PRINTED: 01/03/2018 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP		(X3) DATE SURVEY COMPLETED			
		345172	B. WING		C 11/28/2017
NAME OF PR	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262	11120/2011
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 561 SS=G	§483.10(f) Self-detern. The resident has the promote and facilitate through support of renot limited to the righ (1) through (11) of thi §483.10(f)(1) The resactivities, schedules waking times), health care services consist assessments, and plaapplicable provisions §483.10(f)(2) The reschoices about aspect facility that are significable signification of the community activities facility. §483.10(f)(8) The resparticipate in other acreligious, and community activities facility. This REQUIREMENT by: Based on record rever physician interview, a facility failed to honor request to go to the hold delayed medical treating the residence of the respective of the hold and the residual treating the resi	mination. right to and the facility must a resident self-determination sident choice, including but the specified in paragraphs (f) is section. Sident has a right to choose (including sleeping and a care and providers of health ent with his or her interests, an of care and other of this part. Sident has a right to make is of his or her life in the cant to the resident. Sident has a right to interact community and participate in both inside and outside the sident has a right to citivities, including social, unity activities that do not the soft of other residents in the series of other residents in the series of other residents in the series of the resident's decision and inspiral which resulted in the the resident's decision and inspiral which resulted in the there impingement in 1 out	F 56	In addition to the Plan of Correction (POC) submitted, we also respectfully submit the following. Our center is registered with North Carolina QIO and we have reached out to them for additional assistance and support relation to this survey cycle. The QIO has	
ABORATORY I	,	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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.

Electronically Signed

12/04/2017

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		345172	B. WING			11	/28/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MERIDIAN	CENTED			70	07 NORTH ELM STREET		
WERIDIAN	CENTER			Н	IIGH POINT, NC 27262		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 561	Continued From page	<u>.</u> 1	F	561			
	Commutation page		' '	001	schodulod a quality advisor to visit and		
	Findings included:				scheduled a quality advisor to visit and assist in a broader QI plan for the center		
	Findings included.				It is our goal to utilize their expertise fo		
	The resident was adn	nitted on 9/5/17, discharged			process improvement related to	ı	
		7 and readmitted to the			compliance.		
	-	The facility diagnoses were			Compilance.		
		, osteomyelitis of vertebra			Resident #1 went to the hospital and		
	1	abscess, sepsis, thoracic			received services on October 1st, 2017	7	
	discitis, and multiple I				10001100 011 000001 101, 2017	•	
		ouen cungence.			The Center Nurse Executive (CED) and	d	
	Resident #1's 14-day	MDS dated 9/19/17			Assistant Center Nurse Executive (ACI		
		had an intact cognition, was			completed 100% audit of all residents f	•	
	not feeling depressed				the desire for transfer to the hospital. N		
		r. The resident was on			residents were determined to have the		
	scheduled and as nee				desire for transfer to the hospital. Any		
	regimen. The resider	nt had frequent pain.			resident who is identified for transfer to		
	Resident #1 had a ca	re plan dated 9/5/17 that			the hospital or who had a significant		
	included goals and in	terventions for pain. The			change in condition, the physician will I	be	
	I -	sed each shift and pain red as scheduled and as			notified at the time of discovery.		
	needed.				Licensed nurses, including weekend st	aff.	
					agency and part time staff, were educa		
	Pain medication orde	rs were: Gabapentin 300			on 12/1/17 regarding honoring the		
		day ordered on 9/12/17			residents' decision and request to be		
	_	ion used for nerve pain);			transferred to the hospital. The CNE,		
	Tizanidine 4 milligram	ns every 6 hours as needed			ACNE, Unit Managers (UM) will audit,		
	for muscle spasm; Ty	lenol 1000 milligrams every			through interviews, alert and oriented		
		9/27/17 (non-narcotic pain			residents, five days per week including		
		en 800 milligrams 3 times a			one weekend day x 4 weeks, two days	per	
	day ordered on 9/29/	17 (anti-inflammatory).			week including one weekend day x 4		
					weeks, then weekly x 4 weeks.		
		29/17 at 12:51 pm revealed					
		in assessment of 10 out of			The CNE will review the findings of the		
		(level scale of 1 to 10 with			audits and present findings to the Qual	ity	
		in). The pain made it hard			Assurance Performance Improvement		
		caused limited day-to-day			(QAPI) team monthly for 3 months.		
	I -	as documented as being					
		as not satisfied with his					
	current level of pain.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	OATE SURVEY COMPLETED
		345172	B. WING _			C 11/28/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262	<u>'</u>	20,20
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 561	Continued From pag	ge 2	F 5	61		
		9/30/17 at 2:30 am Resident anidine HCL 6 mg as needed le relaxer).				
		10/1/17 at 2:29 am Resident needed Tizanidine HCL 6 mg				
	Nurses' note dated 10/1/17 at 6:56 am Resident #1 was provided as needed Tizanidine HCL 6 mg for back pain.					
