DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM A							
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
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 08/29/2019	
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	B		441	14 WILKINSON BLVD		
		-1		GA	ASTONIA, NC 28056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE G CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was completed in 8/29/19. There were a total of 9 allegations and none were substantiated. Event ID# Y4N711.		F	000			
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

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.

PRINTED: 09/10/2019

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u> 0938-0391</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	X2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING	B. WING			R-C 08/29/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
				4414 WILKINSON BLVD				
MEADOW	WOOD NURSING CENTE	=R		GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	SHOULD BE COMPLETION			
F 000	INITIAL COMMENTS On 08/29/19 the Division of Health Service Regulation conducted an on-site revisit. The facility is back into compliance effective 8/02/19. Event ID# 8VBM12.		F	000				
	JIRECTORS OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	INC		TITLE		(X6) DATE	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTIONBUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING	B. WING			R-C 08/29/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET				
				4414 WILKINSON BLVD				
MEADOW	WOOD NURSING CENTE	=R		GASTONIA, NC 28056				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG       CROSS-REFERENCED TO THE APPRODUCTION         DEFICIENCY       DEFICIENCY			LD BE	BE COMPLETION			
F 000	INITIAL COMMENTS		F	F 000				
	Regulation conducted	sion of Health Service an on-site revisit. The mpliance effective 8/02/19.						
I ABORATORY I	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	IRE		TITLE		(X6) DATE	

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