PRINTED: 04/09/2019 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345307	B. WING		C 03/07/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	33/07/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
E 000	Initial Comments		E 000		
F 000		3.73, Emergency at ID# SBE711.	F 000		
F 641	Due to the system b deficiencies could no 11th day following the Accuracy of Assessm	eing down the statement of t be posted until 3/22/19 (the e survey exit date).	F 64		4/1/19
SS=E	resident's status. This REQUIREMENT by: Based on record rev interviews the facility Minimum Data Set (N condition (Resident # (Resident #2) and dia and #41) for 5 of 5 sa MDS assessments w Findings included: 1. Resident #19 was 05/09/14. A physician's order for 10/18/18 indicated st scheduled Risperdal every bedtime as nee	is accurately reflect the is not met as evidenced riew, staff, and pharmacist failed to accurately code the MDS) to reflect the skin fall), fall occurrence agnoses (Resident #33, #7 ampled residents whose rere reviewed for accuracy. admitted to the facility on or Resident #19 dated		1. The corrective action for the resider affected by the alleged deficient practic were accomplished for the following residents Res #2, #33, #7, #41 and # which was modified on 3/5/19 to reflect res #19 did not receive the antipsychol medication during the look back period which is 7 days. 2. All residents have the potential to be affected by the alleged deficient practic. The MDS Nurse have reviewed the pharmacist notes, incident/accidents to and new residents □ admission diagnous of 3/8/19 to ensure the most recent MDS information accurately reflects earesidents status. The MDS assessment for ten (10) residents were audited 3/1-3/15/19 by the Administrator and	t de la
ADODATODY	DIDECTOR'S OR PROVINER	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE	(X6) DATE

Electronically Signed 04/01/2019

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

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345307	B. WING _			1	07/2019
NAME OF P	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0172013
				44	414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTE	ER .		G	ASTONIA, NC 28056		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 641	Continued From page		F 6	641			
		nly physician's orders from for Resident #19 indicated			Treatment/Unit Nurse for accuracy.		
		ms (mg) 1 tablet orally at			3. Education was provided to the MDS		
		nd if not used in 14 days			nurse on 3/19/19 by DHSR in Marion N	IC	
	was discontinued on	11/02/2018.			which consisted of accuracy of		
	A				assessments regarding coding, timely	and a	
		cist monthly visit note dated sperdal was discontinued for			submission, initial assessments, quarte		
	Resident #19 on 11/0	•			assessments and annually assessmen to help to ensure that the deficient	เร	
	INCOME	2/10.			practice does not recur.		
	A review of Resident #19's quarterly Minimum						
		ssment dated 01/08/19			4.Monitoring to ensure compliance		
	indicated Resident #1	9 had been coded under			regarding accuracy of assessments: The	ne	
	Section N Medication	Received as receiving an			Administrator and Acting DON will		
	antipsychotic medicat	tion times 7 days.			continue to audit three random section		
					5 residents MDS per week x 4 weeks t	nen	
	On 03/04/19 at 10:34				2 per week x□s 4 weeks starting		
	conducted with the ph				3/11`/2019.		
	Resident #19's Rispe medication was disco				Data will be summarized and presente	d to	
					the facility Quality Assurance Performa	nce	
	On 03/04/19 at 2:01 F				Improvement Committee meeting mon	•	
		DS Coordinator who stated the facility on 01/24/19 and			x 2 months by the Administrator and or Acting DON. Any issues or trends		
		ent #19's quarterly MDS			identified will be addressed by the Qua	lity	
	assessment dated 01	· •			Assurance Performance Improvement	iity	
		hat Resident #19 had an			Committee as they arise and the plan	will	
		Risperdal on 11/2/18. The			be revised to ensure continued		
		ified that the pharmacist			compliance. The Administrator and or		
	indicated in the pharn				Acting Director of Nursing are respons	ble	
	12/05/18 that Resider	nt #19's Risperdal			for implementing and maintaining the		
		tion had been discontinued			acceptable plan of correction.		
		Coordinator verified during					
		of 01/02/19 to 01/08/19 that			Corrective action will be completed on	or	
		received an antipsychotic			before 4/1/2019.		
		ays. The MDS Coordinator					
		should not have been coded					
	under Section N Med	assessment dated 01/08/19 ications Received as					
	Larrace Cooline 14 Mca	iodiiorio i todorivou do	1		I		1

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	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		03/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From pag		F 6	41		
	receiving an antipsy days. The MDS Cooneed to submit a mode MDS assessment date Resident #19 had not medication during the On 03/04/19 at 2:30 conducted with the in (DON) who stated how the duarterly MDS assess have been accurated #19 had not received during the look back 01/08/19. The DON that the quarterly MID 01/08/19 would be not accurately reflect Residually and the disconducted with the away her expectation assessment dated 0 accurately coded to received antipsychotic day look back period her expectation was assessment 01/08/1 submitted to accurate	chotic medication times 7 radinator stated she would diffication to the quarterly ated 01/8/19 to indicate of received an antipsychotic e 7 day look back period. PM an interview was interim Director of Nursing er expectation was that the essment dated 01/8/19 would by coded to reflect Resident d an antipsychotic medication period from 01/02/19 to stated her expectation was DS assessment dated indiffied and submitted to esident #19 did not receive ation during the 7 day look PM an interview was administrator who stated it that quarterly MDS 1/08/19 would have been reflect Resident #19 had not tic medication during the 7 d. The Administrator stated the quarterly MDS 9 would be modified and eley reflect Resident #19 had chotic medication during the				
	1/10/17 with a diagn with behavioral distu	admitted to the facility on osis that included dementia irbance, Heart failure, Major generalized anxiety disorder, chronic pain, lack of				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345307	B. WING			C 03/07/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		03/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	recent Minimum Dat dated 1/9/19 indicate as not having a fall for the previous assessing the month of Novem #29 had 2 falls. A far 11/19/18. Review of Resident: 11/2/18 stated the nution assistant (NA) that the bed. The note conting Resident #29's room found face down with laceration was noted #29's head. 911 was was transported by the to the hospital. Review of a nursing resident #29 had an from wheelchair by the prevent further recurt therapy referral and transfers to staff. Interview with the Military in the prevent with th	story of falling. The most a Set (MDS) assessment ed Resident #29 was coded or since admission or during	F 6			
	revealed that she was of falls verbally by no review of Resident # 11/2/18 and 11/19/18 the Resident #10 ha	meetings. She further as occasionally made aware ursing staff. Following the 29's nursing note dated the MDS coordinator stated 2 falls should have been lated 1/9/19 and were not.				

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F 641	1:33 PM revealed that falls to be coded corn lnterview with the Ad PM revealed it was hassessments be accomposed and Parkinson's disease and Parkinson's disease and Parkinson's disease and that she did not a Coordinator until 02/0 the previous MDS Coordinator until 02/0 the previous MDS Coordinator until 02/0 the previous MDS Coordinator until 02/0 the diagnoses should the MDS Coordinator until 02/0 the MDS Coordinator until 02/0 the diagnoses should the MDS Coordinator until 02/0 the MDS C	Consultant on 3/07/19 at at it is her expectation for the ectly on the MDS. ministrator on 3/7/19 at 4:28 er expectation that MDS urately coded for falls. admitted to the facility on ses which included dementia ase. #33's admission Minimum essment, dated 01/22/19, 33 was not coded under gnoses as having dementia ase. on 03/06/19 at 9:29 AM, the licated that the dementia and diagnoses were not coded start working as the MDS 04/19. She further indicated bordinator, who was no rked on the MDS. She stated if have been coded because it's responsibility was to summary or Admission FL2 ies. on 03/06/19 at 10:16 AM, the ed that the dementia and diagnoses were not coded in the previous Director of MDS Coordinator quit. She	F 6	41		
	During an interview of	on 03/07/19 at 10:30 AM, the				

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F 641	Continued From page		F 6	641			
	expectation was the	dementia and Parkinson's nould have been coded on					
	01/30/19 with diagnos	admitted to the facility on ses which included dalaheimer's disease.					
	A review of Resident #41's admission MDS assessment, dated 02/05/19, indicated Resident #41 was not coded under Section I: Active Diagnoses as having respiratory failure and Alzheimer's disease.						
	MDS Coordinator ind failure and Alzheimer not coded. She furthe the admission MDS bediagnoses were not of MDS Coordinator also she quit. She stated to	· ·					
	Administrator indicate and Alzheimer's disea coded on the MDS be of Nursing (DON) and further indicated her diagnoses should have	n 03/06/19 at 10:16 AM, the ed that the respiratory failure ase diagnoses were not ecause the previous Director d MDS Coordinator quit. She expectation was the ve been coded on the MDS. n 03/07/19 at 10:30 AM, the					
	Corporate Nurse Cor						

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F 641	Alzheimer's disease coded on the MDS. 5. Resident #7 was a 9/23/16 with diagnose fibrillation, and gastro (GERD). A review of Resident revealed a physician' Xarelto 5 mg to be gi fibrillation. Another pl 11/1/18 for Ranitidine bedtime for GERD. A review of the quarte (MDS) dated 12/7/18 cognitively intact. Fur revealed atrial fibrillar coded as active diagram An interview conduct the MDS Coordinator the position and the coded by the prior MI agreed the atrial fibril were not coded accu submit a modification. An interview conduct the Corporate Nurse	diagnoses should have been diagnoses stately and stated and diagnoses diagnoses rately and stated should be should diagnoses rately and stated should be should diagnoses should be should diagnoses should be should diagnoses should diagnose shoul	F 6-	41		
F 656 SS=D	accurately coded by	the MDS Coordinator. Comprehensive Care Plan	F 6	56		4/1/19

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	ROVIDER OR SUPPLIER WOOD NURSING CENT	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	33.61.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 656	implement a comprecare plan for each resident rights set for §483.10(c)(3), that is objectives and timef medical, nursing, an needs that are ident assessment. The codescribe the followin (i) The services that or maintain the reside physical, mental, an required under §483 (ii) Any services that under §483.24, §483 provided due to the under §483.10, inclutreatment under §48 (iii) Any specialized rehabilitative service provide as a result or recommendations. It findings of the PASA rationale in the reside (iv) In consultation we resident's represental (A) The resident's produced outcomes. (B) The resident's produced contact agencicentities, for this purp (C) Discharge plans plan, as appropriate	decility must develop and shensive person-centered sesident, consistent with the arth at §483.10(c)(2) and includes measurable rames to meet a resident's iffied in the comprehensive imprehensive care plan must be are to be furnished to attain lent's highest practicable if psychosocial well-being as 6.24, §483.25 or §483.40; and 6.25 or §483.40 but are not resident's exercise of rights adding the right to refuse 6.3.10(c)(6). Services or specialized is the nursing facility will if PASARR if a facility disagrees with the facility medical record. If the resident and the facilities must document the desire to return to the fessed and any referrals to the estand of the rappropriate in the rappropriate	F 656		

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F 656	section. This REQUIREMENT by: Based on record rev facility failed to developlans for 1 of 1 reside rehabilitation and res #33). Findings included: Resident #33 was ad 01/14/19 with multiple dementia and Parkins A review of the annual dated 01/22/19, indic severe cognitive imparts assistance with 1-per bed mobility, transfer revealed Resident #3 incontinent of bowel a for developing pressure. A review of a care plankesident #33 was incontinent of bowel a for developing pressure. A review of a care plankesident #33 was incontinence and cognoal of the care plankesident #30 with the facility would minimal dignity and risk of inferperiod. Further review there were no interverse plan goal. A review of a care plankesident #30 with the facility would minimal dignity and risk of inferperiod. Further review there were no interverse plan goal. A review of a care plankesident #30 with the facility would minimal dignity and risk of inferperiod. Further review there were no interverse plan goal.	iew and staff interviews, the op interventions for care ent reviewed for torative services (Resident mitted to the facility on e diagnoses that included son's disease. If Minimum Data Set (MDS), ated Resident #33 had airment and required limited son physical assistance for s, and dressing. The MDS 3 was coded as being and bladder and was at risk are ulcers. In, dated 01/29/19, revealed continent of bowel, at risk for ty, dignity, and at risk for s related to bladder nitive deficits. The target dated 02/15/19, revealed mize the resident's loss of ection through next review of the care plan revealed nitions listed to carry out the	F 65	1. The Corrective action for the affected by the alleged deficie will be accomplished for the foresident #33 in order to carry or plan goals, effective intervention added to resident □s care plan 03/06/19. 2. In order to identify other resident practice. The Nobesignee have audited the resident practice. The Nobesignee have audited the residensure interventions are in platout the care plan goals of the southern and the MDS Nurse, Social Worke Dietary supervisor, and the Tholirector by the Administrator of Developing/Implementing Concare Plan and how to put app Interventions in place for care trigger to assist with ensuring practice does not recur. 4. Monitoring to ensure complicating Develop/Implement Comprehensive Care Plan: The Administrator and or Interdiscing member will audit five resident per week x□s 4 weeks then 2 x□s 4 weeks in order to ensure compliance. Data will be summarized and	ent practice ollowing out the care ons were on on sidents that ed by the MDS and or sidents care ting to ace to carry residents. 8/28/2019 to er/ Activities, nerapy regarding mprehensive propriate plans that the deficient siance ine ine increase in the care plans per week re	

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NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	0	5/0//2019
		_		4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTE	iR .		GASTONIA, NC 28056		
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F 657 SS=E	general debilitation. T plan, dated 02/15/19, be kept as active, mo possible; would be free of aspiration; would be would be free from codecline in bowel or blanot exhibit any signs of through next review pcare plan revealed the listed to carry out the During an interview of MDS Coordinator indicated updating Resident #3 she did not have an a interventions were not completed for each recompleted for each	ladder and bowel alkdown, depression, and he target goal of the care revealed the resident would bile, and independent as see from signs or symptoms and free from skin breakdown; anstipation; would have no adder function; and would be symptoms of depression ariod. Further review of the are were no interventions care plan goal. In 03/06/19 at 9:29 AM, the cated she did not start Coordinator until 02/04/19. She was responsible for 3's care plan. She stated answer as to why the added to the care plans. In 03/07/19 at 10:30 AM, the sultant indicated her are plans to be fully esident. In 03/07/19 at 01:15 PM, the add her expectation was for each resident. She hare plan was not completed Director of Nursing and an quit at the same time. I Revision (ii)-(iii)	F 6	the facility Quality Assurance Pel Improvement Committee meetin x 2 months by the Administrator Acting DON. Any issues or trendidentified will be addressed by the Assurance Performance Improve Committee as they arise and the be revised to ensure continued compliance. The Administrator a Acting Director of Nursing are refor implementing and maintainin acceptable plan of correction. Corrective action will be complebefore 4/1/2019.	and or ds ne Quality ement e plan will and or esponsible ng the	4/1/19