		10/1/17 at 7:36 am Resident can't stand the pain" and the hospital."				
	10/1/17 revealed sh the facility at 7:26 at to be sent to the hos pain. The NP docur at 9:13 am and orde	NP) progress note dated e received a voice mail from that Resident #1 requested spital because of his back mented she returned the call ared a urinalysis, urine culture ck x-ray, and to be called re available.				
	the family called to s in pain on the phone doing anything abou	10/1/17 at 5:01 pm revealed state Resident #1 was crying e and the facility was not at his pain. The family was an order for a back x-ray a done).				
	Nurses' note dated 10/1/17 at 5:18 pm revealed Resident #1's family arrived. The resident stated he was going to the hospital (signed himself out and left the building).					
	Nurses' note dated	10/1/17 at 5:23 pm revealed				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	DING		TE SURVEY MPLETED
		345172	B. WING			C 1/28/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262	l I	1/20/2017
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 561	upon call back from that at 5:24 pm that the rego to the ED) due to NP progress note da revealed the NP received that Resident #1 was leave and go to the high NP called the facility informed that the reshis family took him to indicated the back x-been completed yet (A review of the 24-hod dated 10/1/17 reveal of lower back pain armedications were given of night shift the resident hand wants to on-call Physician's Amessage. Staff was A review of the Emer record dated 10/1/17 diagnosed with intracresident had blood or was treated for pain in pain reliever), Decadinflammation) and To anti-inflammatory) [pat the facility]. The nand a magnetic resort the body) of the lumb next morning.	to transfer to the hospital he NP. The NP was notified esident signed himself out (to pain. The NP replied "ok." Ited on 10/1/17 at 6:22 pm sived a voice mail at 5:22 pm sonce again threatening to cospital due to his back pain. at 5:23 pm and was ident signed himself out and the hospital. The note ray and urinalysis had not (in the facility). Four shift report for day shift ed the resident complained and as needed pain ren on night shift. At the end dent stated he "can't stand to go to the hospital." The sesistant was called and left a awaiting a call back. In gency Department's (ED) revealed Resident #1 was etable back pain. The cultures drawn. The resident with Dilaudid (strong narcotic ron (steroid to reduce acute)	F 56			

AMERIDIAN CENTER 345172 B. WING	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	TIPLE CONSTRUCTION NG	(XC	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET			345172	B. WING			
					707 NORTH ELM STREET	DE	11/20/2017
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X1) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPONED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
resonance imaging (MRI: scans inside of the body) which reported a lumbar epidural abscess and sepsis (infection in the blood). The resident was admitted to the hospital and treated for sepsis resulting from the spinal abscess and required surgery to remove the spinal epidural abscess and to provide a laminectomy (orthopedic procedure to remove the vertebral disc and fuse two spinal processes together). A review of the NP progress note dated 10/2/17 revealed the family took Resident #1 to the Emergency Department (ED) for intractable back pain 10/1/17. The resident received Dilaudid, Decadron, and Toradol, had blood cultures drawn, and an order for a magnetic resonance imaging (MRI) the next morning. The resident informed the NP that he was crying like a baby because the pain was so bad, he could not take it anymore. On 11/28/17 at 2:00 pm an interview was conducted with Resident #1. Resident #1 stated that he had several days of uncontrolled pain. The resident informed the nurse, the NP and his family about the increased pain. The resident stated on 10/1/17 during the early morning the pain had gotten unbearable. The resident stated that he requested to go to the hospital several times because he knew something was wrong. The resident was informed the NP refused to send him to the hospital after waiting all day for an answer. The resident called his family crying in pain to take him. The resident stated to a send him to the hospital after waiting all day for an answer. The resident called his family crying in pain to take him. The resident stated that his family took him to the hospital on 10/1/17 in the evening. On 11/28/17 at 4:00 pm an interview was attempted with the NP. The NP had resigned	F 561	resonance imaging (body) which reported and sepsis (infection was admitted to the backers resulting from required surgery to reabscess and to provi (orthopedic procedur disc and fuse two spiral forms of the NP provided from the NP that because the pain was anymore. On 11/28/17 at 2:00 conducted with Resident informed the NP that because the pain was anymore. On 11/28/17 at 2:00 conducted with Resident informed family about the incresident informed family about the incresident unbethat he requested to times because he kn. The resident was informed the NP that he requested to times because he kn. The resident was informed the the hosp an answer. The resident was informed the him to the hosp an answer. The resident was informed the him to take him. If amily took him to the evening.	MRI: scans inside of the dia lumbar epidural abscess in the blood). The resident hospital and treated for the spinal abscess and emove the spinal epidural ide a laminectomy re to remove the vertebral inal processes together). Trogress note dated 10/2/17 pook Resident #1 to the rent (ED) for intractable back resident received Dilaudid, dol, had blood cultures for a magnetic resonance ext morning. The resident is the was crying like a baby is so bad, he could not take it if the nurse, the NP and his reased pain. The resident ring the early morning the rearable. The resident stated go to the hospital several new something was wrong. The resident to the hospital several new something was wrong. The resident stated that his resident stated that his resident stated that his resident stated that his resident on 10/1/17 in the	F	561		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		riple construction		(X3) DATE SURVEY COMPLETED
