DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	<u>D. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	COM	E SURVEY PLETED
		345307	B. WING				C / 20/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	B			4414 WILKINSON BLVD		
MEADOW		-1		C	GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550 SS=G	Resident Rights/Exer CFR(s): 483.10(a)(1)(§483.10(a) Resident I The resident has a rig self-determination, an access to persons an outside the facility, ind this section. §483.10(a)(1) A facilit with respect and dign resident in a manner promotes maintenanch her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, must establish and m practices regarding the provision of services of residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise	cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, ad communication with and d services inside and cluding those specified in by must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. clility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen		550	DEFICIENCY)		1/18/19
	free of interference, c reprisal from the facili rights and to be suppo	sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the SUPPLIER REPRESENTATIVE'S SIGNATURE	=		TITLE		(X6) DATE

Electronically Signed

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.

01/22/2019

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		ECONSTRUCTION	(X3) DATE	0. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, í			· /	LETED
				-		(С
		345307	B. WING			12/	20/2018
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	ER			1414 WILKINSON BLVD		
					GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 550	Continued From page	e 1		550			
1 000		rights as required under this		550			
	subpart.	ngnis as required under this					
		T is not met as evidenced					
	by:						
		ons, record review, staff and			1. Incontinence care was provided to		
		he facility failed to treat one			Resident #13 by a certified nursing		
		by leaving the resident lying			assistant 12/16/18.		
	•	urine and stool from 12:41					
		2/16/18 for 1 of 5 residents			2.All residents requiring incontinence ca		
	dependent on staff fo (Resident #13).	or incontinence care			were assessed by the Registered Nurse Interim Director of Nursing from 1/16/20		
	(Resident #15).				through 1/18/2019 for any adverse effe		
	Findings included:				with none observed.	013	
	Decident #12 was rea	admitted to the facility on			2 All purping staff wars advasted on		
		admitted to the facility on inal admission on 10/08/09			3.All nursing staff were educated on proper incontinence care on 1/16/19		
		gnoses: neuromuscular			through 1/18/19 by the Registered		
		er, history of urinary tract			Nurse/Interim Director of Nursing. All st	taff	
		ressive episode, anxiety,			were educated by the Registered Nurse		
		and left hands, history of			Interim Director of Nursing		
	cellulitis of lower extr	emities with sepsis,			1/16/19-1/18/19, that all staff are		
	unsteadiness of feet	and type 2 diabetes mellitus.			responsible for acknowledging call light	s	
					and to inform the appropriate staff if the		
		#13's Annual Minimum Data			need is outside of their scope and on th	ne	
		/28/18, indicated he was			components of the Concern/Grievance		
		l was totally dependent on MDS further indicated			policy. In addition, the above education		
		ways incontinent of bowel			will be included in subsequent new-hire orientations.	;	
		S revealed that he displayed					
		ard others but had no			4. In order to ensure compliance the		
	rejection of care.				Director of Nursing/ Interim Director of		
	-				Nursing will be responsible for this aspe	ect	
	A review of the Activit	ties of Daily Living (ADL)			of the Plan of Correction. The Registered	əd	
		Area Assessment (CAA) and			nurse will randomly check the complian		
		CAA associated with the			of Certified Nursing Assistants providing		
		Resident #13 needed			incontinence care-5 residents per week	X	
		ing as the resident was			4weeks, then 2 residents per week x		
		and bladder and staff			4weeks. The Social Service Director wi	11	
	provided incontinent	care routinely and as			Interview random cognitive residents		