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F 657	the comprehensive a (ii) Prepared by an in includes but is not lin (A) The attending ph (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prathe resident and the An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev team after each asse comprehensive and assessments. This REQUIREMENT by: Based on observation interviews, the facility revise care plans to r needs for: 2 of 2 resi (Resident #15 and #3 reviewed for activities #11) and 1 of 2 resid ulcers (Resident #10 Findings Included:	7 days after completion of assessment. Iterdisciplinary team, that nited to ysician. e with responsibility for the d and nutrition services staff. Icticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined to development of the e staff or professionals in a sine of the resident. It is a staff or professionals in the participation of the resident or the staff or professionals in the participation of the resident. It is not met as evidenced ons, record review and staff or failed to review and/or reflect the individual care dents reviewed for accidents (28), 1 of 5 residents ents reviewed for pressure	F 68	The corrective action for the reside affected by the alleged deficient prawill be accomplished for the following residents # 15 and # 28 reviewed activities of daily living, and Res # 10 pressure ulcers in which up dated on plans were completed on 3/19/19. 2. In order to identify residents that the potential to be affected by the sideficient practice. The MDS and Scients affected by the sideficient practice.	actice ng or 10 for care have ame

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				3) DATE SURVEY COMPLETED			
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				44	414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTI	ER		G	ASTONIA, NC 28056		
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F 657	Continued From page	e 11	F6	657			
		e diagnoses that included			Worker have audited resident care plan	าร	
		end-stage renal disease,			as of 3/15/19 in order to ensure that ca		
	diabetes, and chronic	-			plans are revised and updated quarterl		
	,	•			and as needed to accurately reflect the	•	
	Review of the annual	Minimum Data Set (MDS)			resident⊡s condition.		
	dated 01/01/19 indica	ated Resident #15 had					
	moderate impairment	in cognition and required			3. The Administrator has in-serviced th		
	extensive to total staf				MDS, Social Worker/Activities, Therapy		
		ept for eating. Side rails			Director and Dietary supervisor regard	ng	
		eing used during the MDS			the regulation components of		
	assessment period.				Comprehensive Care Plans on 3/28/19		
	Povious of the care of	ans for Resident #15, with a			help to ensure the deficient practice do not recur.	es	
		/19, revealed no care area,			not recur.		
		for the use of side rails.			4. Monitoring to ensure compliance		
	goar or intorventione	ior are dee or erde raile.			regarding Care Plan Timing and Revisi	on:	
	Observations conduc	ted on 03/03/19 at 11:55			The Administrator and or Acting DON v		
	AM, 03/04/19 at 9:06	AM and 03/06/19 at 6:02			continue to audit starting 3/18/19 5		
	AM revealed Resider	nt #15 was lying in bed in a			random care plans per week x□s' 4		
	supine (lying face up	ward) position with half side			weeks then 3 per week x□s 4 weeks ir	i .	
	rails located at the he	ead of the bed and in the			order to ensure that care plans are		
		oth the right and left side.			updated accurately with goals and		
		tions, Resident #15 made			interventions in place. Physician orders		
	•	side rails to move or			antibiotics will be audited 2 x's a week	x's	
	reposition himself.				3 weeks then 1x per week x's 2 weeks		
	During an interview o	n 02/07/10 at 0:51 AM			begining 3/15/19 in order to sustain		
		n 03/07/19 at 9:51 AM evealed Resident #15			compliance.		
		sistance for bed mobility and			Data will be summarized and presente	d to	
		firmed both the right and left			the facility Quality Assurance Performa		
		s raised whenever Resident			Improvement Committee meeting mon		
	#15 was lying in bed.				x 3 months by the Administrator and or	•	
	, 5				Acting DON. Any issues or trends		
	During an interview o	n 03/07/19 at 11:17 AM, the			identified will be addressed by the Qua	lity	
		plained she started her			Assurance Performance Improvement		
		facility on 01/24/19 and			Committee as they arise and the plan v	vill	
		OS position on 02/04/19.			be revised to ensure continued		
		he right and left side rails			compliance. The Administrator and or		
	were used whenever	Resident #15 was lying in			Acting Director of Nursing are responsi	ble	

Facility ID: 923314

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345307	B. WING _			1	C /07/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTI			44	REET ADDRESS, CITY, STATE, ZIP CODE 14 WILKINSON BLVD ASTONIA, NC 28056	1 03/	0112019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	bed. The MDS Coord wouldn't necessarily of side rail use but wintervention on anoth activities of daily livin were reviewed/revise team quarterly and R should have been up when the quarterly M completed. During an interview of Corporate Nurse Corporate Nurse Corporate Nurse Corporate Nurse Corporate Nurse Corporate respectation for caquarterly and accurate plans were revised an accurately reflect the 2. Resident #28 was 07/11/18 with multiple left-sided hemiplegia body), dementia, and Review of the quarter dated 01/22/19 indicated 01/22/19 indicated on the plans were revised and the plans were revised and accurately reflect the 2. Resident #28 was 07/11/18 with multiple left-sided hemiplegia body), dementia, and Review of the quarter dated 01/22/19 indicated on the plans were revised and the	dinator explained she create a separate care plan ould add it as a goal and/or er care plan such as falls or g. She added care plans d by the interdisciplinary esident #15's care plans dated to reflect side rail use DS dated 01/01/19 was In 03/07/19 at 11:55 AM the isultant (CNC) stated it was are plans to be updated ely reflect the resident's care in 03/07/19 at 1:52 PM the t was her expectation care and updated as needed to resident's condition.	F	857	for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on before 4/1/2019.	or	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	' '	DATE SURVEY COMPLETED
		345307	B. WING _			C 03/07/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		03/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	position (lying face up side of the bed close Resident #28's bed wall with a fall mat pot the bed and wall. A solocated at the head of the upright position. Conducted on 03/05/1 at 6:01 AM revealed upright position while bed. During these of made no attempt to un reposition himself. During an interview of Nurse Aide (NA) #2 required total staff as same position when I repositioned by staff. place fall mats on the Resident's #28's bed against the wall, they between the wall and since he tended to lie confirmed the left side whenever Resident # During an interview of MDS Coordinator expemployment with the transitioned to the MI She confirmed a side Resident #28 was lying Coordinator explained create a separate car would add it as a goal another care plan such sides and the care plan such wall with the care plan such and the care plan such	ot #28 lying in a supine oward) up against the right to the wall. The right side of was pushed up against the ositioned lengthwise between side rail on the left side of the bed was noted to be in Additional observations 19 at 3:06 PM and 03/06/19 the half side rail was in the Resident #28 was lying in oservations, Resident #28 see the side rail to move or 103/07/19 at 9:51 AM evealed Resident #28 sistance and stayed in the lying in bed until turned and She explained they used to offloor on each side of but since putting the bed up now placed the fall mat in bed to protect his knees of close to the wall. NA #2 the rail was always raised 128 was lying in bed. In 03/07/19 at 11:17 AM, the obtained she started her facility on 01/24/19 and 025 position on 02/04/19. Tail was used whenever	F6	957		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 03/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4414 WILKINSON BLVD GASTONIA, NC 28056	•	03/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 657	included the intervent placed on the floor or #28's bed. The MDS Resident #28's fall caupdated to reflect the addition to the use of care plans were revieinterdisciplinary team #28's care plans shouthe quarterly MDS dacompleted. During an interview of Corporate Nurse Conher expectation for caquarterly and accurate needs. During an interview of Administrator stated in plans were revised an accurately reflect the second and the second plans were revised and accurately reflect the second plans were revise	tion that fall mats were to be a each side of Resident Coordinator acknowledged are plan should have been a revised intervention in the left side rail. She added ewed/revised by the quarterly and Resident all have been revised when atted 01/24/19 was on 03/07/19 at 11:55 AM the asultant (CNC) stated it was are plans to be updated at rely reflect the resident's care and updated as needed to resident's condition. admitted to the facility on a diagnoses that included fracture of the third lumbar akness and low back pain. Ty Minimum Data Set (MDS) atted Resident #11 had intact dextensive assistance of 1 are walking, locomotion and view of the MDS revealed to steady with his balance	F	557		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION			PLETED
		345307	B. WING _				C 07/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY 4414 WILKINSON BLVD GASTONIA, NC 2805)	, 50	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	therapy services for a strengthening. During an on intervie Restorative Aide (RA Resident #15 with reambulation and balanthis last day of restorative Aide (RA Resident #15 with reambulation and balanthis last day of restorative MDS Coordinator expemployment with the transitioned to the MI The MDS Coordinator ADL care plan and an included an active intrestorative therapy for She added care planthe interdisciplinary to the interdisciplinary to the interdisciplinary to the molonger of the molonger of the property of the completed. During an interview of the corporate Nurse Corporate N	ald provide Resident #11 with ambulation, standing and w 03/07/19 at 10:50 AM the confirmed she provided	F	557	DEFICIENCY)		
	Administrator stated plans were revised a accurately reflect the 4. Resident #10 was 08/28/2018 with a dia	on 03/07/19 at 1:52 PM the it was her expectation care nd updated as needed to resident's condition. admitted to the facility on agnosis that included Type 2 h unspecified complications,					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345307	B. WING _		_		C 07/2019
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, ST 4414 WILKINSON BLVD GASTONIA, NC 28056	TATE, ZIP CODE	1 00/	01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	through stage IV, and to the coccyx. The mode Set (MDS) assessme revealed Resident #1 impaired, required ex turning and reposition Stage I or greater. Review of Resident #9/11/18 revealed a "for potential for pressure to immobility, inconting alteration in hydration ankle stage IV identified on unstageable identified IV identified on 10/22 unstageable identified Resident #10's curren non-pressure areas wand remain free from interventions included it is intact and adhering treatment nurse, and and monitor lab work updated to include he Aeruginosa or osteon administration of an at Review of Resident #2/22/19 reveled heavy aeruginosa.	kidney disease with stage I I a stage 4 pressure wound out recent Minimum Dated and dated 12/20/2018 O was cognitively severely tensive assistance for an and had pressure ulcer in an and had pressure ulcer in an	F	957			
	Review of physician of	order dated 2/26/19 stated					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345307	B. WING		C 03/07/2019
	ROVIDER OR SUPPLIER	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	03/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 657	cipro 500 milligrams (intramuscularly (IM) gweeks per pharmacy An interview with the 03/06/19 at 11:29 AM aware of changes to during morning meeti that she was occasion by nursing staff. Duri #10's physician order indicated that the carupdate to reflect Resi wound. Interview with the nur 1:05PM revealed it w	mg) for 6 weeks and entamicin 0.1 percent for 6 order.	F 65	7	
F 658 SS=E	#10's care plan shoul include an infection of Interview with the fact at 4:28PM revealed it resident care plans be current medical status Services Provided McCFR(s): 483.21(b)(3) §483.21(b)(3) Comproved The services provided as outlined by the commustiful Meet professional This REQUIREMENT by: Based on observation	lity administrator on 3/7/19 was her expectation e updated to reflect their s. eet Professional Standards (i) ehensive Care Plans d or arranged by the facility, mprehensive care plan,	F 65	The corrective action for the residents affected by the alleged deficient practic	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING		0:	C 3/07/2019	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1	0.020.10	
				4414 WILKINSON BLVD			
MEADOW	WOOD NURSING CENTI	ER		GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 658	Continued From page	e 18 sician's order for wound care	F 65	8 were accomplished for the follo	wina		
	for 1 of 3 sampled rescondition (Resident # physician's order for	sidents reviewed for skin		residents #19 was rectified on 3 # 10 was rectified on 3/7/19`, at # 24 was rectified on 3/7/2019.	3/4/19 , res		
		ailed to follow a physician's ack for 1 of 1 resident (Resident #24).		 Residents in the facility have potential to be effected by the a deficient practice. An audit on re charts were reviewed and chec 	lleged esidents		
	Findings included:			3/7/19 by the night nurses to en physician orders, MAR's and TA	sure that		
	1. Resident #19 was 05/09/14.	admitted to the facility on		being reviewed and followed ar discontinued medications have removed from the carts. Audits	nd been		
	(MDS) assessment d Resident #19 was co required extensive as	erly Minimum Data Set ated 01/08/19 indicated gnitively impaired and esistance with bed mobility and was total dependent		completed on 3/8/2019-3/15/20 Unit nurse/treatment nurse to e orders were checked against th accurate.	nsure all		
	for transfer and toileti diagnoses included h			3. All nurses were in-serviced o 3/28/2019 regarding verifying p orders before providing wound	hysician care and		
	were to cleanse Resi ankle/leg with wound calcium alginate (abs promotes wound hea (nonstick dressing), v	cleanser, pat dry, and apply orbent material that ling), cover with telfa vrap with kerlix (gauze		verifying physician orders to ob the Administrator and HR Direct ensure services provided meet professional services. 8 random resident physician ord audits and checked against the charts by the Treatment/ Unit N	ders were residents urse on		
	needed.	e every second day and as		3/11/19-3/15/19 to ensure that of have not changed.			
	conducted of the Wor wound care on Resid venous stasis ulcer w prior dressing to the I 03/03/19 and stated t	AM an observation was und Nurse (WN) performing ent #19's left ankle/leg round. The WN removed the eft ankle/leg that was dated the wound had silvadene is calcium alginate on the		Nurses will sign off starting 3/18 daily snack sheets verifying recresidents snacks. In addition, verifying orders before providing care will be include in subsequence.	eiving rifying ng wound		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _				C 07/2019	
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0112013	
					4 WILKINSON BLVD			
MEADOW	WOOD NURSING CENT	ER			STONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Continued From pag	e 19	F 6	558				
	wound. The WN clear wound with wound c dry, applied calcium with telfa, and wrapp kerlix, as per physici wound was observed symptoms of infection slight brownish color. On 03/04/19 at 11:18 conducted with the W Monday through Frich Nursing (DON) per control treatment administrated administered wound ankle/leg vascular we stated when she characteristics.	leansed the left ankle/leg leanser, patted the wound alginate, covered the wound bed the left ankle/leg with an's order. The left ankle/leg d with no signs and in, had no odor, and had a ed drainage. 5 AM an interview was VN who stated she worked day and the Director of locumentation on the tion record (TAR) had care to Resident #19's left ound on 03/03/19. The WN inged the dressing on lvadene and calcium alginate fit ankle/leg wound. The WN had discontinued the			4. Monitoring in order to ensure compliance regarding Services Provide Meet Professional Standards: Starting 3/19/19 the Administrator and or Acting DON will audit resident physician order per week x□s 4 weeks then 3 per weel x□s 4 weeks. In addition, the unit nurs and or DON will look at the daily orders and check them against the labs and s off 5x's week x's 4 weeks. Nurses will complete medication carts audits one (x per week x 3 months than one (1) x p week x 2 months to ensure all medications are dated, are labeled appropriately, and no meds have expirif so discarded according to the State a Federal guidelines and to make sure solutions are sustain.	rs k e e s ign 1) per ed		
	should not have bee left ankle/leg wound further stated the left showed no signs and On 03/04/19 at 2:36 conducted with the Edid not have a wound 03/03/19 and she per Resident #19's left as she did not verify the order prior to perform #19's left ankle/leg as had been discontinue DON stated she assordered silvadene in as the wound treatment.	19. The WN stated silvadene in applied to Resident #19's on 03/03/19. The WN it ankle/leg wound had it symptoms of infection. PM an interview was DON who stated the facility it direatment nurse on informed wound care to inkle/leg. The DON indicated its physician's wound treatment ining wound care on Resident ind applied silvadene which its ed by the physician. The interview is the physician had addition to calcium alginate ent for Resident #19's left its edocument in applied silvadene which is the physician in the interview is left in the interview is left in applied to the physician in the interview in the physician in the interview is left in the interview i			Data will be summarized and presente the facility Quality Assurance Performa Improvement Committee meeting mon x 2 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Quatassurance Performance Improvement Committee as they arise and the plant be revised to ensure continued compliance. The Administrator and or Acting Director of Nursing are respons for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on before 4/1/2019.	ince thly dility will		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	' '	OATE SURVEY COMPLETED
		345307	B. WING _			C 03/07/2019
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	'	33/3//23/10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	Continued From pag		F 6	58		
		the physician's order prior to are on Resident #19's left				
	conducted with the A expectation was that have been followed by performed wound cat ankle/leg on 03/03/1 stated her expectation have verified the physician further stat the nurse would have performing wound caphysician felt no harmonic station was the second caphysician felt no harmonic second caphysician felt no harmonic second caphysician felt no harmonic station was the second caphysician felt no harmonic se	PM an interview was administrator who stated her at the physician's order would by the DON when she re on Resident #19's left 9. The Administrator further on was that the DON would visician's order prior to a care for Resident #19. PM a telephone interview the physician who stated it that his wound care order for have been followed. The ted his expectation was that the verified his order prior to are for Resident #19. The more resulted to Resident #19 in of silvadene to the left D3/03/19.				
	08/28/2018 with a di Diabetes mellitus wit Hypertensive chronic through stage IV, an to the coccyx. The m Set (MDS) assessmerevealed Resident # impaired, required ex	admitted to the facility on agnosis that included Type 2 th unspecified complications, to kidney disease with stage I d a stage 4 pressure wound nost recent Minimum Dated tent dated 12/20/2018 10 was cognitively severely extensive assistance for ning and had pressure ulcer				
		#10's care plan initiated ocus" of resident had				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345307	B. WING			C
	ROVIDER OR SUPPLIER WOOD NURSING CENTI			STREET ADDRESS, CITY, STATE, ZIP CO 4414 WILKINSON BLVD GASTONIA, NC 28056		03/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 658	potential for pressure to immobility, incontir alteration in hydration ankle stage IV identified on unstageable identified IV identified on 10/22 unstageable identified Resident #10's currer non-pressure areas wand remain free from interventions included it is intact and adherit treatment nurse, and and monitor lab work Review of Resident #2/22/19 reveled heavaeruginosa. Review of Resident #coccyx obtained 2/22 Osteomyelitis. Review of physician ocipro 500 milligrams (gentamicin 0.1 perceorder. Physician order dated 80mg intramuscularly order continued with (3/1/19) and at Peak creating level (3/1/19 physician. Review of Resident #revealed no lab for tree	e ulcer development related hence and potential for hontrition related to medial ied on 11/15/18. Right hip 11/20/18, right heel don 10/29/18, coccyx stage 1/18 and left hip that was don 2/5/19. The goal stated in pressure ulcers and would show signs of healing infections. The domonitor dressing to ensure ing, report lose dressing to report any signs of infection infection. 1/210's wound culture obtained by growth of pseudomonas 1/210's wound biopsy of the 1/19 revealed acute 1/216/19 stated Gentamicin for 6 weeks per pharmacy 1/2126/19 stated Gentamicin for (IM) every 24 hours. The draw trough before 3rd dose after 3rd (3/1/19) dose and (b) per pharmacy and	Fé	358		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345307	B. WING _			C 3/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 4414 WILKINSON BLVD GASTONIA, NC 28056	•	5/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 658	Interview with the Me 3:37 PM revealed it was obtained as order. Interview with the Nu 1:05PM revealed after records the facility marough, Peak and Cragentamicin. She furthave been drawn on Trough was obtained had not completed that as of 3/7/19. Interview with the fact 3/7/19 at 3:39PM revent managed the labs and responsible for obtain preferable that the late Interview with the fact at 4:28PM revealed it labs orders be obtain physician. She further labs should have been identified by the physician. Resident #24 was 3. Resident #24 was 3. Resident #24 was 3. Resident #24 was 3.	acy recommendations. Edical Director on 3/6/19 at was his expectation that labs ed. It is a Consultant on 3/7/19 at er review of the facilities issed obtaining the lab for reatine after the 3rd dose of ther indicated the lab should 3/1/19. She stated the lab on 3/4/19 and the facility are Peak or the Creatine level considered the pharmacy and the facility would be also be were drawn as ordered. Editive Administrator on 3/7/19 at was her expectation that are das ordered by the er indicated Resident #10's en obtained on 3/1/19 as sician order.	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 03/07/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		03/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 658	F 658 Continued From page 23 Further review of the medical record revealed a		F 6	58		
		dated 11/13/18 which read in				
	(MDS) dated 01/15/1 had severe impairme supervision with set- The MDS further ind a mechanically altere	erly Minimum Data Set 19 indicated Resident #24 ent in cognition and required up assistance for eating. icated Resident #24 received ed diet and had no significant uring the MDS assessment				
	with a revised date of at risk for choking ar poor intake at meals	#24's nutrition care plan, of 01/31/19, revealed she was od skin breakdown related to output. Interventions included for serve supplements as				
	03/04/19 at 2:50 PM snacks, each individ names, was delivere the nurses' desk to be There were no sandy snack labeled with R	ation was conducted on to 3:20 PM. A tray of ually labeled with resident d by dietary staff and left on the distributed to the residents. Wiches noted on the tray or a lesident #24's name. Staff elivering a snack to Resident				
	1:00 PM revealed Remechanically soft die tray card. Resident did not eat any of he	conducted on 03/05/19 at esident #24 was served a et as indicated on her meal #24 ate all of the desert but r regular meal. An ed on 03/05/19 at 3:23 PM				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCT			COMPLETED		
		345307	B. WING			C 03/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	<u> </u>	03/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	revealed Resident #2	e 24 4 was sitting upright in bed d movements. There was	F 65	8		
	Dietary Cook (DC) re prepared for resident be delivered at 10:00 DC explained they we	n 03/05/19 at 10:48 AM, the vealed snacks were s with a physician's order to AM and 3:00 PM daily. The ere short-staffed and 10:00 provided to the residents as				
	Dietary Aide (DA) #1 responsible for prepa delivered to the residuated he forgot to pro	ring afternoon snacks to be ents at 3:00 PM. The DA				
	Nurse Aide (NA) #3 rout snacks mid-morn NAs to deliver to the snacks delivered wer name which were us. She did not recall eve out on the tray as a stated there were tim sandwich for Resider indicated it was not o confirmed she had no snack to Resident #2					
	During an interview o	n 03/05/19 at 12:32 PM, the				