		345172	B. WING			C 11/28/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 707 NORTH ELM STREET HIGH POINT, NC 27262	, ZIP CODE	11/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)	
F 561	available. On 11/28/17 at 4:15 conducted with the MMD stated that he wa #1 and would need to The MD stated that FED if he wanted to call to treat in the factor of the management of the manage	om an interview was fledical Director (MD). The as not familiar with Resident or review his medical record. Resident #1 could go to the The NP made a judgement ility. om an interview was a #1. Nurse #1 stated that Resident #1 on 9/28/17 the m to 11:30 pm). Nurse #1 very familiar with the resident. The NP at 11:59 pm that ring back pain 8 out of 10 lieved with his regular m. The NP ordered ams now one dose which	F	561		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ON NUMBER: A. BUILDING COMPL		ATE SURVEY DMPLETED	
		345172	B. WING _			C 11/28/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262		11/20/2017
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 561	to call his family to the state of that the result is the property of the state of	ait anymore" and was "going take him" (to the ED). Nurse esident had a right to go to the urse #1 stated that she had in entire shift for a response tast. Nurse #1 stated that she as resident to the ED without is stated that the Unit Manager ours a day and she could have it stated she would send a man emergency via an order if necessary. The fort Nurse #1 was informed amily came and took the is pm an interview was informed amily came and took the interviewed Resident #1's the resident had selected him. The resident had selected him is the resident's interview in the NP ordered labs, as x-ray and chose not to the ED and that if the resident had a significant	F	,		
	order. The MD agree go to the ED himsel information from the On 11/28/17 at 6:35 conducted with Nur. NA stated she was 10/1/17 evening shi	send the resident without an eed that if the resident was to if there would be no medical e facility provided. If pm an interview was sing Assistant #1 (NA). The assigned to Resident #1 on ft (3pm - 11:30 pm). The NA lent was "hurting real bad" and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345172	B. WING				C 28/2017
NAME OF PR	ROVIDER OR SUPPLIER		•	70	REET ADDRESS, CITY, STATE, ZIP CODE 7 NORTH ELM STREET 1GH POINT, NC 27262		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	was present when the facility and stated she the ED. On 11/28/17 at 6:45 p conducted with the Administrator stated to	nim. The NA stated that she e resident's wife came to the was taking the resident to	F	561			
F 580 SS=G	S483.10(g)(14) Notifice (i) A facility must immodulate consult with the residence consistent with his or representative(s) who consistent with his or representative and his physician intervention (B) A significant chan mental, or psychosoci deterioration in health status in either life-the clinical complications (C) A need to alter the a need to discontinue treatment due to advect the commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic	cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring a; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or b; eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or efer or discharge the	F	580			12/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			
		345172	B. WING _		C 11/28/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262	117202317
(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 SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 580	resident and the resident when there iswhen there is- (A) A change in room as specified in §483.1 (B) A change in residence in §483.1 (C) The facility must represent in the representative in the resident was additionally the resident was additionally included: The resident was additionally included:	also promptly notify the lent representative, if any, or roommate assignment $0(e)(6)$; or ent rights under Federal or as as specified in paragraph ecord and periodically mailing and email) and resident stinct part. A facility estinct part (as defined in e in its admission agreement eion, including the various et the composite distinct y the policies that apply to en its different locations is not met as evidenced ew, resident interview, and staff interviews, the the physician of the change in condition which treatment for sepsis and ass with nerve impingement	F 5	In addition to the Plan of Correction (POC) submitted, we also respect submit the following. Our center is registered with North Carolina QIC we have reached out to them for additional assistance and support to this survey cycle. The QIO has scheduled a quality advisor to visit assist in a broader QI plan for the lit is our goal to utilize their experting process improvement related to compliance. Resident #1 went to the hospital as received services on October 1st,	tfully cond cond distribution content content cond cond cond cond cond cond cond cond

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
			7 t. BOILBING	·		С
		345172	B. WING		,	11/28/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
MEDIDIAN	LOENTED			707 NORTH ELM STREET		
