated Resident #13 required staff assistance with most ADL due to poor vision and safety awareness. NA#2 confirmed Resident #13 had a chair alarm that would alert staff any time she attempted to get up unassisted. During an interview on 03/01/18 at 11:00 AM the DON stated it was her expectation physician orders were obtained when personal alarms were put into place as a safety intervention or discontinued when no longer needed. The DON was unaware a personal alarm had been placed on Resident #13's wheelchair and added there was no indication of need noted in Resident #13's medical record for a personal alarm. The DON stated she observed the personal alarm on the back of Resident #13's wheelchair and confirmed there was no physician's order. 2. Resident #27 was admitted to the facility on 12/04/17 with diagnoses that included history of deep vein thrombosis and late onset Alzheimer's	F 658	2- A facility wide review of current residents was conducted evaluating the 1) presence of personal safety alarms and coinciding orders and care plans for personal safety alarms and 2) the presence of transmission- based precautions and coinciding order for the same. The audit confirms the presence of physician orders for all residents using personal safety alarms. The audit reassessed a resident's need for the personal safety alarm; resulting in the 1) discontinuation of three (3) personal safety alarms. Resident care plans have been amended to reflect the personal safety alarm changes. Lastly, the facility has no residents requiring transmission-based precautions nor care plans noting transmission-based precautions as an intervention. 3- A review of facility policies related to 1) processing physician orders, 2) fall risk strategies specific to personal safety alarms, and 3) activation of transmission-based precautions has been conducted. No revisions to these policies are needed. All Full Time, Part Time, and Per Diem licensed nurses will be in serviced on the above policies/ processes, while the nursing assistants will be re in serviced to the fall risk strategies specific to personal safety alarm policy. 4- The LNHA is responsible for POC compliance. The Quality Assessment and Assurance (QAA) team and its members will be responsible for the ongoing monitoring of this process through the 1) weekly DON and charge nurse rounds for	

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F 658	Continued From page 16 disease. Review of the quarterly MDS dated 01/15/18 coded Resident #27 with moderate impairment in cognition and required extensive to total staff assistance with all ADL except for eating. The MDS revealed bed and chair alarms were used daily. Review of Resident #27's fall care plan, last reviewed on 01/23/18, revealed she was at risk for falls due to poor balance, use of psychotropic medications and poor cognition. Interventions included the use of a personal alarm at all times. Review of the February 2018 medication administration record for Resident #27 revealed an order dated 12/29/17 which read, personal alarm at all times. Review of Resident #27's medical record revealed no physician order to discontinue the use of the personal alarm. Observations of Resident #27 on 02/27/18 at 11:38 AM, 02/28/18 at 9:03 AM and 03/01/18 at 2:44 PM revealed no personal alarm on the bed or geri-chair. During an interview on 02/28/18 at 12:20 PM Nurse Aide (NA) #2 stated Resident #27 required staff assistance for all transfers and did not attempt to get up unassisted. NA#2 confirmed Resident #27 did not have a bed or chair alarm. During an interview on 03/01/18 at 11:00 AM the DON stated it was her expectation physician orders were obtained when personal alarms were put into place as a safety intervention or	F 658	four (4) weeks evaluating the use of personal safety alarms and activation of contact precautions; ensuring the appropriateness of the same, the presence of supportive orders, and care plan interventions. 2) Monday through Friday reviews of all new orders as written on the discharge summaries and confirmed by the resident's attending physician. 3) Quarterly care plan reviews for residents with personal safety alarms and contact precautions shall be conducted by the care plan coordinator; confirming compliance with the care planned interventions. All findings will be promptly addressed with responsive action and reported to the QAA team during routine meetings. After three (3) months, the QAA Coordinator and LNHA will determine the frequency of ongoing reviews, but shall occur not less than quarterly for one (1) year. Date of compliance: 3/29/18	

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F 658	Continued From page 17	F 658		

discontinued when no longer needed. The DON confirmed Resident #27 no longer required the use of a personal bed or chair alarm. The DON added she would have expected for staff to obtain a physician's order when the alarms were discontinued.

3. Resident #189 was originally admitted to the facility on 11/18/16 and readmitted following a hospital stay on 02/23/18 with diagnoses that included respiratory failure, dyspnea, COPD, and heart failure.

Review of the quarterly MDS dated 01/22/18 coded Resident #189 with intact cognition. The MDS indicated Resident #189 had no infections and did not receive antibiotic medication during the assessment period.