		IDENTIFICATION NUMBER		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345307	B. WING _		C 03/07/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	1 00/01/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		ION (X5) LD BE COMPLETION PRIATE DATE
F 658	Medical Director (MD appetite was very erroshe wouldn't eat. He order for her to receiv 3:00 PM so she would the days she didn't eathe would expect for the ordered. During an interview of	stated Resident #24's atic and there were times explained he wrote the re a sandwich as a snack at d have something to eat on at her lunch. The MD stated he snack to be provided as	F 6	58	
F 677 SS=D	dietary staff to place of to residents as ordered was included for Resistated it was her experienced. ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A residual out activities of daily leservices to maintain opersonal and oral hydris REQUIREMENT by:	is not met as evidenced	F 6		4/1/19
	Based on observation interview the facility for 1 of 5 dependent resistant The findings included Resident #13 was ad 12/17/18 with a diagram Hemiplegia and Hemiplegia and Hemiplegia and Hemiplegia and Hemiplegia to thrive, model interview.	mitted to the facility on osis that included iparesis following cerebral t non-dominate side, adult		Nail Care was provided on residen by the C.N.A on 3/4/19 resident has pruritus which causes resident #13 scratch consistently. 2. All Residents have the potential taffected by the alleged deficient prathe Administrator completed an aud 03/08/2019-3/15/2019 to ensure the other resident was affected. 3. Certified nursing assistants receivable to the consumption of the constraint of the c	to be actice; lit on at no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345307	B. WING				C
NAME OF D	20//DED OD OUDDUIED	343307			TREET ARRESTO CITY OTATE ZIR CORE	03/	07/2019
NAME OF PI	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	ER			114 WILKINSON BLVD		
				G	ASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 677	Continued From pag	e 26	F 6	677			
		esophageal reflux disease.			in-service on Performing nail care on		
		imum Data Set (MDS)			3/8/19 and How to perform nail care or	1	
		2/17/18 revealed Resident			3/31/2019 on residents requiring		
		assistance with eating,			assistance. The education will continue	to.	
		with personal hygiene and			be included in subsequent new-hire	, 10	
	was moderately cogr				orientation.		
	was moderatory eeg.	mavely impaired.			onomation.		
	Review of Resident #	#13 care plan revealed no			4.The Administrator and or designee w	ill	
	care plan for Activitie				continue to randomly checked complia		
	'	, 3			starting 3/18/19 of Certified Nursing		
	Observation on 3/3/1	9 at 12:57 pm revealed			Assistants providing ADL care including	1	
	resident to be in her				toileting and nail care- 6 residents per		
	observation a family	member was present while			week x 5 weeks, then 3 residents per		
	resident meal tray wa	as being set up. Staff			week x 4 weeks.		
	member (name unkn	low) was observed to set up					
	Resident #13's meal	tray on the bedside table.			Data will be summarized and presente	d to	
	The resident was ob-	served to have a brown and			the facility Quality Assurance Performa	nce	
	black substance und	erneath the nails of her right			Improvement Committee meeting mon		
		bstance was present while			x 2 months by the Administrator and or		
	resident ate food iter	ns by hand.			Acting DON. Any issues or trends		
					identified will be addressed by the Qua	lity	
		ent #13's family member on			Assurance Performance Improvement		
		evealed the substance			Committee as they arise and the plan	vill	
		t #13's nails were most likely			be revised to ensure continued		
		Resident #13 would rectally			compliance. The Administrator and or		
		ne indicated Resident #13's			Acting Director of Nursing are responsi	ble	
	nails normally looked	ilke that.			for implementing and maintaining the acceptable plan of correction.		
		ent #13 on 3/3/19 at 1:05 pm					
	revealed she was un	aware of when her nails					
	were last cleaned.				Corrective action will be completed on before 4/1/2019.	or	
	Observation of Resid	dent #13 on 3/3/19 at 3:51					
	pm revealed the resi	dent to be seated in front of					
	the nursing station co	overed with a blanket. The					
	_	could be observed clutching					
		t. The fingernail of resident's					
	right hand were obse	erved to have brown matter					
	underneath.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 03/07/2019	
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		00/01/2010	
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F 677	Continued From pag	e 27	F 6	77			
	am revealed the resi the main dining roon hand were observed underneath. Observation of Resi revealed the residen Nursing Assistant (N resistive to care.	dent #13 on 3/4/19 at 8:48 dent to be eating breakfast in n. The fingernails of her right to have a brown substance dent #13 on 3/4/19 at 4:11 pm t to be receiving nail care by A) #4. Resident #13 was not					
	revealed she had no underneath Residen her to clean and cut that she had worked	on 3/4/19 at 4:13 pm ticed the brown substance t #13's nails which prompted them. NA#4 further indicated with Resident #13 yesterday not recall seeing any brown inderneath her nails.					
	1:24 pm revealed it was her expensed it was her expensed it was her expensed it was her expensed in the second in	urse Consultant on 3/7/19 at was communicated to her buld rectally dig. She further expectation that residents and their hands cleaned prior					
	revealed she had probath but did not comshe wasn't looking a	on 3/7/19 at 1:28 pm ovided Resident #13 with a plete nail care. She stated t her nails to identify any th Resident #13 nails.					
	at 4:28PM revealed residents received a have hands cleaned indicated it was impo	cility Administrator on 3/7/19 it was her expectation that ssistance with nail care and prior to dining. She further ortant to ensure hand hygiene to Resident #13 being					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	(X3) DATE SURVEY COMPLETED		
		345307	B. WING		C 03/07/2019	
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION	
F 677	Continued From page observed to rectally d		F 6	77		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)		F 70	00	4/1/19	
	alternatives prior to in a bed or side rail is us correct installation, us	. mpt to use appropriate stalling a side or bed rail. If sed, the facility must ensure se, and maintenance of bed t limited to the following				
	, , , ,	the resident for risk of rails prior to installation.				
	bed rails with the resi	the risks and benefits of dent or resident or tresident otain informed consent prior				
	, , , ,	that the bed's dimensions e resident's size and weight.				
	and maintaining bed This REQUIREMENT by: Based on observatio	d specifications for installing		The corrective action for the res		
	for the use of side rail reviewed for side rails	s for 2 of 2 residents (Residents #15 and #28).		were accomplished on Resident 3/8/19 and resident # 15 on 3/29	#28 on	
	09/28/17 with multiple	admitted to the facility on ediagnoses that included end-stage renal disease,		2. Residents with side rails have potential to be affected by this ci deficiency. Residents with side r reassessed on 3/28/19 by the C Registered Nurse for the use of	ited rails were OTA and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			1	C 07/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	0772013	
					414 WILKINSON BLVD			
MEADOW	WOOD NURSING CENT	ER			GASTONIA, NC 28056			
					T			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 700	Continued From pag	ue 29	F 7	700				
	diabetes, and chroni	c pain.			COTA completed an audit on bed rails 3/28/19-3/31/19 and found no addition			
	dated 01/01/19 indic moderate impairmen extensive to total sta	Il Minimum Data Set (MDS) ated Resident #15 had It in cognition and required Iff assistance with all cept for eating. Side rails			residents to be assessed for side rails. COTA will be responsible for notifying nurses of any residents that are in nee bed rails and updated SR assessment	ed of		
	_	eing used during the MDS			2 Licensed Nurses were re-educated	hv		
	assessment period.	eing used during the MDS			3. Licensed Nurses were re-educated the Administrator to the use of bed rail and assessing residents for positioning	s		
	Review of the care p	lans for Resident #15, with a			of 3/11/2019. The side rail assessmer	ıts		
	revised date of 01/23	3/19, revealed no care area,			will be completed within 14 days upon			
	goal or interventions	for the use of side rails.			admission, when a significant change occurs, quarterly, and annual in order	to		
	Review of Resident	#15's medical record			ensure compliance. In addition; the ab			
	revealed the most re	cent side rail assessment			education will be included in subseque			
	was a quarterly date	d 10/16/18. The side rail			new-hire orientations.			
		not include a summary of						
		s, other interventions used,			4.Montoring performance to make sure	3		
	or rationale for the co	ontinued use of side rails.			that solutions are sustained: The Side r			
	The side rail assessi	ment was not signed by the			use assessments will continue to be			
	person completing th	ne form.			audited starting 4/1/2019 1 x's per wee	k x		
					3 month and 1 x per week x' 1 month b	у		
	Observations conduc	cted on 03/03/19 at 11:55			the Director of Nursing, and or License	:d		
		6 AM and 03/06/19 at 6:02			Nurses.Any issues or trends identified			
	AM revealed Reside	nt #15 was lying in bed in a			be addressed by the Quality Assurance	е		
	supine (lying face up	oward) position with half side			Performance Improvement Committee	as		
		ead of the bed and in the			they arise, and the plan will be revised	to		
	upright position on b	oth the right and left side.			ensure continued compliance.			
		ations, Resident #15 made						
	•	e side rails to move or			Data will be summarized and presente			
	reposition himself.				the facility Quality Assurance Performa			
					Improvement Committee meeting mon	•		
	_	on 03/07/19 at 9:51 AM			x 3 months by the Administrator and or	•		
		revealed Resident #15			Acting DON. Any issues or trends			
		ssistance for bed mobility and			identified will be addressed by the Qua			
		nfirmed both the right and left			Assurance Performance Improvement			
	side rails were alway #15 was lying in bed	s used whenever Resident .			Committee as they arise and the plan be revised to ensure continued	WIII		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING			1	C / 07/2019	
	ROVIDER OR SUPPLIER WOOD NURSING CENTE			44	TREET ADDRESS, CITY, STATE, ZIP CODE 114 WILKINSON BLVD ASTONIA, NC 28056	1 03	107/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE	
F 700	MDS Coordinator expemployment with the transitioned to the MI She was not aware or completing side rail at they were due. The I she had not complete Resident #28 since so the facility. During an interview or Nurse #1 confirmed From both sides of the both of falls. She confirmed responsible for compowhen notified by the I due. Nurse #1 added the facility for 4 month was not informed any due or completed any Resident #15. During an interview or Corporate Nurse Conficensed nurses were side rail assessments stated it was her expeutilizing side rails to he completed quarterly. During an interview or Administrator stated it side rail assessments thours of a resident's at then quarterly.	n 03/07/19 at 11:17 AM, the plained she started her facility on 01/24/19 and DS position on 02/04/19. If the facility's protocol for ssessments or how often MDS Coordinator confirmed at a side rail assessment for tarting her employment with a side rail assessment side the hall Nurse was leting side rail assessments MDS Coordinator they were at she had been employed at the sand during that time she as side rail assessments were a side rail assessments were a side rail assessments were a side rail assessments for a side rail assessments for a side rail assessments for the sultant (CNC) confirmed responsible for completing as when due. The CNC ectation for resident's	F	700	compliance. The Administrator and or Acting Director of Nursing are respons for implementing and maintaining the acceptable plan of correction. Corrective action will be completed on before 4/1/2019.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			1	C 07/2019
	ROVIDER OR SUPPLIER	ER		44	REET ADDRESS, CITY, STATE, ZIP CODE 14 WILKINSON BLVD ASTONIA, NC 28056	1 03/	0772013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	07/11/18 with multiple left-sided hemiplegia body), dementia, and Review of the quarter dated 01/22/19 indica moderate impairment total staff assistance except for eating. Side being used during the Review of the care place of 10/30 goal or interventions and Review of Resident # revealed the most recompleted was a quaside rail assessment the evaluation factors #28 used side rails or bed as an enabler to An observation condupt PM revealed Resident position (lying face upside of the bed close Resident #28's bed wwall with a fall mat pothe bed and wall. As located at the head of the upright position. Conducted on 03/05/1 at 6:01 AM revealed furgight position while bed. During these obtained and the position while bed. During these obtained and survey and the second conducted on the upright position while bed. During these obtained and survey and the second conducted on the upright position while bed. During these obtained and the upright position while bed.	e diagnoses that included (paralysis on one side of the muscle weakness. Ity Minimum Data Set (MDS) ted Resident #28 had in cognition and required with all activities of living de rails were not coded as a MDS assessment period. In the sident #28, with a Market Resident #28, with	F	700			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER WOOD NURSING CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP COI 4414 WILKINSON BLVD GASTONIA, NC 28056	DE	00.	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 700	Nurse Aide (NA) #2 required total staff as same position when I repositioned by staff. side rail was always twas lying in bed. During an interview of MDS Coordinator expemployment with the transitioned to the ME She was not aware or completing side rail at they were due. The Nashe had not complete Resident #28 since state facility. During an interview of Nurse #1 confirmed Fewhen lying in bed. Si was responsible for cassessments when in Coordinator they were had been employed as	n 03/07/19 at 9:51 AM evealed Resident #28 sistance and stayed in the lying in bed until turned and NA #2 confirmed the left used whenever Resident #28 n 03/07/19 at 11:17 AM, the lolained she started her facility on 01/24/19 and los position on 02/04/19. If the facility's protocol for ssessments or how often MDS Coordinator confirmed at a side rail assessment for tarting her employment with n 03/07/19 at 3:23 PM, Resident #28 used side rails he confirmed the hall Nurse ompleting side rail otified by the MDS ed due. Nurse #1 added she at the facility for 4 months	F 7				
	side rail assessments side rail assessments During an interview o Corporate Nurse Conlicensed nurses were side rail assessments stated it was her experitizing side rails to he completed quarterly.	n 03/07/19 at 11:55 AM the sultant (CNC) confirmed responsible for completing when due. The CNC ectation for resident's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345307	B. WING _			C 03/07/2019		
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	ER .		STREET ADDRESS, CITY, 4414 WILKINSON BLVD GASTONIA, NC 28056		00/01/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)	DATE		
F 700	side rail assessments hours of a resident's a then quarterly.	t was her expectation for to be completed within 24 admission to the facility and		700		4/1/10		
F 756 SS=D	CFR(s): 483.45(c)(1)(1)(\$483.45(c) Drug Regises \$483.45(c)(1) The drumust be reviewed at I licensed pharmacist. \$483.45(c)(2) This resofthe resident's medical direction of the resident's medical direction of the resident direction for and these reports must (i) Irregularities included up that meets the condition of the condition of the resident direction for a direction for a direction of the resident direction of the resident direction and the irregularity the sident's medical rection has been taken be no change in the rephysician should doct the resident's medical rection of the resident's medical rection has been taken be no change in the rephysician should doct the resident's medical resident's medical rection has been taken be no change in the rephysician should doct the resident's medical resi	imen Review. Ig regimen of each resident east once a month by a view must include a review cal chart. It carmacist must report any tending physician and the etor and director of nursing, st be acted upon. Ide, but are not limited to, any riteria set forth in paragraph an unnecessary drug. In the documented on a port that is sent to the end the facility's medical of nursing and lists, at a at's name, the relevant drug, the pharmacist identified. It is in the evice of that the identified evice and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in		756		4/1/19		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		03/07/2019	
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	•	
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F 756	drug regimen review limited to, time frame the process and step when he or she iden requires urgent action. This REQUIREMEN by: Based on record reconsultant and physician failed to puthe Pharmacist Consultant and gradual dose reduing medications for 1 of unnecessary medications included: Resident #41 was action.	d procedures for the monthly that include, but are not es for the different steps in os the pharmacist must take tifies an irregularity that in to protect the resident. This not met as evidenced view, staff, Pharmacist ician interviews, the rovide a timely response to sultant's recommendation for cition of psychoactive 5 residents reviewed for titions (Resident #41).	F 75	1.On 3/07 /19 the physician reviewed resident #41 medical record and addressed the Pharmacy recommendation. 2.Resident □s with Pharmacy Consult recommendation consideration of a Gradual Dose Reduction have the potential to be affected by this cited deficiency that the physician failed to provide a timely response to the		
	dated 01/30/19, indicated 01/30/19, indicated 7.5 milligrams (mg) pendoscopic gastrost behaviors. A review of Resident revealed on 02/06/19 (PC) recommended Dose Reduction (GE A review of the admit (MDS), dated 02/16/had severe cognitive of the MDS indicated	an's order for Resident #41, cated Zyprexa (antipsychotic) per PEG tube (percutaneous pmy) at bedtime for #41's medical record the Pharmacist Consultant consideration of a Gradual PR) for Zyprexa. #85ion Minimum Data Set #19, revealed Resident #41 #19 impairment. Further review the Resident #41 had trouble pags but had no behaviors		Pharmacy Consultant □s Recommendation for a gradual dose reduction of psychoactive medication 3. The Administrator on 3/19/19 re-educated the Physician and Direct Nursing when the pharmacy recommendation report is received free the Pharmacy Consultant via email the recommendations will be given to the Director of Nursing and healthcare provider, either the physician or nurse practitioner. The DON have audited the March recommendations on 3/11/2019 and informed the physician of any recommendations that required his additional attention. The Director of Nursing will continue follow-up with the Medical Director via	or of om ne to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345307	B. WING		C 03/07/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/07/2019	
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTE	ER		GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 756	A review of Resident revealed on 03/04/19 recommendation consizyprexa. During an interview of PC indicated no responsive recommendation, dat monthly review on 03 the process of how the recommendation report He further explained is sent via email to the Influence Administrator, and Methe facility should the and give them to the Interpretated the physician or nurse further stated the progression of the PC revealed the order for the recommendation and The PC revealed the order for the recommendation. From that	#41's medical record the PC had a pending sideration of a GDR for n 03/06/19 at 12:55 PM, the conse from the health care of for Resident #41's GDR ed 02/06/19, during his /04/19. The PC explained e monthly pharmacy ort was sent to the facility. that the monthly report was Director of Nursing (DON), edical Director. He stated in take the recommendations health care provider, either e practitioner. The PC vider would review the would make a response. provider would write an endation or write a ontinuation of the	F 75	DEFICIENCY)	en e in ice on ited ded ed ed ed ues	
	or consult tab and if the nursing staff would we the next month he work pharmacy or consult to stated his expectation completed within the was admitted to the far resident needed to stimulate medication, Zyprexa at the reafter.	s chart under the pharmacy here was an order, the rite the order. The PC stated buld look under the tab in the chart. He further in was the GDR should be first 2 weeks after a resident acility to determine if a fill be on the psychotropic and evaluated quarterly		5. The Administrator and or Director of Nursing are responsible for implement and maintaining the acceptable plan o correction. Corrective action will be completed on before 4/1/2019.	ing f	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345307	B. WING		03/07/	2019
	ROVIDER OR SUPPLIER	rer		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	1 00/01/	2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE C	(X5) COMPLETION DATE
F 756	cracks due to staffin that a GDR should hindicated that the probeen taking care of He further indicated happened to the Ferecommendations. In nurse practitioner reand took care of modid not know if the nrecommendations of the Director of Nurse to answer any quest to answer any quest During an interview Corporate Nurse Coexpectations would recommendations with followed up by the Ewithin one week after made. During an interview Administrator indicates his recommendation in the next through all the emair recommendations. Sphysician, PC, and son the same day the recommendations. She would expect for response to the PC's hours after the recommendation of the recommendation after the recommendation after the recommendations.	thought pharmacy hay have slipped through the g issues. He further stated have been completed. He evious DON may not have pharmacy recommendations. he did not know what bruary 6th pharmacy He revealed that usually his viewed the recommendations st of them, but he stated he hurse practitioner looked at the r not. Sing (DON) was not available tions. on 03/07/19 at 10:30 AM, the ensultant indicated her be that pharmacy rould be addressed and DON and healthcare provider er the recommendation was on 03/07/19 at 1:15 PM, The ted that the PC would send a via email to the her late at at day she was not able to go lis to review the PC's She further indicated that the she were not always present at the PC made his The Administrator revealed or the physician to provide a se recommendations within 24 mmendation was made.	F 75			
F 758	Free from Unnec Ps	sychotropic Meds/PRN Use	F 75	58	4/1	1/19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345307	B. WING		03/07	7/2019		
	ROVIDER OR SUPPLIER WOOD NURSING CENTI	ER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	, 33.0.123.1			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 758	Continued From page	e 37	F 75	8				
SS=D	CFR(s): 483.45(c)(3)	(e)(1)-(5)						
	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compreheresident, the facility not sychotropic drugs at unless the medication specific condition as in the clinical record; §483.45(e)(2) Reside	hotropic drug is any drug that is associated with mental vior. These drugs include, a drugs in the following ensive assessment of a must ensure that ents who have not used are not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic all dose reductions, and						
	drugs; §483.45(e)(3) Reside psychotropic drugs p	ents do not receive ursuant to a PRN order on is necessary to treat a						
	diagnosed specific co in the clinical record; §483.45(e)(4) PRN o are limited to 14 days	ondition that is documented and rders for psychotropic drugs s. Except as provided in attending physician or						