WERIDIAN	N CENTER			HIGH POINT, NC 27262		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 580	revealed the reside not feeling depress psychosis or behaves cheduled and as regimen. The reside Resident #1 had a included goals and pain was to be assemedication administ needed. A review of the 24-revealed the resided pain and as needed on night shift. At the resident stated he to go to the hospital Assistant (which is called and left a me call back. Nurses' noted date Resident #1 was copain and had requently not the pain and to the hospital. A review of the teledetails dated 10/1/2 ordered an x-ray of spine. Nurses' note dated	ay MDS dated 9/19/17 ant had an intact cognition, was ed, and there was no vior. The resident was on needed pain medication dent had frequent pain. Care plan dated 9/5/17 that interventions for pain. The ressed each shift and pain stered as scheduled and as thour shift report dated 10/1/17 and complained of lower back dipain medications were given be end of night shift the can't stand the pain and wants al." The on-call Physician's the Nurse Practitioner) was essage. Staff was awaiting a did 10/1/17 at 7:25 am revealed complaining of increased back ested to go to the hospital. The was called and left a message that the resident wanted to go aphone/verbal order signature that 2:10 pm revealed the NP of the lower back and lumbar 10/1/17 at 5:23 pm revealed	F 58	The CNE and ACNE comple audit of all residents for the or transfer to the hospital. No redetermined to have the desire to the hospital. Any resident identified for transfer to the hospital change the physician will be notified discovery. If physician or an staff not in agreement to transferred to the hospital, cent have resident transferred to Licensed nurses, including wagency and part time staff, won 12/1/17 regarding alerting physician concerning any sigchange in condition as well a residents' decision and requitransferred to the hospital. The ACNE, UM will audit, through alert and oriented residents, week including one weekend weeks, two days per week in weekend day x 4 weeks, the weeks. The CNE will review the find audits and present findings the team monthly for 3 months.	desire for esidents were re for transfer who is nospital or e in condition, at the time of my medical esfer the ter staff will hospital. I weekend staff, were educated to the gnificant est to be the CNE, h interviews, five days per d day x 4 encluding one en weekly x 4 ings of the	
	there were no orde	rs to transfer to the hospital the NP. The NP was notified				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	e) MULTIPLE CONSTRUCTION BUILDING		COMPLETED	
		345172	B. WING _			C 11/28/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262	I	11/20/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 580	go to the ED) due to Nurse Practitioner (I 10/1/17 at 6:22 pm voice mail at 5:22 pm again threatening to due to his back pair pm and was informed himself out and his inhospital. A review of the Emerecord dated 10/1/1 seen and diagnosed A review of the NP prevealed the family Emergency Department 10/1/17. On 11/28/17 at 2:00 conducted with Resthat he had several The resident stated morning the pain haresident stated that hospital several time something was wrotinformed by Nurse stothe hospital after The resident called take him. The resident on 11/28/17 at 4:30 conducted with Nurse was assigned to the was assigned to	resident signed himself out (to pain. The NP replied "ok." NP) progress note dated on revealed the NP received a m that Resident #1 was once pleave and go to the hospital in. NP called the facility at 5:23 and that the resident signed family took him to the regency Department's (ED) in revealed Resident #1 was in dividing with intractable back pain. Progress note dated 10/2/17 took Resident #1 to the ment (ED) for intractable back in pain interview was ident #1. Resident #1 stated days of uncontrolled pain. In on 10/1/17 during the early indigotten unbearable. The he requested to go to the eas because he knew ing. The resident was if the NP refused to send him waiting all day for an answer, his family crying in pain to lent stated that his family took on 10/1/17 in the evening. In pain interview was see #1. Nurse #1 stated that that in Resident #1 on 10/1/17 day in). Nurse #1 stated that she	F 5	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С
		345172	B. WING		11/3	28/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				707 NORTH ELM STREET		
MERIDIAN	CENTER			HIGH POINT, NC 27262		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	called at 7:35 am and resident had increase change. Nurse #1 state back from the NP tow Nurse #1 stated that san entire shift for a repast. Nurse #1 stated send a resident to the #1 stated that the Unithours a day for concecalled her for further instated she would send emergency via ambulinecessary. On 11/28/17 at 5:28 p conducted with the Middle Mi	the resident. The NP was left a message that the d back pain and this was a ated that she received a call ard the end of her day shift. She had not waited almost sponse from an NP in the d that she did not like to ED without an order. Neel that Manager was available 24 was and she could have enstructions. Nurse #1 d a resident to the ED in an ance without an order if was an interview was redical Director (MD). The dreviewed Resident #1's red him. The MD stated the 1/17 because of the back pain. The MD stated is right to go to the ED and felt the resident had a rey could send the resident with ED himself there would	F 58	<u>'</u>		
F 600 SS=G	acceptable to respond	d to the facility.	F 60	00		12/4/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345172 B. WING			C 11/28/2017		
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE		
MERIDIAN	CENTER			707 NORTH ELM STREET		
MERIDIAN	OENTER			HIGH POINT, NC 27262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY 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 600	Continued From page	e 12	F 6	00		