Review of Resident #189's infection care plan, last reviewed on 02/23/18, revealed she had a urinary tract infection and contact precautions were in place. Interventions included contact precautions with care and antibiotic therapy as ordered.

An observation on 02/26/18 at 2:28 PM revealed a contact isolation precaution sign hanging on Resident #189's bedroom door which read: perform hand hygiene, gloves when entering room, gowns for direct patient care whenever clothing may come in contact.

During an interview on 03/01/18 at 11:00 AM the DON indicated physician orders were obtained when a resident was placed on isolation precautions and when isolation precautions were removed. The DON confirmed there was no

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F 658	Continued From page 18 physician's order for contact isolation precautions for Resident #189. She added Resident #189's need for contact isolation precautions was documented on the hospital discharge summary and the nurse forgot to transcribe the order upon her return to the facility.	F 658		
F 812 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 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 defrost an ice cream freezer and failed to label and date multiple portion food items discovered in the ice cream freezer and 2-door standing freezer. The facility also failed to maintain sanitary walls behind the dishwashing machine and failed to ensure the floor of the walk-in cooler was free of standing water.	F 812	1- The ice cream freezer has been defrosted. The frozen, undated frozen chicken parts, biscuits, bread, and beans were discarded. The wall behind the dishwasher has been cleaned. The standing water near the walk-in cooler was removed. The floor threshold in the walk-in cooler was replaced. Kitchen is	3/22/18

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F 812	Continued From page 19 Findings included: Observations conducted during the initial tour of the kitchen on 02/26/18 at 10:30 AM with the Dietary Manager (DM) revealed the following: 1. An ice cream freezer with top sliding doors had approximately 3 inches of thick ice accumulation along the inside walls of the freezer with one 8-ounce container of ice cream stuck in the ice on the top of the back wall of the freezer. The freezer also contained 4 clear plastic bags of frozen chicken parts that were not dated or labeled. 2. A standing 2-door reach-in freezer contained: one clear bag of frozen biscuits that was not labeled or dated, an opened loaf of bread that was not dated and one opened bag of beans that was not dated. 3. The wall behind the dishwashing machine was observed with dark black build-up that looked like mildew. 4. Standing water was observed on the right side of the floor of the walk-in cooler underneath the wire shelving unit. During an interview on 02/26/18 at 10:30 AM the DM explained she had been employed for less than a week and was still in the process of learning the kitchen procedures. The DM confirmed the ice cream freezer had ice accumulation along the inside walls and needed to be defrosted. The DM stated it was her expectation for food items to be dated and labeled when opened or removed from the	F 812	free from standing water. The dietary employees inconsistently followed policies/ processes related to food storage, cleaning schedules, and equipment checks. The process is being strengthened by the initiation of education and auditing. 2- A full kitchen review was conducted to further review practices surrounding uncooked food storage, cleaning schedules, equipment functionality, and infection control practices. The facility, along with the Food Service contractor and Certified Dietary Manager (CDM) are actively addressing findings. 3- The facility has reviewed the policies or schedules of its' contract food service company, HSG; confirming the presence of compliance guidelines for 1) food storage, 2) cleaning schedules of walls, and 3) equipment functionality checks. No revisions are needed at this time. All dietary staff (Full time, Part time, and Per Diem) will be re in serviced to the noted policies and above. 4- The LNHA is responsible for POC compliance. The Quality Assessment and Assurance (QAA) team and its members will be responsible for the ongoing monitoring of this process through the 1) Daily Kitchen rounds by the certified dietary manager (CDM) or cook; ensuring compliance with food storage, cleaning schedules, equipment functionality. 2) Weekly rounds for four (4) weeks, then monthly for three (3) months by the NHA, of the kitchen using a Food Service Audit tool to evaluate regulator compliance with food storage, wall cleaning schedules,	

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F 812	Continued From page 20 original carton and placed in the freezer. The DM added she felt staff were not aware they needed to label and date frozen items when placed in the freezer. The DM stated she had not noticed the black buildup on the wall behind the dishwashing machine and confirmed it needed cleaned. She was unaware if kitchen walls were part of the daily or weekly cleaning schedule. The DM stated she noticed the water on the floor of the walk-in cooler earlier in the morning and could not determine where it was coming from. She indicated maintenance would need to be notified. An interview on 02/28/18 at 3:20 PM with the Administrator revealed he was aware of the concerns observed during the initial tour of the kitchen and expected food items to be dated and labeled. He explained they had previously put systems in place to monitor the cleaning of the kitchen, labeling of food items and maintenance of equipment. He added improvement was a constant work in progress.	F 812	and equipment functionality checks. All findings will be promptly addressed with responsive action and reported to the QAA team during routine meetings. After three (3) months, the QAA Coordinator and LNHA will determine the frequency of ongoing reviews, but will not be less than quarterly for one (1) year. Date of Compliance: 3/29/18	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had	F 867	1- A review of the past three (3) monthly Quality Assessment and Assurance (QAA) meeting minutes has been conducted. Documentation related to physician's order variances and kitchen cleaning/	3/22/18