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
345307		345307	B. WING		03/07/2019		
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP COD 4414 WILKINSON BLVD GASTONIA, NC 28056	IE		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 758	Continued From page	e 38	F 7	58			
	beyond 14 days, he or rationale in the reside indicate the duration	RN order to be extended or she should document their ent's medical record and for the PRN order.					
	the appropriateness	ttending physician or er evaluates the resident for					
	Based on record rev Consultant, Nurse Co interview the facility for duration order was ob drug for 1 of 5 residen	onsultant, and Physician's ailed to ensure a specific otained for a psychotropic nts reviewed for		1.On 3/11 /19 the physician r resident #5 medical record ar from the physician is to continurrent schedule which is PR	nd the order nue with N		
	Resident #5 was adm 10/8/15 with diagnose Alzheimer's dementia Review of the most re Set (MDS) assessme			2.Resident □s receiving PRN anti-psychotic drugs have the be affected by this cited deficithe facility failed to ensure a siduration order was obtained fipsychotropic drug. Audit was by the Nurses on Residents the PRN meds on 3/11/19-3/15/19 know other residents were affected to the deficient practice.	e potential to iency that specific for a completed hat receive 9 to ensure		
	8/23/18 revealed a pl (antianxiety medication reevaluate in 6 month note included the curn 0.5 mg ½ tab at bedtin hours as needed (PR agitation or anxiety.	an's progress note dated an to continue Lorazepam on) as currently ordered and as. The Physician progress rent Lorazepam orders for me and 0.5 mg every 6 N) for acute episodes of acy Medication Regimen stated in part that the		3. Education: The Administrat in-serviced the Physician and Nursing on 3/19/2019 regardi regulation component to prov duration for antianxiety medic 483.45 (e) (4) PRN orders for psychotropic drugs are limited Except as provided in 483.45 attending physician or prescri practitioner believes that it is	I Director of ing the ride a specific cations. d to 14 days. (5), if the libing		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345307	B. WING			C 03/07/2019	
NAME OF PI	ROVIDER OR SUPPLIER	1 222		STREET ADDRESS, CITY, STATE, ZIP CODE		370772019	
				4414 WILKINSON BLVD			
MEADOWWOOD NURSING CENTER			GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	Continued From pag	e 39	F 75	8			
F 758	resident had been priming at bedtime for an Lorazepam 0.5 mg e since 11/2016. The FPRN Lorazepam ord specific duration of the provided with any ne regulations. An interview was conconsultant on 3/7/19 had written a pharmatic Physician on 2/6/19 ft Lorazepam. The Phase emailed the pharmatic day he visits the Consultant noted the not been addressed 3/4/19 and he had resulted that due to recommendations be have reached that due to recommendations in Physician also stated 2/6/19 pharmacy recknow what happened what recommendation on 3/4/19. The interview Physician was aware provide a specific du medications.	escribed Lorazepam 0.25 xiety since 3/2018 and very 6 hours PRN for anxiety Pharmacist noted duration of er ended 2/2019 and a ne PRN Lorazepam must be w order per CMS Inducted with the Pharmacy I at 11:59 AM revealed he acy recommendation to the for a duration for the PRN Immacy Consultant explained macy recommendations to a Director of Nursing (DON) facility. The Pharmacy I 2/6/19 recommendation had at the time of his review on sent the recommendation. I ysician on 3/6/19 at 3:40 PM I the pharmacy I ing emailed they might not w DON and therefore he ved the pharmacy a timely manner. The I he did not receive the ommendation and did not I to it and was unaware of ins the pharmacy had made iew further revealed the I it was the CMS regulation to ration for antianxiety	F 75	for the PRN order to be extend 14 days, he or she should door rationale in the resident s me and indicate the duration for the order in order to ensure the depractice will not recur. The above regulations will be included in new-hire orientations 4. Monitoring in order to ensure solutions are sustained 5 residences for antipsychotic drugs, psychotropic drugs, and 5 residences will be audited monthly starting 3/20/19 by the Acting Licensed Nurse. Data will be summarized and the facility QA Committee more three (3)months by the Director and or Licensed Nurse. Any is trends identified will be address Quality Assurance Performance Improvement Committee as the and the plan will be revised to continued compliance. 5.The Director of Nursing and Nurse are responsible for implement and maintaining the acceptable correction. Corrective action completed of	ument their dical record ne PRN efficient ove subsequent et hat dents PRN 5 residents dents new x 3 months DON or a coresented to othly x's or of Nursing sues or seed by the see sey arise, ensure energy en		
	3/6/19 at 3:25 PM rev	orporate Nurse Consultant on vealed she was unaware the additions were not being					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING		0;	C 03/07/2019	
	NAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
F 758	the CMS regulation to for antianxiety medical Consultant was award recommendations we Administrator, but was had received them. To the Corporate Nurse pharmacy recommendations from the DON received Interview with the Admandary recommendations from the CMS regularity of the pharmacy regularity of the pharmacy regularity. Label/Store Drugs and CFR(s): 483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the capplicable. §483.45(h) Storage of §483.45(h)(1) In accessional principle appropriate accessor instructions, and the capplicable.	anner. She was aware of provide a specific duration ations. The Corporate Nurse the pharmacy bere emailed to the DON and is unaware if the new DON in the interview further revealed Consultant expected the dations to be printed out sician for his review as soon the email. In the initial control of the manacy of the email of the manacy of th		761		4/1/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345307	B. WING		C 03/07/2019	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/07/2019	
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTE	ER .		GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 761	Continued From page	e 41	F 76	1		
	biologicals in locked of	compartments under proper				
	_	and permit only authorized				
	personnel to have acc	· · · · · · · · · · · · · · · · · · ·				
	\$493 45(b)(2) The fac	cility must provide separately				
	•	affixed compartments for				
		drugs listed in Schedule II of				
	_	Orug Abuse Prevention and				
		nd other drugs subject to				
		he facility uses single unit				
	package drug distribu	ition systems in which the				
	quantity stored is min	imal and a missing dose can				
	be readily detected.					
		is not met as evidenced				
	by:					
		n, record review, and staff		Resident #14 Victoza Insulin Flex F	-	
	•	failed to discard an opened		opened and undated was discarded by		
		en that was not dated when		the Nurse Consultant on 3/5/19. Resid		
		evemir 10 milliliter (ml)		#15 Levemir Insulin with an open date	OT	
	insulin vial that was o			01/16/19 was discarded by the Nurse Consultant on 3/5/19. Resident #10		
	_	n vial that was outdated, a en that was not dated when		Novolog Insulin vial dated 01/16/19 wa		
		ed NovoLog insulin Flex		discarded by the Nurse Consultant on	15	
		ed when opened and were		3/5/19.Resident #9 Lantus insulin Flex		
	available for use in 1	•		Pen and Novolog Insulin Flex Pen wer		
		or 2 modication darte.		open and undated was discarded by the		
	Findings included:			Nurse Consultant on 3/5/19.		
	1. a. A review of the r	nanufacturer's		2.Resident□s receiving medications ha	ave	
		licated Victoza insulin Flex		the potential to be affected by this cited		
		ded 30 days after opening.		deficiency that the facility failed to disc		
				insulin that was not dated when opene		
	Resident #14 was ad	mitted to the facility on		and insulin that was expired. Audit of		
		sis of diabetes mellitus.		medication carts were completed by		
				License Nurses on 03/06/19 any conce	erns	
	A physician's order da	ated 09/01/17 indicated		identified were immediately corrected.		
		receive Victoza insulin Flex				
	Pen 18 milligram (mg) per 3 milliliter (ml) inject				
	1.8 mg subcutaneous	sly (under skin) daily 6:00		3.Re-education was completed by the		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		03/07/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2010	
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENT	ER		GASTONIA, NC 28056		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
F 761	Continued From pag	e 42	F 76	1		
	AM for diabetes mell	itus.		Director of Nursing and or Licensed N on 03/08/19 to the start of the license		
		5 AM Resident #14's Victoza		Nurse next shift; regarding F761 and		
		observed on medication cart		policy for labeling and storage of drug	-	
	•	use and was opened and		and biologicals for Licensed Nursing		
	undated.			Audits were completed for the medica		
	On 03/05/10 at 11:00) AM an interview was		carts on 03/08/19-03/15/19 by the Dir		
		e #1 who stated Resident		of Nursing and Licensed Nurse to ens that no other expired or open and und		
		Flex Pen was on medication		medications were available for usage		
		dent use. Nurse #1 stated		that insulins were appropriately labele		
		ered Victoza insulin Flex Pen		and dated as to when they were oper		
	to Resident #14. Nurse #1 stated the facility			based on manufactures guidelines in		
	policy was to date in	sulin when opened. Nurse #1		order to ensure that the deficient prac	tice	
	stated without an ope	ened date there was no way		does not recur.		
		esident #14's Victoza insulin				
	Flex Pen had expired	d.		4.Monitoring performance in order to		
				ensure solutions are sustained The		
		AM an interview was		Director of Nursing, MDS Coordinator		
		Corporate Nurse (CN) who		Licensed Nurses will complete medica	ation	
	· ·	on was that nursing staff e Victoza insulin Flex Pen for		carts audits one (1) x per week x 3 months than one (1) x per week x 2		
				months starting 3/16/19 to ensure all		
		t was opened as per facility ted because Resident #14's		medications are dated, are labeled		
	•	Pen had not been dated		appropriately, and no meds have exp	ired	
		ere was no way to determine		if so discarded according to the State		
	-	expired. The CN removed		Federal guidelines.		
		za insulin from medication		<u> </u>		
		ed the medication cart audits		Results of these audits will be reported	ed to	
	for expired and unda	ted medications had not		the QAPI Committee meeting one (1)	x per	
	been conducted.			month x's 4 months by the Administra		
				and or designee. Any issues or trends		
		AM an interview was		identified will be addressed by the Qu		
		Director of Nursing (DON)		Assurance Performance Improvemen		
		ctation was that staff would		Committee as they arise, and the plan	1 WIII	
		#14's Victoza insulin Flex		be revised to ensure continued		
		he DON stated because		compliance.		
		za insulin Flex Pen had not				
	DEEN GALEG WITEH OD	en then there was no way to	1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING	B. WING		C 03/07/2019		
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	0112019	
					114 WILKINSON BLVD			
MEADOWWOOD NURSING CENTER			G	ASTONIA, NC 28056				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI				(X5) COMPLETION DATE	
F 761	Continued From page	e 43	F 7	61				
	DON stated there was checking outdated or On 03/05/19 at 11:39	AM an interview was			5.The Administrator and or Director of Nursing are responsible for implementi and maintaining the acceptable plan of correction.	-		
	expectation was that dated when opened a Administrator stated t	dministrator who stated her insulin would have been as per facility policy. The here was no system in place or expired medication.						
	b. A review of the man recommendations ind had to be discarded 4	icated Levemir insulin vial						
		mitted to the facility on sis of diabetes mellitus.						
	Resident #15 was to i	ated 09/28/17 indicated receive Levemir insulin 100 units subcutaneously at mellitus.						
	insulin 10 ml vial date	AM Resident #15's Levemir d 01/16/19 when opened dication cart #2 ready for expired.						
	#15's Levemir insulin #2 ready for resident had not administered #15. Nurse #1 stated date insulin when ope expired. Nurse #1 sta	AM an interview was #1 who stated Resident vial was on medication cart use. Nurse #1 stated she Levemir insulin to Resident the facility policy was to ened and discard when ted Resident #15's Levemir d and should have been						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345307	B. WING			C 03/07/2019
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	<u> </u>	00/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 761	conducted with the C stated her expectation would have discarded vial dated 01/16/19 ft protocol. The CN rerexpired Levemir insuffered and undated conducted. On 03/05/19 at 11:3 conducted with the E who stated her expensave discarded Resinsulin vial dated 01/2 was no system in place expired medication. On 03/05/19 at 11:3 conducted with the A expectation was that expired insulin as pendiministrator stated for checking outdate. C. A review of the mare expensave discarded with the A expectation was that expired insulin as pendiministrator stated for checking outdate. C. A review of the mare expensave of the	AM an interview was Corporate Nurse (CN) who on was that nursing staff at the expired Levemir insuling for Resident #15 per facility moved Resident #15's alin vial from medication cartine medication cart audits for a medication shad not been at AM an interview was Director of Nursing (DON) ctation was that staff would dent #15's expired Levemir (16/19. The DON stated there are for checking outdated or a staff would have discarded ar facility policy. The there was no system in place dor expired medication. anufacturer's dicated NovoLog insulin vial 28 days after opening. dmitted to the facility on one is of diabetes mellitus. dated 12/18/18 indicated a receive NovoLog insulin 100 and scale 8:00 AM, 12:00 PM,	F 76	51		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED C	
		345307	B. WING			03/07/2019	
	ROVIDER OR SUPPLIER WOOD NURSING CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 761	was observed on m resident use and was On 03/05/19 at 11:0 conducted with Num #10's NovoLog insu #2 ready for resider had not administere #10. Nurse #1 stated date insulin when of expired. Nurse #1 sinsulin vial had expidiscarded. On 03/05/19 at 11:2 conducted with the stated her expectati would have discardinsulin vial dated 01 facility protocol. The expired NovoLog in #2. The CN stated the expired and undated conducted. On 03/05/19 at 11:3 conducted with the who stated her expending the work of the wo	ge 45 I dated 01/16/19 when opened edication cart #2 ready for as expired for 20 days. O AM an interview was se #1 who stated Resident lin vial was on medication cart at use. Nurse #1 stated she do NovoLog insulin to Resident do the facility policy was to pened and discard when tated Resident #10's NovoLog red and should have been AT AM an interview was Corporate Nurse (CN) who on was that nursing staffed the expired NovoLog /16/19 for Resident #10 per e CN removed Resident #10 p	F 70	·			
	expired medication. On 03/05/19 at 11:3 conducted with the expectation was the expired insulin as possible.	ace for checking outdated or 9 AM an interview was Administrator who stated her at staff would have discarded er facility policy. The I there was no system in place					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345307	B. WING _			l	07/2019	
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CI 4414 WILKINSON BL GASTONIA, NC 28		1 03/	0772013	
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 761	d. A review of the mare commendations in or Pen had to be discard and Novolog insulin F28 days after opening. Resident #9 was adm 12/17/18 with diagnor. A physician's order days and the first Pen 60 units subcutated and the first Pen 14 units subcutated with meals. On 03/05/19 at 10:55 insulin Flex Pen and were observed on mare identified by Lantus and Novolog insulin Flex Pen and Novolo	I or expired medication. nufacturer's licated Lantus insulin Flex ded 28 days after opening Flex Pen had to be discarded g. nitted to the facility on sis of diabetes mellitus. ated 12/11/18 indicated eceive Lantus insulin Flex	F	761				
	Resident #9's Lantus Pen had expired. On 03/05/19 at 11:21	as no way to determine when and NovoLog insulin Flex AM an interview was orporate Nurse (CN) who						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345307	B. WING		0.	C 3/07/2019
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	1 0.	310112013
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 761	would have dated the the NovoLog insulin F when they were open The CN stated because NovoLog insulin Flex when opened there we when the insulin had Resident #9's Lantus NovoLog insulin Flex #2. The CN stated the expired and undated conducted. On 03/05/19 at 11:31 conducted with the D who stated her expect have dated Resident and NovoLog insulin DON stated because NovoLog insulin Flex when open then there when the insulin had there was no system outdated or expired in the control of the control o	n was that nursing staff Lantus insulin Flex Pen and Flex Pen for Resident #9 ed as per facility protocol. se Resident #9's Lantus and pen had not been dated ras no way to determine expired. The CN removed insulin Flex Pen and Pen from medication cart e medication cart audits for medications had not been AM an interview was irector of Nursing (DON) tation was that staff would #9's Lantus insulin Flex Pen Flex Pen when opened. The Resident #9's Lantus and pen had not been dated e was no way to determine expired. The DON stated in place for checking medication.	F 7	61		
F 801 SS=F	expectation was that dated when opened a Administrator stated to for checking outdated Qualified Dietary Staff CFR(s): 483.60(a)(1)(1)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	dministrator who stated her insulin would have been as per facility policy. The here was no system in place or expired medication.	F 8	01		4/1/19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED	
		345307	B. WING			C 03/07/2019	
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		5570772513	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 801	taking into consideral individual plans of call and diagnoses of the in accordance with the required at §483.70(). This includes: §483.60(a)(1) A qualified number of the control of the c	the food and nutrition service, ation resident assessments, are and the number, acuity a facility's resident population the facility assessment e) diffied dietitian or other attrition professional either for on a consultant basis. A cother clinically qualified I is one whose or higher degree granted by the dedilege or university in the equivalent foreign degree) the academic requirements of the nor dietetics accredited by the nall accreditation organization surpose. It least 900 hours of practice under the stered dietitian or nutrition attrified as a dietitian or laby the State in which the steed. In a State that does not or certification, the individual the met this requirement if he as a "registered dietitian" by Dietetic Registration or its	F 80	01			
	requirements of para this section. (iv) For dietitians hire November 28, 2016,	agraphs (a)(1)(i) and (ii) of ed or contracted with prior to meets these requirements after November 28, 2016 or					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345307	B. WING _		03/07/2019	
	ROVIDER OR SUPPLIER WOOD NURSING CENTI	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	, 33.0.123.13	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE COMPLÉT	
F 801	clinically qualified nut employed full-time, the person to serve as the nutrition services who (i) For designations processed to the following results of the following res	alified dietitian or other rition professional is not the facility must designate a see director of food and portion to November 28, 2016, requirements no later than 5 or 28, 2016, or no later than 1 28, 2016 for designations 016, is: manager; or revice manager; or revice manager; or larl certification for food and safety from a national so or higher degree in food or in hospitality, if the se food service or restaurant an accredited institution of the established standards for rest or dietary managers,	F8	01		
	from a qualified dietitic qualified nutrition proof This REQUIREMENT by: Based on interviews a Certified Dietary Macompetencies and skand nutrition services	managers, and tly scheduled consultations an or other clinically fessional. is not met as evidenced the facility failed to employ anager with the ills required to carry out food from 2/1/19 and continuing yey 3/3/19 through 3/7/19 for		The facility as of 3/11/2018 has he certified food serve manager. The has also employed a qualified regulatician which started on 2/27/19 consultant basis. 2. No residents were identified as been affected by the alleged deficipractice.	facility listered on a having	

STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ <i>'</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345307	B. WING		C 03/07/2019
NAME OF PROVIDER	R OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,
ME4 DOM/MOOD	NUIDOINIO OENITE			4414 WILKINSON BLVD	
MEADOWWOOD	NURSING CENTE	:R		GASTONIA, NC 28056	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 801 Conti	nued From page	: 50	F 80	01	
Upon 10:51 being Regis revea previo once aware stated reside She s to woo Interv PM re the fa and h stated reside one a reside furhte a coo also a Admir food a was n Dietal F 812 SS=F \$483. The fa	initial entry into AM, staff identi- in charge of the otered Dietitian (I led she was at tous week and plate amonth. She fut there was no did she did not know the did not know the second White with the Adrawald her current of the second White with the Adrawald there was cility since 2/1/1 ad been to the fid she expected the she expected the she expected the she was ent's menu cards on the fid she position actively recruiting instrator confirm and nutrition service to the she was ent's menu cards on the sh	the kitchen on 3/3/19 at fied the Administrator as kitchen. Interview with the RD) on 3/6/19 at 2:03 PM the facility one time the anned to be at the facility rther revealed she was ietary manager. She also ow who was monitoring mus or food preferences. Contract with the facility was rednesday of each month. Ininistrator on 3/5/19 at 3:02 as no dietary manager for 9. The RD was also new acility one time. She further the nurses to monitor the field Administrator indicated no trained to update the statth is time. The interview sted she planned to promote of dietary manager but was grow the position. The field she was in charge of vices at the facility and she federal regulation for a se on the staff. Ore/Prepare/Serve-Sanitary 2) The red of from sources for the position of the staff. Ore of the staff. Ore of from sources for the food from sources for the staff of the staff of the staff of the staff. Ore of the staff of the s	F 84	3. The Consultant has re-educated the Administrator on ensuring that a Certif Dietary Manager or Certified food serv manager is always in place according the qualified dietary staff regulations. 4. Monitoring to ensure compliance the Regional Consultant will sign off month x's three months. Data will be summarized and presente the facility Quality Assurance Performal Improvement Committee meeting mon x 3 months by the Administrator and of Acting DON. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plant be revised to ensure continued compliance. Corrective action will be completed on before 4/1/2019.	e to e la