F 600	§483.12 Freedom froe Exploitation The resident has the neglect, misappropria and exploitation as dincludes but is not lim corporal punishment, any physical or chem treat the resident's misses §483.12(a) The facilities graphs and subset on record reversion that the physician interview and facility failed to initiate complaints of increase managed by the current out of 3 residents (Resident #1 was admitted to the hospital 10/2/1 facility on 10/27/17. The poly substance abuse thoracic, intra-spinal discities, and multiple Resident #1 's 14-darevealed the resident not feeling depressed psychosis or behavior and explosion of the properties of the properti	right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. The verbal, mental, sexual, or oral punishment, or is not met as evidenced iew, resident interview, and staff interviews, the emedical treatment for sed pain that was not ent medication regimen in 1 esident #1). The facility diagnoses were encoted iew, resident interview in a second in the sec	F 6	In addition to the Plan of Corre (POC) submitted, we also resp submit the following. Our center registered with North Carolina we have reached out to them fadditional assistance and suppto this survey cycle. The QIO hascheduled a quality advisor to assist in a broader QI plan for It is our goal to utilize their exp process improvement related to compliance. Resident #1 went to the hospit received services on October of Licensed nurses completed 10 assessment of all residents. Nowere determined to have unresincreased pain. If any resident	pectfully er is QIO and or port related has visit and the center. ertise for o al and 1st, 2017. 0% pain o residents solved or verbalizes	
	facility on 10/27/17. poly substance abuse thoracic, intra-spinal discitis, and multiple Resident #1 's 14-da revealed the resident	The facility diagnoses were e, osteomyelitis of vertebra abscess, sepsis, thoracic back surgeries. By MDS dated 9/19/17 had an intact cognition, was		Resident #1 went to the hospit received services on October 1 Licensed nurses completed 10 assessment of all residents. No	al and 1st, 2017. 10% pain o residents	
	psychosis or behavio	r. The resident was on eded pain medication		I	verbalizes the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345172	B. WING				C 28/2017
NAME OF PROVIDER OR SUPPLIER	<u> </u>		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	20/2017
			70	07 NORTH ELM STREET		
MERIDIAN CENTER			Н	IGH POINT, NC 27262		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Resident #1 had a care plar included goals and intervent pain was to be assessed ear medication administered as needed. Nurses ' note dated 9/29/17 revealed Resident #1 had a 10 out of 10 almost constant 10 with 10 being the worst pit hard to sleep at night and day-to-day activities. The pas being new. The resident his current level of pain. Pain medication orders were milligrams 3 times a day ord (anti-seizure medication use Tizanidine 4 milligrams ever for muscle spasm; Tylenol 12 hours ordered on 9/27/17 reliever); and Ibuprofen 800 day ordered on 9/29/17 (anti A review of the medication a (MAR) for September and C the resident was administer Tylenol and Ibuprofen as ordered on 9/28/18 at 9:00 am 0 level plevel pain; 9/29/17 at 9 am 5 level pain pain; 9/30/17 at 9:00 am 10 level level pain; and 10/1/17 at 9:00 am 10 level level pain; and 10/1/17 at 9:00 am 10 level	tions for pain. The ich shift and pain scheduled and as 7 at 12:51 pm pain assessment of tly (level scale of 1 to pain). The pain made caused limited ain was documented was not satisfied with the e: Gabapentin 300 dered on 9/12/17 and for nerve pain); by 6 hours as needed 1000 milligrams every 7 (non-narcotic pain milligrams 3 times a di-inflammatory). Administration record 20tober 2017 revealed and the Gabapentin, dered. The pain in the MAR was as The pain and 10:00 pm 8 and 10:00 pm 8 level pain and 10:00 pm 4	F	600	discovery and a change in condition assessment will be initiated by licensed nursing staff and communicated to the physician and/or medical staff. Licensed nurses, including weekend stagency and part time staff, were educated on 12/1/17 regarding awareness of complaints of increased or unresolved pain that is not managed by current medication regiment as well when to follow-up with physician and initiate a change in condition assessment. The CNE, ACNE, and UM will audit, throug interviews, alert and oriented residents five days per week including one week day x 4 weeks, two days per week including one weekend day x 4 weeks, then weekly x 4 weeks. The CNE will review the findings of the audits and present findings to the QAP team monthly for 3 months.	taff, ated h s, end	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345172	B. WING _			C 11/28/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 707 NORTH ELM STREET HIGH POINT, NC 27262	E	11120/2011	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 600	level pain Nurses' note dated revealed Resident # back pain with spass tips. The NP was montinued use of nemedications (Ibupro Nurses' note dated #1 was provided Tiz for back pain (musch Nurses' note dated #1 was provided as for back pain. Nurses' note dated #1 was provided as for back pain. Nurses' note dated #1 was provided as for back pain. Nurses' note dated #1 complained he "c" requested to go to the facility at 7:26 at to be sent to the hos pain. The NP called and ordered a urinal sensitivity, and a bawhen the results we A review of the telepdetails dated 10/1/1	9/29/17 at 10:30 pm 1 complained of migrating ms and numbness to finger ade aware and ordered for wly scheduled pain fen: anti-inflammatory). 9/30/17 at 2:30 am Resident anidine HCL 6 mg as needed to relaxer). 