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F 867	Continued From page 21 previously put into place. This failure related to two recited deficiencies that were originally cited following the 01/20/17 recertification survey and recited again on the current recertification and complaint survey. The recited deficiencies were in the areas of services provided meet professional standards and food procure, store/prepare/serve - sanitary. The continued failure of the facility during four federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 1.a. 483.20 Services provided meet professional standards: Based on observations, record review and staff interviews, the facility failed to obtain a physician's order for the use of a chair alarm for 1 of 2 sampled residents (Resident #13) observed with a personal alarm, failed to obtain a physician's order to discontinue the use of a chair and bed alarm for 1 of 2 sampled residents (Resident #27) with orders for a personal alarm, and failed to transcribe an order for contact isolation precautions for 1 of 1 sampled resident (Resident #189) reviewed for infection. During the recertification survey of 01/20/17 the facility was cited for failure to implement a physician's order for double portions for 1 of 4 residents reviewed for nutrition. b. 483.35 Food procure, store/prepare/serve - sanitary: Based on observations and staff interviews the facility failed to defrost an ice cream freezer and failed to label and date multiple portion food items discovered in the ice	F 867	infection control practices could not be located. The QAPI process in use by the facility inconsistently assessed compliance with the use of scheduled, intermittent monitoring of previously identified concerns, the performance of root cause analysis (RCA) and/or activation of Performance Improvement Plans (PIPs) in response to the same. The process is being strengthened by the initiation of education and auditing. 2- A review of Plans of Correction (POC) activated in response to the 1/2017 survey, along with the Quality Assurance and Performance Improvement (QAPI) tools used for this process reflects a snapshot of in-service training and follow-up monitoring. A QAPI enhancement is under development. 3- An enhanced QAPI process and related audit tools are under development and/or have been created and activated to further strengthen the QAPI process in relation to the POC. NHA, all department heads, MDS nurse, Nurse Managers (Full time, Part time, Per diem) will be re in serviced on QAPI plan and newly designed audit tools. 4- The LNHA is responsible for POC compliance. The Quality Assessment and Assurance (QAA) team and its members will be responsible for the ongoing monitoring of this process through the 1) strategic audit roll out, 2) Review of all audits, reviews, and reports during routine QAA meetings, 3) Performance of root cause analysis (RCA) with findings, 4) the development of action plans and Performance Improvement Plans (PIPs)	

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 _____	C 03/01/2018

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

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F 867	Continued From page 22 cream freezer and 2-door standing freezer. The facility also failed to maintain sanitary walls behind the dishwashing machine and failed to ensure the floor of the walk-in cooler was free of standing water. During the recertification survey of 01/20/17 the facility was cited for failure to use proper hand hygiene before handling clean plastic cups, insulated coffee mugs, and insulated dome covers during observations of dishwashing. During an interview on 03/01/18 at 2:58 PM the Administrator stated the kitchen manager had conducted weekly tray line and cleaning audits for 6 weeks after the recertification survey of 01/20/17. The kitchen manager then re-started weekly tray line and cleaning audits since July 2017 as an ongoing process until now. On February 2018, the facility had completed a deep clean for the kitchen as an one-time event. The Administrator explained the kitchen manager was new in the position for less than one week. He attributed the repeated tags to turnover in kitchen leadership role and lack of effective communication system between nursing staff and the medical professional. The Administrator added the repeated areas of concern would be reviewed by the QAA committee and a performance improvement plan would be developed to correct the deficiencies.	F 867	related to findings and 5) comprehensive QAA meetings and reflective minutes. The QAPI plan will be rolled out by the QAA Coordinator and LNHA. Findings will be addressed promptly with responsive action and reported to QAA during routine meetings. The QAA Coordinator and LNHA will determine the frequency of ongoing monitoring of all audits, reviews, and reports, based on compliance with set goals. Date of Compliance: 3/29/18	