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING			C 3/07/2019	
NAME OF PI	ROVIDER OR SUPPLIER	0.10001		STREET ADDRESS, CITY, STATE, ZIP CODE	•	3/07/2019	
				4414 WILKINSON BLVD			
MEADOW	WOOD NURSING CENT	ER		GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	Continued From pag	e 51	F 81	2			
F 812	from local producers and local laws or reg (ii) This provision do facilities from using p gardens, subject to c safe growing and foc (iii) This provision do from consuming food §483.60(i)(2) - Store serve food in accords standards for food se This REQUIREMENT by: Based on observation facility failed to correctly cle observe correct hand kitchen, and failed to dishwashers dispensed ishes and equipment Findings included: 1. Observations of the AM to 11:10 AM reveal Unsealed flour base by Whole eggs of undecoler in a metal confundated. c. Box of green peppiwere moldy.	subject to applicable State ulations. es not prohibit or prevent produce grown in facility compliance with applicable ad-handling practices. es not preclude residents its not procured by the facility. It prepare, distribute and ance with professional ervice safety. The is not met as evidenced ons and staff interviews, the ctly store dry food items, at the food items stored in 1 of 1 to discard moldy food items, an ice machine, failed to discard moley food items, and ice machine, failed to discard moley food items, and ice machine, failed to discard moley food items, and ice machine, failed to discard moley food items, and ice machine, failed to discard moley food items, and ice machine, failed to discard moley food items, and ice machine in the ensure one of one kitchen and the machine.	F 81	The corrective action that was the deficient practice of unsea bag in dry storage area was re thrown out on 3/3/19, whole ecover and dated with the date were cooked which was 3/3/19 peppers that were bad were d 3/3/19, the ice machine was c 3/3/19, the corn meal and grits discard on 3/3/19. The cook h in-serve on infection control of the Administrator. The PH lever dishwasher was corrected on 2. No residents were identified been affected by the alleged practice. 3. Education was provide on 3 all the dietary staff regarding is control and on 3/10/19 regarding in control and on 3/10/19 regarding in control and on 3/10/19 regarding in the dietary staff regarding in control and on 3/10/19 regarding in the dietary staff regarding in control and on 3/10/19 regarding in the dietary staff regarding in control and on 3/10/19 regarding in the dietary staff regarding in control and on 3/10/19 regarding in the dietary staff regarding in control and on 3/10/19 regarding in the dietary staff regarding in control and on 3/10/19 regarding in the dietary staff regarding in control and on 3/10/19 regarding in the dietary staff regarding in the die	led flour emoved and ggs was that they 9. The green iscard on leaned on s were ad received in 3/3/19 by el for the 3/7/19. as having deficient		
	food with right hand,	ebris inside lid. ove on left hand scooping tying food bag with both sh bag closed, then washing		and dating food by the Admini addition, a cleaning schedule place for the dietary departme Administrator to ensure that the	was put in nt by the		