10/1/17 at 2:29 am Resident needed Tizanidine HCL 6 mg 10/1/17 at 6:56 am Resident needed Tizanidine HCL 6 mg 10/1/17 at 7:36 am Resident needed Tizanidine HCL 6 mg NP) progress note dated the hospital." NP) progress note dated the received a voice mail from m that Resident #1 requested spital because of his back in the facility back at 9:13 am lysis, urine culture and ck x-ray and to be called	F	500			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING		` '	(X3) DATE SURVEY COMPLETED C 11/28/2017	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 707 NORTH ELM STREET HIGH POINT, NC 27262		11/20/2017	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	revealed the NP recethat Resident #1 was leave and go to the hNP called the facility informed that the reshis family took him to indicated the back x-been completed yet. A review of Resident 10/2/17 revealed the resonance imaging (body) which reported and sepsis (infection was admitted to the sepsis resulting from required surgery to rabscess and to provi (orthopedic procedured disc and fuse two sports and fuse fuse in 10/1/17. The resonance imaging (resident informed the baby because the patake it anymore. On 11/28/17 at 2:00 conducted with Residual the had several control of the fact	sted on 10/1/17 at 6:22 pm elived a voice mail at 5:22 pm sonce again threatening to nospital due to his back pain. at 5:23 pm and was elident signed himself out and to the hospital. The note gray and urinalysis had not (in the facility). If #1 's hospital record dated resident had a magnetic MRI: scans inside of the dalumbar epidural abscess in the blood). The resident hospital and treated for the spinal abscess and emove the spinal epidural idea a laminectomy re to remove the vertebral inal processes together). It was not entered to the date of the date of the spinal abscess and emove the spinal epidural idea a laminectomy re to remove the vertebral inal processes together). It was not entered to the entered to the spinal epidural idea a laminectomy re to remove the vertebral inal processes together). It was not entered to the entered to the entered en	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345172	B. WING _			C 11/28/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 707 NORTH ELM STREET HIGH POINT, NC 27262	DDE	20.20
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	stated on 10/1/17 dupain had gotten unb that he requested to times because he kn. The resident was inf NP refused to send waiting all day for arhis family crying in pstated that his family 10/1/17 in the evening. On 11/28/17 at 4:30 conducted with Nursishe was assigned to evening shift (3:00 pstated that she was Nurse #1 informed to Resident #1 was has scale that was not rescheduled medication. Unurse #1 stated that Resident #1 on 10/1. The NP was called at the resident had incount of 10 scale and its stated that she recent toward the end of he ordered labs, back a culture/sensitivity. Note the NP that the resident had incount of 10 scale and its stated that she recent toward the end of he ordered labs, back a culture/sensitivity. Note the NP that the resident had incount of 10 scale and its stated that she recent toward the end of he ordered labs, back a culture/sensitivity. Note that the resident had incount of 10 scale and its stated that she recent toward the end of he ordered labs, back a culture/sensitivity. Note that the resident had incount of 10 scale and its stated that she recent that she recent toward the end of he ordered labs, back a culture/sensitivity. Note that the resident had incount of 10 scale and its stated that she recent that she rece	reased pain. The resident uring the early morning the earable. The resident stated go to the hospital several new something was wrong. Formed by Nurse #1 that the him to the hospital after an answer. The resident called rain to take him. The resident or took him to the hospital on ang. pm an interview was see #1. Nurse #1 stated that a Resident #1 on 9/28/17 the rem to 11:30 pm). Nurse #1 very familiar with the resident. The NP at 11:59 pm that wing back pain 8 out of 10 elieved with his regular	F	600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345172	B. WING		11/28/2017
	ROVIDER OR SUPPLIER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 600	"was not going to w to call his family to the stated that the react of the wanted. Not waited almost a from an NP in the p did not like to send an order. Nurse #1 was available 24 ho called her. Nurse #1 resident to the ED in ambulance without next day during report that the resident 's resident to the ED. On 11/28/17 at 4:50 conducted with Nurse could not remembe complaints of increastated she was one on ight shifts (3:00 pn the hall where Residuated that she was different halls. On 11/28/17 at 5:28 conducted with the MD stated that he he record and remember pain management is polysubstance abust heavy medications: Ibuprofen, and Motrivas called on 10/1/increased back pair and back x-ray and	resident informed her he ait anymore" and was "going take him" (to the ED). Nurse esident had a right to go to the urse #1 stated that she had in entire shift for a response ast. Nurse #1 stated that she a resident to the ED without stated that the Unit Manager ours a day and she could have in an emergency via an order if necessary. The fort Nurse #1 was informed family came and took the in pm an interview was se #2. Nurse #2 stated she resident #1 and his ased back pain. Nurse #2 duty on 9/29/17 evening and in to 7:00 am) responsible for dent #1 resided. Nurse #2 frequently assigned to	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345172	B. WING			C 11/28/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 707 NORTH ELM STREET HIGH POINT, NC 27262		11720/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 675 SS=G	to assess. The resic smoking or sitting in of pain when the NF 9/29/17. The MD sright to go to the ED the resident had a send the resident wi agreed that if the reshimself there would from the facility proving the facil	g back pain and was difficult dent would be up and his bed and not complaining as whim on 9/28/17 and tated that it was a resident 's and that if the facility staff felt ignificant change they could thout an order. The MD sident was to go to the ED be no medical information ided. pm an interview was sing Assistant #1 (NA). The assigned to Resident #1 on it (3pm - 11:30 pm). The NA ent was "hurting real bad" and him. The resident had more ously seen and this was a if not see the NP on evening I that she was present when came to the facility and stated esident to the ED. pm an interview was Administrator. The that if a resident chose and he hospital it was his/her right		675		12/4/17
