## Statement of Deficiencies and Plan of Correction

### Building _____________________________

### Provider/Supplier/CLIA Identification Number:

345172

### Name of Provider or Supplier

**Meridian Center**

### Street Address, City, State, Zip Code

707 North Elm Street
High Point, NC 27262

### Provider's Plan of Correction

**Each corrective action should be cross-referenced to the appropriate deficiency.**

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>(X5) Completion Date</th>
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<tbody>
<tr>
<td>F 580 SS=D</td>
<td>F 580</td>
<td></td>
<td>§483.10(g)(14) Notification of Changes. (Each deficiency must be preceded by full regulatory or LSC identifying information)</td>
<td>2/6/18</td>
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</table>

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is:

- A change in room or roommate assignment as specified in §483.10(e)(6); or
- A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
F 580 Continued From page 1

§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

This REQUIREMENT is not met as evidenced by:

Based on medical record review and staff and Nurse Practitioner interviews, the facility failed to notify the Nurse Practitioner of a resident fall for 1 of 3 (Resident #1) sampled for falls.

Findings included:

The resident was admitted to the facility on 4/10/16 with diagnosis including: Frontotemporal Dementia, Picks Disease and Degenerative Disc Disease.

A review of the most recent Quarterly Minimum Data Set (MDS) assessment dated 1/9/18 revealed the resident required extensive assistance with 2 people for bed mobility and extensive assistance assist of one person for transfers. The resident was ambulatory with a walker.

A review of the medical record on 1/23/18 at 10:30 AM revealed a nurses note on 1/11/18 at 2300, the resident was lowered to the floor with the assistance of the nursing assistant when his legs became weak. The responsible party was notified. A further review of the medical record did not indicate that the Nurse Practitioner had been notified.

Facility failed to notify Nurse Practitioner of a resident fall. It was an oversight/human error that the nurse forgot to call the NP about a resident's fall.

1. Nursing staff failed to inform Physician or NP of fall in timely manner. Medical Director and NP have been made aware of resident #1 having had a fall.

A 100% audit of all falls in the last 30 days was completed by the Center Nurse Executive to ensure MD/NP/responsible party notification is completed and documented.

The CNE or Assistant Center Nurse Executive will complete training for licensed nurses on notifying the MD/NP for all events/changes of conditions in a timely manner. Handbooks will be placed at all nurses' stations for quick references for events and changes of conditions.

All events will be reviewed 5 times per week in the clinical morning meeting/stand up to ensure notification of
## Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:**

**Meridian Center**

**Address:**

707 North Elm Street, High Point, NC 27262

### Summary Statement of Deficiencies

**ID** | **Prefix** | **Tag** | **Provider's Plan of Correction**
---|---|---|---
F 580 | | | Notified.

A phone interview on 1/23/18 at 10:25 AM revealed she was on duty on the 11th and was going to change the residents' bed because it was wet. She asked the resident to stand and his legs became weak so she assisted him to the floor. She stated she called for assistance, notified the nurse and got the residents blood pressure.

**Event ID:** F 580

An interview with the Nurse Practitioner on 1/23/18 at 11:45 AM revealed she was not notified of the incident on 1/11/18 where the resident was lowered to the floor. She further revealed she would have expected to be notified due to the resident's history and his previous fall on 1/8/18 with fractures of T11 and L1.

A phone interview on 1/23/18 at 12:56 PM with the Nurse #1, who was on duty on 1/11/18 when the incident occurred, revealed the nursing assistant called her to the room and she entered to find the resident sitting on the floor. She revealed the nursing assistant told her the residents' legs became weak and she assisted him to the floor. The nurse revealed she did not notify the Nurse Practitioner because she didn't consider the incident a fall. She revealed she notified the responsible party and added the incident to the change of condition that was already in the system from the fall on 1/8/18.

**Event ID:** F 580

An interview with the Director of Nursing on 1/24/18 at 8:44 AM revealed a fall is any change from one surface to another, including sliding out of a bed or a wheelchair or being assisted to the floor. She revealed she did consider the incident on 1/11 with this resident to be a fall and would

**Event ID:** MD/NP/RP was completed and documented. Results of these audits will be brought to the monthly Quality Assurance and Performance Improvement Committee for review.

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**Event ID:** F 580

**Facility ID:** 923288

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<table>
<thead>
<tr>
<th>Event ID: KMS411</th>
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<td>Continued From page 3 have expected the nurse to assess the resident, call the physician or Nurse Practitioner on duty, complete a change of condition and notify the responsible party. She stated that the facility has conducted inservicing following this incident on what was considered a fall and what actions to take.</td>
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