Facility ID: 923314

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345307	B. WING _			C 03/07/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	10112013
MEADOW	WOOD NUIDOING OFNITE	-n		44	414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTE	:K		G	ASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	: 52	F 8	312			
	knife at sink, then add on stove still wearing f. One unsealed bag	_			practice will not recur. 4.Monitoring to ensure compliance a		
	unsealed bag of grits				every two week cleaning schedule hav been put in place for the ice machine a		
	,	Cook #2 on 3/5/19 at 1:30			a daily/ weekly dietary cleaning schedu		
		not clean the ice machine in			as of 3/7/19 the Administrator and or fo		
	, ,	She further stated she had on the cleaning log as			service manager will audit the covering and dating food and the dish washing	l	
		e machine on the January or			process 3 x's a week on all three shifts	for	
	February cleaning log	-			3 months and check for rotten food dai		
	, 5				x's 3 months in order to ensure	,	
	Interview with Dietary	Cook #1 on 3/5/19 at 10:48			compliance.		
		e cleaned the ice machine,					
		down. She stated she had			Data will be summarized and presented		
		ide of the ice machine. She			the facility Quality Assurance Performa		
		sign the cleaning log as			Improvement Committee meeting mon	inly	
	having cleaned the ic	e macnine.			x's 3 months by the Administrator and Food Service Manager. Any issues or		
	Interview with Dietary	Aide on 3/5/19 at 2:00 PM			trends identified will be addressed by the	he	
		er cleaned the ice machine.			Quality Assurance Performance	.0	
	He further stated he s				Improvement Committee as they arise		
	cleaning log for clean	ing the ice machine.			and the plan will be revised to ensure		
					continued compliance. The Administrat	or	
	There was no dietary	manager on staff. Interview			and or Food Service Manager are		
		the administrator on 3/3/19			responsible for implementing and		
		ner expectation that eggs			maintaining the acceptable plan of		
		overed, green peppers			correction.		
	•	if moldy, flour would be meal and grits would be			Corrective action will be completed on	or	
	_	nachine would be cleaned			before 4/1/2019.	OI .	
	regularly.	lacilile would be cleaned			Delote 4/1/2019.		
		e kitchen on 3/5/19 at 2:00					
		hide wearing gloves handling					
		shed the gloves in running way some clean dishes, then					
		n put away more clean					
		ame gloves. The dietary aide					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345307	B. WING		C 03/07/2019
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	, 00000
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 812	Interview with the acrevealed her expect would observe corret the dietary aide was administrator to rew potential cross contact. There was no dietar and kitchen tour with at 2:10 PM revealed observe correct han. 3. Review of the kith operating specificatil least 50 parts per mithe machine's final ridishware and equipped and optimal chlorine ppm. Observation on 3/5/Dietary Aide was was dishwashing machin Aide on 03/05/19 at was unaware of how used in the dishwas interview with the dinever checked the dispensing the correst further stated he just log 'like everybody eve	changed gloves and he et tired." Iministrator 3/5/19 at 3:15 PM ation was the dietary aide et hand/glove hygiene and instructed by the ash all the dishes due to amination. In manager on staff. Interview in the administrator on 3/3/19 and the expectation staff would deglove hygiene at all times. In the dishwashing machine's cons revealed it required at a fillion (PPM) of chlorine during inse cycle to sanitize ment washed in the machine attration was between 50-100. In at 2:00 PM revealed a shing dishes in the kitchen in the expectation with the Dietary 2:00 PM revealed the aide of to test the sanitizing agent the expectation. Further expectation in the machine expectation in the sanitizing agent in the sanitizing	F 81		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345307	B. WING			C 03/07/2019	
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		00/07/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	Continued From pag	e 54	F 8	12			
	Cook #1 using chloring to test the amount of dispensed by the dissanitizing agent was to the water for sanitizing agent was the water for sanitizing water for sanitizing agent was the water for sanitizing agent was the water for sanitizing water for water for sanitizing water for wat						
	2:05 PM revealed sh administrator and the the dishwasher was further stated she did the dish machine not to sanitize the dish w	e maintenance director that not working correctly. She I not know what to do about dispensing sanitizing agent are. She also stated she did dishwasher as this was					
	at 1:20 PM revealed	nintenance Director on 3/7/19 he did not handle repairs for o the facility having a ide repair company.					
	Maintenance Directo service company on the kitchen's dish wa chlorine sanitizing ag machine's chlorine so	e request emailed to the r by the dish machine's 3/7/19 at 2:16 PM revealed sher was not dispensing any lent on 3/5/19 because the queeze tube, the chlorine line r were not working and all					
	chlorine test strip pro	performing the dishwasher cess on 3/6/19 at 8:27 AM 100 ppm chlorine in the cturer operating instructions.					
		ministrator on 3/5/19 at 3:15 s responsible for the kitchen					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		C 03/07/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	1 00/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 812	Manager and it was had dishwasher chemical correct amount of chlidishes and the dishwashes and the dishwashes and the dishwashes and the dishwasher performa staff responsibility for	e absence of a Dietary her expectation that the test strip would read the orine for sanitizing the asher performance would be per day. She further stated tract with a dishwasher repair	F 812		
F 813 SS=C	10:42 AM revealed to their training from He but there were no recestated her expectatio to follow the cleaning handling, use correct foods appropriately. Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a storage of foods brown and other visitors to estorage, handling, an This REQUIREMENT by: Based on family intefacility failed to have and storage of foods	policy regarding use and ight to residents by family ensure safe and sanitary	F 813	No residents were identified as having been affected by the alleged deficient practice.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345307	B. WING _				C /07/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTI	ER		44	TREET ADDRESS, CITY, STATE, ZIP CODE 414 WILKINSON BLVD ASTONIA, NC 28056	1 03/	0112013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 813	handling, and consur (Resident #4). Findings included: Interview with Reside 3/3/19 at 11:37 AM redaily basis and she heamily food policy. Interview with the Add 10:42 AM revealed the policy regarding food family or visitors for the she was unaware of a brought into the facility.	e 56 Inption for 1 of 1 resident ent #4 family member on evealed she brings food on a ad never been provided a ministrator on 3/7/19 at the facility does not have a brought into the facility by the residents. She also stated a corporate policy about food by. The interview further it be a policy and she would	F	313	2. In order to ensure compliance a policy was put in place on 3/7/2019 by the Administrator regarding the use and storage of foods brought to residents by family to ensure safe and sanitary storage. An audit was completed on 3/18/19 by the Social worker to determine residents that are receiving food into the facility from family. 3. Education regarding the facility policy was provided to the families by the Social worker on 3/29/19 via mail All staff have received in-service on the facility policy families use and storing food as of 3/8/2019. The policy will also be included in the facility Admission package. In addition, newly hired Staff will also received during subsequent orientation.	y iine ne / cial / e / on ed	
					4.Monitoring performance to make sure that the solutions are sustained Dietary/Nursing staff will start auditing 3/11/2019 the refrigerator behind the nursing station where resident food is stored 3x's per week x's one (1) month and then 2x's per week x's one (1) mort to ensure that residents' name and date on food, to ensure that non-perishable foods are stored in re-sealable containers, and for is discarded that show signs of foodbord danger. Data will be summarized and presented the facility Quality Assurance Performal Improvement Committee meeting months 2 months by the Administrator and or Social Worker. Any issues or trends	on inth e is e bood rne d to ince thly	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345307	B. WING _	B. WING			C 07/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	ER .		44	TREET ADDRESS, CITY, STATE, ZIP CODE 114 WILKINSON BLVD ASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 813	Continued From page	e 57	F	813	identified will be addressed by the Qua Assurance Performance Improvement Committee as they arise and the plan v be revised to ensure continued compliance.	vill	
F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(g)(2)(F 8	867	before 4/1/2019.		4/1/19
	§483.75(g)(2) The quassurance committee (ii) Develop and impleaction to correct ident This REQUIREMENT by: Based on observatio	•			No residents were identified as havi been affected by this alleged deficient	ng	
	Assessment and Assifialed to maintain impromonitor interventions previously put into platwo recited deficiencia following the 03/01/18 survey, the 12/20/18 investigation and wer 03/07/19 revisit, annucomplaint investigation were in the areas of A (ADL) care provided food procurement, sto The continued failure federal surveys of recomplaint investigation were in the areas of A (ADL) care provided food procurement, sto The continued failure federal surveys of recomplaint investigation were in the areas of A (ADL) care provided food procurement, sto The continued failure federal surveys of recomplaints.	urance (QAA) committee Ilemented procedures and that the committee had ace. This failure related to les that were originally cited annual recertification			practice. 2. The Administrator completed an audi on 03/08/2019-3/15/2019 regarding AD Nail Care to ensure compliance and or identify any potential nail concerns. 3. Education: The quality Assurance Committee were in-serviced on 3/26/19 regarding the previous tags and the systems that need to be put in place. Certified nursing assistants received in-service on Performing nail care on 3/8/19 and How to perform nail care on 3/31/2019. In addition, Education regarding the facility policy was provide to the families by the Social Worker on	oL O	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 03/07/2019		
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRE	ESS, CITY, STATE, ZIP CODE	1 03/	0112013	
				4414 WILKINSO				
MEADOW	WOOD NURSING CENT	ER		GASTONIA, N				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	(EA	ACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	COMPLETION DATE	
F 867	Continued From pag	e 58	F 8	67				
	Findings included:			in-service use and s policy will	via mail. All staff have receive on the facility policy on fal storing food as of 3/8/2019. Il also be included in the fac on package. Newly hired Sta	milies .The cility		
	This tag is cross refe	renced to:			eive education during subse on. to ensure that the deficie	•		
	Residents: Based on and staff interview, the nail care for 1 of 5 de #13). During the revisit and 12/20/18 the facility of provide toileting assist dependent residents. b. 483.60 Food Procestore/Prepare/Serve observations and stafailed to correctly sto label and date food it cooler, failed to discate to correctly clean ice correct hand/glove hyfailed to ensure 1 of dispensed chemicals equipment washed in During the annual recool/1/18 the facility of dirty wall behind the	urement, - Sanitary: Based on ff interviews, the facility re dry food items, failed to rems stored in 1 of 1 walk-in and moldy food items, failed machine, failed to observe regione in the kitchen, and 1 kitchen dishwashers 1 to sanitze dishes and 1 the machine. certification survey of reas cited for failure to clean a dishwashing machine, label		4. The Adi be respond of Correct Designees will audit place regaudit will x's per we cleaning for the ice dietary cleaninistr manager food and a week of and chect months in the facility Improven x 2 month Acting Dolidentified	to ensure interventions are garding ADL toileting/nail calbe done on random resider wheek x's 4 weeks. Every two schedule have been put in emachine and a daily/ week leaning schedule as of 3/7/rator and or food service will audit the covering and the dish washing process on all three shifts for 3 months for rotten food daily x's 3 morder to ensure compliance be summarized and preservy Quality Assurance Performent Committee meeting ments by the Administrator and ON. Any issues or trends I will be addressed by the Committee meeting ments of the summarized and preservy Quality Assurance Performent Committee meeting ments by the Administrator and ON. Any issues or trends I will be addressed by the Committee meeting ments of the summarized and preservy Quality Assurance Performent Committee meeting ments by the Administrator and ON. Any issues or trends I will be addressed by the Committee meeting ments of the summarized and preservy Quality Assurance Performents of the summarized and preservy Quali	e Plan d or e still in are ents 5 o week place ekly 19 the dating 3 x's ths ce. nted to mance nonthly d or		
	items, remove standi	ining multiple-portion food ng water in the walk-in ne stand-up freezer that had n.		Committe	ce Performance Improveme ee as they arise and the pla ed to ensure continued ace.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345307	B. WING_			С	
NAME OF D	20//255 05 0//55//55	345307	B. WING _			03/07/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW	WOOD NURSING CENTE	R		4414 WILKINSON BLVD			
				GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 867	Administrator explained correcting and monitor concern and she felt to correct the deficiencied time it took to figure of solutions for compliar stated plans would be	n 03/07/19 at 4:08 PM the ed their focus had been on oring the identified areas of the systems put into place to es broke down due to the out the issues and research noce. The Administrator e developed with a strongering to ensure compliance.	F8	The Administrator and or Acting of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be complemented before 4/1/2019.	he		

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F 000 INITIAL COMMENTS On 03/07/19, the Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an onsite revisit. While some deficiencies cited on the complaint investigation on 01/17/19 were corrected effective 02/08/19, the facility remains out of compliance. (F 677) ADL Care Provided for Dependent Residents SS=D SFR(s) 483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide nall care for 1 of 5 dependent residents (Resident #13). The findings included: Resident #13 was admitted to the facility on 12/17/18 with a diagnosis that included Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominate side, adult failure to thrive, moderate protein-calorie malnutrition, Parkinson's disease, Alzheimer's disease and gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) assessment dated 12/17/18 revealed Resident #13 required limited assistance with personal hygiene and was moderately cognitively impaired. Review of Resident #13 care plan revealed no care plan for Activities of Daily living.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
MEADOWWOOD NURSING CENTER MEADOWWOOD NURSING CENTER MEACH DEPENDENT WIST SET PRECEDED BY FULL REGULATORY OR I SCIDENTIFYING INFORMATION) FOOD INITIAL COMMENTS INITIAL COMMENTS FOOD INITIAL COMMENTS FOOD INITIAL COMMENTS INITIAL COMMENTS FOOD INITIAL COMMENTS INITIAL COMMENTS INITIAL COMMENTS INITIAL COMMENTS INITIAL COMMENTS INIT			245207	D WING				
MEADOWWOOD NURSING CENTER 2414 WILKINSON BLVD GASTONIA, NC 28056 CASTONIA, NC 28056 C	NAME OF D	DOVIDED OD CUIDDUED	345307	B. WING _	CTE	DEET ADDRESS SITV STATE ZID SODE	03/	07/2019
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FRETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS On 03/07/19, the Division of Health Service Regulation, Nursing Home Licensure and Certification conducted an onsite revisit. While some deficiencies cited on the complaint investigation on 01/17/19 were corrected effective 02/09/19, the facility remains out of compliance. CFR(s): 483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide nail care for 1 of 5 dependent residents (Resident #13). The findings included: Resident #13 was admitted to the facility on 12/17/18 with a diagnosis that included Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominate side, adult failure to thrive, moderate protein-calorie mainutrition, Parkinson's disease, Alzheimer's disease and gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) assessment dated 12/17/18 revealed Resident #13 required limited assistance with personal hygiene and was moderately cognitively impaired. Review of Resident #13 care plan revealed no care plan for Activities of Daily living.	MEADOW	WOOD NURSING CENTE	ER					
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Regulation, Nursing Home Licensure and Certification conducted an onsite revisit. While some deficiencies cited on the complaint investigation on 01/17/19 were corrected effective (02/08/19, the facility remains out of compliance. (F 677) SS=D CFR(s): 483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide nail care for 1 of 5 dependent residents (Resident #13). The findings included: Resident #13 was admitted to the facility on 12/17/18 with a diagnosis that included Hemiplegia and Hemiplegia	F 000	INITIAL COMMENTS	;	FC	000			
out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide nail care for 1 of 5 dependent residents (Resident #13). The findings included: Resident #13 was admitted to the facility on 12/17/18 with a diagnosis that included Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominate side, adult failure to thrive, moderate protein-calorie malnutrition, Parkinson's disease, Alzheimer's disease and gastro-esophageal reflux disease. The most recent Minimum Data Set (MDS) assessment dated 12/17/18 revealed Resident #13 required limited assistance with eating, extensive assistance with personal hygiene and was moderately cognitively impaired. Review of Resident #13 care plan revealed no care plan for Activities of Daily living. Nail Care was provided on resident #13 by the C.N.A on 3/4/19 resident has pruritus which causes resident #13 by the C.N.A on 3/4/19 resident has pruritus which causes resident #13 to scratch consistently. 2. All Residents have the potential to be affected by the alleged deficient practice; the Administrator completed an audit on O3/08/2019-3/15/2019 to ensure that no other resident was affected. 3. Certified nursing assistants received in-service on Performing nail care on 3/8/19 and How to perform nail care on 3/8/19 and How to perform nail care on 3/31/2019 on resident will continue to be included in subsequent new-hire orientation. 4. The Administrator and or designee will continue to randomly checked compliance starting 3/18/19 of Certified Nursing		Regulation, Nursing F Certification conducte some deficiencies cite investigation on 01/17 02/08/19, the facility r ADL Care Provided for	Home Licensure and ed an onsite revisit. While ed on the complaint 7/19 were corrected effective remains out of compliance. or Dependent Residents	{F 6	77}			4/1/19
The most recent Minimum Data Set (MDS) assessment dated 12/17/18 revealed Resident #13 required limited assistance with eating, extensive assistance with personal hygiene and was moderately cognitively impaired. Review of Resident #13 care plan revealed no care plan for Activities of Daily living. 3/8/19 and How to perform nail care on 3/31/2019 on residents requiring assistance. The education will continue to be included in subsequent new-hire orientation. 4.The Administrator and or designee will continue to randomly checked compliance starting 3/18/19 of Certified Nursing		out activities of daily I services to maintain gersonal and oral hygothis REQUIREMENT by: Based on observation interview the facility for 1 of 5 dependent resist The findings included Resident #13 was ad 12/17/18 with a diagonal Hemiplegia and He	living receives the necessary good nutrition, grooming, and giene; is not met as evidenced in, record review and staff ailed to provide nail care for dents (Resident #13). I: mitted to the facility on noisis that included iparesis following cerebral ft non-dominate side, adult erate protein-calorie on's disease, Alzheimer's			by the C.N.A on 3/4/19 resident has pruritus which causes resident #13 to scratch consistently. 2. All Residents have the potential to be affected by the alleged deficient practic the Administrator completed an audit of 03/08/2019-3/15/2019 to ensure that no other resident was affected. 3. Certified nursing assistants received	e ee; n	
starting 3/18/19 of Certified Nursing		The most recent Mini assessment dated 12 #13 required limited a extensive assistance was moderately cogn	mum Data Set (MDS) 2/17/18 revealed Resident assistance with eating, with personal hygiene and hitively impaired.			3/8/19 and How to perform nail care on 3/31/2019 on residents requiring assistance. The education will continue be included in subsequent new-hire orientation. 4.The Administrator and or designee w	e to	
						•	nce	(X6) DATE