	applies to all care ar residents. Each res facility must provide	ndamental principle that nd services provided to facility ident must receive and the the services to attain or maintain				

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		345172	B. WING _		C 11/28/2017	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MERIDIAN	I CENTER			707 NORTH ELM STREET HIGH POINT, NC 27262		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 675	Continued From pag	e 19	F 6	75		
	the highest practical psychosocial well-be resident's comprehe of care. This REQUIREMEN' by: Based on record revelophysician interview, facility failed to provicare and services who pain management are treatment for sepsis abscess with nerve i residents (Resident and to the hospital 10/2/1 facility on 10/27/17. polysubstance abuse thoracic, intra-spinal discitis, and multiple Resident #1's 14-day revealed the residen not feeling depresse psychosis or behavious scheduled and as ne regimen. The resider Resident #1 had a caincluded goals and in pain was to be assess	lle physical, mental, and ing, consistent with the nsive assessment and plan Γ is not met as evidenced riew, resident interview, and staff interviews, the de the resident requested nich resulted in uncontrolled and a delay in medical and a spinal epidural mpingement in 1 out of 3 ± 1). mitted on 9/5/17, discharged 7 and readmitted to the The facility diagnoses were exposted sugeries. MDS dated 9/19/17 thad an intact cognition, was		In addition to the Plan of Correctic (POC) submitted, we also respect submit the following. Our center is registered with North Carolina QIC we have reached out to them for additional assistance and support to this survey cycle. The QIO has scheduled a quality advisor to visit assist in a broader QI plan for the It is our goal to utilize their expertis process improvement related to compliance. Resident #1 went to the hospital a received services on October 1st, The CNE and ACNE completed 10 audit of all residents for the desire transfer to the hospital. No resident determined to have the desire for to the hospital. Any resident who is identified for transfer to the hospital who had a significant change in coassessment, the physician will be at the time of discovery to avoid a medical treatment. Licensed nurses completed 100% assessment of all residents. No rewere determined to have unresolv	fully D and related t and center. se for nd 2017. 00% for nts were transfer s al or ondition notified delay in pain sidents	
	milligrams 3 times a	ers were: Gabapentin 300 day ordered on 9/12/17 tion used for nerve pain);		increased pain. If any resident veri unresolved or increased pain, the physician will be notified at the tim	balizes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '			(X3) DATE SURVEY COMPLETED	
		345172	B. WING _	B. WING		C 11/28/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 707 NORTH ELM STREET HIGH POINT, NC 27262			
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 675	for muscle spasm; Till hours ordered on reliever); and Ibuprof day ordered on 9/29. A review of the Septemedication administre documented pain level pain; 9/29/17 at 9 am 5 level pain; 9/30/17 at 9:00 am 1 level pain; and 10/1/17 at 9:00 am 1 level pain (level scale worst pain). Nurses' note dated 9 Resident #1 had a pain of the pain of the pain of the pain of the pain. Nurses' note dated 9 Resident #1 complain with spasms and nur NP was made aware use of newly schedu (Ibuprofen).	ms every 6 hours as needed ylenol 1000 milligrams every 9/27/17 (non-narcotic pain fen 800 milligrams 3 times a 1/17 (anti-inflammatory). The more and October 2017 ration record revealed rel as follows: I level pain and 10:00 pm 8 level rel pain and 10:00 pm 8 level rel pain and 10:00 pm 8 rel pain assessment of 10 out of 10:00 pm 8 rel pain assessment of 10:00 pm 8 rel pain asse	F	discovery to avoid a delay treatment and a change in assessment will be initiated nursing staff and communi physician and/or medical states. Licensed nurses, including agency and part time staff, on 12/1/17 regarding award complaints of increased or pain that is not managed be medication regimen as well follow-up with physician and change in condition assess CNE, ACNE and UM will a interviews, alert and orient five days per week includind day x 4 weeks, two days per including one weekend day then weekly x 4 weeks. Licensed nurses, including agency and part time staff, on 12/1/17 regarding honoresidents' decision and requirents for the hospital. ACNE and UM will audit, the interviews, alert and orient five days per week includind day x 4 weeks, two days per including one weekend day then weekly x 4 weeks. The CNE will review the fir audits and present findings team monthly for 3 months.	condition d by licensed icated to the staff. g weekend staff, were educated eness of unresolved by current Ill as when to ad initiate a sment. The sudit, through ed residents, ag one weekend er week by x 4 weeks, g weekend staff, were educated ering the quest to be The CNE, hrough ed residents, ag one weekend er week y x 4 weeks, hrough ed residents, and one weekend er week y x 4 weeks, hrough ed residents, and one weekend er week y x 4 weeks,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345172	B. WING				C 28/2017
NAME OF PI	ROVIDER OR SUPPLIER			70	REET ADDRESS, CITY, STATE, ZIP CODE 7 NORTH ELM STREET IGH POINT, NC 27262	1 100	20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 675	Continued From page	e 21	F	375			
		0/1/17 at 2:29 am Resident needed Tizanidine HCL 6 mg					
		0/1/17 at 6:56 am Resident needed Tizanidine HCL 6 mg					
		0/1/17 at 7:36 am Resident an't stand the pain" and ne hospital."					
	10/1/17 revealed she the facility at 7:26 am to be sent to the hosp pain. The NP called and ordered a urinaly	P) progress note dated received a voice mail from that Resident #1 requested bital because of his back the facility back at 9:13 amorsis, urine culture and k x-ray and to be called a available.					
	details dated 10/1/17	none/verbal order signature at 2:10 pm revealed the NP a-ray of the lower back and					
	revealed the NP rece that Resident #1 was leave and go to the h NP called the facility informed that the res his family took him to	dent signed himself out and the hospital. The note ray and urinalysis had not					
	record dated 10/1/17	gency Department (ED) revealed Resident #1 was table back pain. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345172	B. WING			C 11/28/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 707 NORTH ELM STREET HIGH POINT, NC 27262		11/26/2017	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 675	was treated for pain pain reliever), Decadinflammation), and Tanti-inflammatory) [pat the facility]. The rand a magnetic reso the body) of the luminext morning to deterpain. A review of Resident 10/2/17 revealed the reported a lumbar egand sepsis (infection was admitted to the infection and require spinal epidural absoluminectomy (orthop the vertebral disc an together). A review of the NP prevealed the family trintractable back pain received Dilaudid, Demedications) and an morning. The reside was crying like a bath bad, he could not take the had several of the resident informer family about the incresited on 10/1/17 dupain had gotten unbersident.	ultures drawn. The resident with Dilaudid (strong narcotic dron (steroid for acute foradol (prescription ain medications not provided nance image (MRI: scan of our spine was ordered for the formine the cause of the back of	F 67	75			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
		345172	B. WING			C 11/28/2017		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 707 NORTH ELM STREET HIGH POINT, NC 27262	IP CODE	11/20/2017		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFII TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIA	
F 675	times because he kn The resident was informed him to the hosp an answer. The resi in pain to take him. family took him to the evening. On 11/28/17 at 4:30 conducted with Nurs she was assigned to evening shift (3:00 postated that she was a Nurse #1 informed th Resident #1 was have scale that was not re scheduled medication Ibuprofen 800 milligr was administered. Nurse #1 stated that Resident #1 on 10/1/ The NP was called a the resident had incr out of 10 scale and the stated that she receive toward the end of he ordered labs, back x	ew something was wrong. Formed the NP refused to solve after waiting all day for dent called his family crying. The resident stated that his exposition on 10/1/17 in the exposition on 10/1/17 in the exposition of the properties		675	ENCY)			
	the NP that the resid hospital. According "I am not sending hir wants more pain mershe informed the resident cursed a Nurse #1 stated the "was not going to was to call his family to ta	ent wanted to go to the to Nurse #1, the NP replied, in to the hospital, he just dication." Nurse #1 stated ident of the NP orders and and had become angry. resident informed her he it anymore" and was "going ake him" (to the ED). Nurse sident had a right to go to the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345172	B. WING _			C 11/28/2017	
NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 707 NORTH ELM STREET HIGH POINT, NC 27262	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 675	CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	675			
	conducted with Nurs NA stated she was a 10/1/17 evening shir stated that the resid this was unusual for	sing Assistant #1 (NA). The assigned to Resident #1 on ft (3pm - 11:30 pm). The NA ent was "hurting real bad" and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345172	B. WING			C	
	ROVIDER OR SUPPLIER	340172		STREET ADDRESS, CITY, STATE, ZIP CODE 707 NORTH ELM STREET HIGH POINT, NC 27262			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5 COMPLET DAT		
F 675	change. The NA did shift. The NA stated the resident's wife ca she was taking the re On 11/28/17 at 6:45 p conducted with the Administrator stated to	not see the NP on evening that she was present when me to the facility and stated sident to the ED. om an interview was	F 6	75			