04/01/2019 **Electronically Signed**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	345307	B. WING			1	-C
NAME OF PROVIDER OR SUPPLIER	0.70007	1	9	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	07/2019
NAME OF TROVIDER OR SOFT EIER				414 WILKINSON BLVD		
MEADOWWOOD NURSING CENTE	R			ASTONIA, NC 28056		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
resident meal tray was member (name unkno Resident #13's meal tr The resident was obset black substance under hand. The brown substance under hand. The brown substance under sident ate food items. Interview with Resident and sident at fecal matter because and goccasionally. She nails normally looked a linterview with Resident revealed she was unawere last cleaned. Observation of Reside pm revealed the resident right hand content to post the blanket. The sident fereight hand was observed the main dining room. The sident revealed the resident the main dining room. The sident revealed the resident revealed the resident revealed the resident the main dining room. The sident revealed the resident revealed the resident revealed the resident	at 12:57pm revealed com. During the nember was present while is being set up. Staff (iv) was observed to set up ray on the bedside table. Earved to have a brown and rneath the nails of her right stance was present while is by hand. Int #13's family member on ealed the substance #13's nails were most likely Resident #13 would rectally indicated Resident #13#s	{F 6	577}	Assistants providing ADL care including toileting and nail care- 6 residents per week x 5 weeks, then 3 residents per week x 4 weeks. Data will be summarized and presented the facility Quality Assurance Performal Improvement Committee meeting monix 2 months by the Administrator and or Acting DON. Any issues or trends identified will be addressed by the Qual Assurance Performance Improvement Committee as they arise and the plan of be revised to ensure continued compliance. The Administrator and or Acting Director of Nursing are responsifor implementing and maintaining the acceptable plan of correction. Corrective action will be completed on before 4/1/2019.	d to ince thly ility will	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	, ,	DATE SURVEY COMPLETED	
		345307	B. WING_			R-C	
	ROVIDER OR SUPPLIER WOOD NURSING CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		DDE	03/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{F 677}	Interview with NA #4 revealed she had not underneath Resident #13's nails and cut them. NA#4 had worked with Resibut she did not recall substance underneat Interview with the Number 1:24 pm revealed it was her expressed and in the resident with NA#2 or expressed she had probath but did not compashe wasn't looking at substance underneat Interview with the fact at 4:28PM revealed it residents received as have hands cleaned proposed in the residents received as have hands cleaned proposed in the residents received as have hands cleaned proposed in the residents received as have hands cleaned proposed in the residents received as have hands cleaned proposed in the residents received as have hands cleaned proposed in the residents received as have hands cleaned proposed in the residents received as have lands cleaned proposed in the residents received as have lands cleaned proposed in the residents received as have lands cleaned proposed in the residents received as have lands cleaned proposed in the residents received as have lands cleaned proposed in the residents received as have lands cleaned proposed in the residents received as have lands cleaned proposed in the residents received as have lands cleaned proposed in the residents received as have lands cleaned proposed in the residents received as have lands cleaned proposed in the residents received as have lands cleaned proposed in the received as have lands received as have lands cleaned proposed in the received as have lands cleaned proposed in the received as have lands	on 3/4/19 at 4:13 pm iced the brown substance which prompted her to clean further indicated that she ident #13 yesterday (3/3/19) seeing any brown or black her nails. The Consultant on 3/7/19 at the second communicated to her all created yield. She further expectation that residents defined hands cleaned prior to consultant on 3/7/19 at 1:28 pm wided Resident #13 with a polete nail care. She stated her nails to identify any her Resident #13 nails. The Washer expectation that sistance with nail care and prior to dining. She further retant to ensure hand hygiene of Resident #13 being	{F 6	77}			

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AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345307	B. WING		R-C 03/07/2019
NAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER OUNDARRY OTATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	BE COMPLETION
F 000	INITIAL COMMENTS		F 00	00	
{F 677}	Regulation, Nursing I- Certification conducts some deficiencies cite investigation on 12/20 effective 01/18/19, the compliance.	ed an onsite revisit. While	{F 67	7}	4/1/19
	§483.24(a)(2) A resid out activities of daily I services to maintain opersonal and oral hyo This REQUIREMENT by: Based on observatio interview the facility for 1 of 5 dependent resident	is not met as evidenced n, record review and staff ailed to provide nail care for dents (Resident #13).		Nail Care was provided on resident # by the C.N.A on 3/4/19 resident has pruritus which causes resident #13 to scratch consistently.	
	12/17/18 with a diagn Hemiplegia and Hem infraction affecting lef failure to thrive, mode malnutrition, Parkinso disease and gastro-e The most recent Mini assessment dated 12 #13 required limited a	mitted to the facility on osis that included paresis following cerebral to non-dominate side, adult erate protein-calorie on's disease, Alzheimer's sophageal reflux disease. The mum Data Set (MDS) 177/18 revealed Resident essistance with eating, with personal hygiene and		 All Residents have the potential to affected by the alleged deficient practithe Administrator completed an audit 03/08/2019-3/15/2019 to ensure that other resident was affected. Certified nursing assistants receive in-service on Performing nail care on 3/8/19 and How to perform nail care of 3/31/2019 on residents requiring assistance. The education will continuous included in subsequent new-hire orientation. 	tice; on no ed
	care plan for Activities	13 care plan revealed no s of Daily living.		4.The Administrator and or designee continue to randomly checked compli	

Electronically Signed 04/01/2019

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345307	B. WING _			/07/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE		
MEADOWWOOD NURSING CENTER				4414 WILKINSON BLVD			
MEADOWNOOD NOROMO DENTER			GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{F 677}	resident to be in hobservation a fam resident meal tray member (name ur Resident #13's me The resident was black substance us hand. The brown resident ate food interview with Res 3/3/19 at 12:59pm underneath Resident ater becarding occasionally. Interview with Resident are last cleaned. Observation of Repm revealed the residents right half the top of the blant resident at the sident at the s	3/19 at 12:57pm revealed er room. During the ily member was present while was being set up. Staff nknow) was observed to set up eal tray on the bedside table. Observed to have a brown and inderneath the nails of her right substance was present while tems by hand. Sident #13's family member on revealed the substance ent #13's nails were most likely use Resident #13 would rectally She indicated Resident #13#s ked like that. Sident #13 on 3/3/19 at 1:05 pm unaware of when her nails esident #13 on 3/3/19 at 3:51	{F 67		I Nursing are including sidents per sidents per and presented to ce Performance neeting monthly trator and or trends I by the Quality approvement and the plan will nued ator and or are responsible taining the on.		
	Observation of Re am revealed the re the main dining ro hand were observed. Observation of Re revealed the resident controls and the resident controls are the resident controls.	esident #13 on 3/4/19 at 8:48 esident to be eating breakfast in om. The fingernails of her right ed to have a brown substance. esident #13 on 3/4/19 at 4:11 pm ent to be receiving nail care by (NA) #4. Resident #13 was not					

NAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 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) FREFIX TAG TAG TAG TAG TAG STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREFIX TAG TAG TAG FROM THE APPROPRIATE TAG FROM THE APPROPRIATE TAG TAG TAG TAG TAG TAG TAG	R-C 03/07/2019 (X5) COMPLETION DATE
MEADOWWOOD NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 677) Continued From page 2 Interview with NA #4 on 3/4/19 at 4:13 pm revealed she had noticed the brown substance underneath Resident #13's nails which prompted her to clean and cut them. NA#4 further indicated that she had worked with Resident #13 yesterday (3/3/19) but she did not recall seeing any brown or black	(X5) COMPLETION
PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 677 Continued From page 2 {F 677} Interview with NA #4 on 3/4/19 at 4:13 pm revealed she had noticed the brown substance underneath Resident #13's nails which prompted her to clean and cut them. NA#4 further indicated that she had worked with Resident #13 yesterday (3/3/19) but she did not recall seeing any brown or black PREFIX TAG	COMPLETION
Interview with NA #4 on 3/4/19 at 4:13 pm revealed she had noticed the brown substance underneath Resident #13's nails which prompted her to clean and cut them. NA#4 further indicated that she had worked with Resident #13 yesterday (3/3/19) but she did not recall seeing any brown or black	
Interview with the Nurse Consultant on 3/7/19 at 1:24 pm revealed it was communicated to her that Resident #13 would rectally dig. She further revealed it was her expectation that residents received nail care and hands cleaned prior to dining. Interview with NA#2 on 3/7/19 at 1:28 pm revealed she had provided Resident #13 with a bath but did not complete nail care. She stated she wasn't looking at her nails to identify any substance underneath Resident #13 nails. Interview with the facility Administrator on 3/7/19 at 4:28PM revealed it was her expectation that residents received assistance with nail care and have hands cleaned prior to dining. She further indicated it was important to ensure hand hygiene was completed due to Resident #13 being	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345307	B. WING		R-C 03/07/2019
NAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		1 33/3//2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON OF THE APPROPRIES OF	JLD BE COMPLETION
{F 000}	INITIAL COMMENTS	;	{F 00	0}	
{F 677}	Regulation, Nursing I Certification conducte some deficiencies cit investigation on 10/2 were corrected effect remains out of compl ADL Care Provided for	ed an onsite revisit. While ed on the complaint 5/18 and recited on 12/20/18 ive 01/18/19, the facility iance. or Dependent Residents	{F 67	7}	4/1/19
SS=D	§483.24(a)(2) A residence out activities of daily services to maintain appersonal and oral hydrogen and the service of the most recent Miniassessment dated 12 #13 required limited and extensive assistance was moderately cognitive to the service of Review of Resident #	lent who is unable to carry living receives the necessary good nutrition, grooming, and giene; is not met as evidenced in, record review and staff ailed to provide nail care for idents (Resident #13). I: mitted to the facility on nosis that included iparesis following cerebral fit non-dominate side, adult erate protein-calorie on's disease, Alzheimer's sophageal reflux disease. mum Data Set (MDS) 2/17/18 revealed Resident assistance with eating, with personal hygiene and itively impaired.		Nail Care was provided on resider by the C.N.A on 3/4/19 resident hat pruritus which causes resident #13 scratch consistently. 2. Residents that have pruritus have potential to be affected by the alleg deficient practice; the Administrator completed an audit on 03/08/2019-3/15/2019 to ensure the other resident was affected. 3. Certified nursing assistants recein-service on Performing nail care 3/8/19 and How to perform nail care 3/8/19 and How to perform nail care 3/31/2019.on residents requiring assistance. The education will combe included in subsequent new-hirorientation. 4. The Nurses and Administrator were sponsible for this aspect of the procrection. The Administrator and designee will randomly check com	s s s to ye the ged r sat no sived son se on stinue to e sill be lan of or
	care plan for Activitie	s of Daily living.		designee will randomly check com	pliance (X6) DATE

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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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	l\ /	(X3) DATE SURVEY COMPLETED	
	345307		B WING			R-C	
		345307	B. WING		•	3/07/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
MEADOWWOOD NURSING CENTER			4414 WILKINSON BLVD				
MEADOWWOOD NURSING CENTER			GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
{F 677}	resident to be in her observation a family resident meal tray was member (name unkn Resident #13's meal The resident was obsidack substance undhand. The brown suresident ate food item Interview with Resident ate food item Interview with Resident fecal matter because dig occasionally. Shails normally looked Interview with Resider revealed she was unwere last cleaned. Observation of Resident fecal matter because dig occasionally occasionally. Shails normally looked Interview with Resider revealed she was unwere last cleaned. Observation of Resident fersidents right hand was observation of Residents right hand was observation of Residents revealed the resident fersident was observed. Observation of Resident fersident	9 at 12:57pm revealed room. During the member was present while as being set up. Staff ow) was observed to set up tray on the bedside table. Served to have a brown and erneath the nails of her right bstance was present while has by hand. ent #13's family member on vealed the substance ::#13's nails were most likely a Resident #13 would rectally the indicated Resident #13#s	{F 67'	of Certified Nursing Assistan nail care- 6 residents per week x The Plan of correction was residents the daily stand up meeting well Department Heads. The Plan Correction monthly audit data reported by each auditor to smonthly Quality Assurance For Committee for review, recommend updated as needed to ecompliance. Corrective action will be combefore 4/1/2019.	eek x 4 weeks, 4 weeks. eeviewed in with the n of ta will be subsequent Performance nmendations insure		

NAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 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) FREFIX TAG TAG TAG TAG TAG STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREFIX TAG TAG TAG FROM THE APPROPRIATE TAG FROM THE APPROPRIATE TAG TAG TAG TAG TAG TAG TAG	R-C 03/07/2019 (X5) COMPLETION DATE
MEADOWWOOD NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 677) Continued From page 2 Interview with NA #4 on 3/4/19 at 4:13 pm revealed she had noticed the brown substance underneath Resident #13's nails which prompted her to clean and cut them. NA#4 further indicated that she had worked with Resident #13 yesterday (3/3/19) but she did not recall seeing any brown or black	(X5) COMPLETION
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Interview with the Nurse Consultant on 3/7/19 at 1:24 pm revealed it was communicated to her that Resident #13 would rectally dig. She further revealed it was her expectation that residents received nail care and hands cleaned prior to dining. Interview with NA#2 on 3/7/19 at 1:28 pm revealed she had provided Resident #13 with a bath but did not complete nail care. She stated she wasn't looking at her nails to identify any substance underneath Resident #13 nails. Interview with the facility Administrator on 3/7/19 at 4:28PM revealed it was her expectation that residents received assistance with nail care and have hands cleaned prior to dining. She further indicated it was important to ensure hand hygiene was completed due to Resident #13 being	