Facility ID: 923314

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		MEDICAID SERVICES	(X2) MULTIP	PLE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		G		OMPLETED
						С
		345307	B. WING			12/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
MEADOW	WOOD NURSING CENT	ER		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 PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 550	Continued From page	e 2	F 55	50		
		or Symptom CAA revealed gression directed toward		about timely call light respon week x 4 weeks then 2 resid		
	staff.	gression directed toward		week x 4 weeks.		
	03/14/18, indicated the self-care performance extensive assistance needs. The care plan incontinence care wa needed for Resident is was encouraged to us A review of the care p revealed that he had aggressive toward car regarding the resident toward caregivers, fu assess and anticipate and comfortable level monitoring, reminding reposition at least ever	from staff for toileting further indicated that s provided routinely and as #13 and that Resident #13 se bell to call for assistance. blan for Resident #13 the potential to be verbally uregivers. The care plan, it being verbally aggressive rther revealed staff were to e resident's toileting needs I and the resident needed g, assistance to turn or ery 2 hours and more often		 The resident council minutes submitted at the next schedu Assurance Performance Imp Committee meeting. The Pla Correction will be reviewed a scheduled Quality Assurance Performance Committee me 1/22/19. The Committee incl Medical Director, Administra of nursing, Registered Nurse Social Service Director, Diet Medical Records/Human Re Director, Maintenance Director staff member. All Plan of Correction auditor to sementale Quality Assurance Director auditor to sementale Quality Assurance Director for the ported by each auditor to sementale Quality Assurance Director for the ported by each auditor to sementale Quality Assurance Director for the ported by each auditor to sementale Quality Assurance Director for the ported by each auditor to sementate Quality Assurance Director for the ported by each auditor to sementate Quality Assurance Director for the ported by each auditor to sementate Quality Assurance Director for the ported by each auditor to sementate Quality Assurance Director for the ported by each auditor to sementate Quality Assurance Director for the ported by each auditor to sementate Quality Assurance Director for the ported by each auditor to sementate Quality Assurance Director for the ported by each auditor to sementate Quality Assurance Director for the ported by each auditor to sementate the ported by ea	uled Quality provement an of at the next e eting on ude the tor, Director e Supervisor, ary Manager, source tor, and line	
		ed. ducted with Resident #13 on 1. The resident provided the		monthly Quality Assurance F Committee for review and recommendations until comp achieved.		
	recordings of call bell of response on 12/16 resident's statements	unresponsiveness and lack /18 that verified the . He stated that on 12/16/18				
	he turned on his call l his personal compute					
	light off without check stated that at 4:41 AN	his room and turned the call king on him. He further /l, he turned his call light on				
	turned off by staff and	der and his call light was I no one responded to his				
		hat at 5:51 AM, he turned on sed record on his voice				

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	(X3) DA	IO. 0938-039	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	CON	MPLETED	
		345307	B. WING		1	C 2/20/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	I •	2/20/2010	
MEADOW	WOOD NURSING CENTI	ER		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 PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
recorde came te		e 3 0 minutes before NA #2 th his recording pushed to	F 55	0			
	by the resident on 12	urveyor heard the the NA #2 and the response /16/18 at 5:51 am. Upon further indicated that NA #2					
	asked Resident #13, bell? What do you ne stated he responded,	"You keep ringing the call ed, huh?" Resident #13 "That should be obvious. I I up all night." Resident #13					
	stated NA #2 did not Resident #13's room 7:30 AM, Resident #1	change his brief, then left and turned off his light. At 13 indicated that he pressed he was soaked with urine					
	and feces and had be without being cleaned his personal compute	een laying there all night d up and pressed record on er voice recorder. He further					
	he told her that he ha she stated that she w	#1 came into his room and id not been cleaned up and vas "in the middle of sending ital and can't make the NA's					
	come in to help. Ther room and did not retu	n, Nurse #1 left the resident's Irrn to his room. At 8:30 AM, Ird that he rang his call light					
	and the under pad wa	ne into his room and e washed his bed 3 times as turned upside down and and the pad looked like					
		3 tearfully reported he felt					
	Worker on 12/18/18 a	ducted with the Social at 1:13 PM. She revealed nces filed for the month of					
	12/18/18 at 3:01 PM.	ducted with NA #3 on She indicated that she went oom on 12/16/18 at 8:30 AM					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING				C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, C	ITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		4414 WILKINSON BI GASTONIA, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	was wet with urine from to his knee cap. NA # #13 soaked with urine was the worst she saw #3 stated that Reside incontinence care. NA was wet all the way the the chux (disposable) was brown. In cleaning she took a chux (disp cotton side of the chur chux pad was soaked that at the end of first of the condition she for he reported regarding being addressed from #3 further stated that that the social worker addressed the grieval mentioned something regarding 3rd shift be right how he was bein A phone interview wa 12/19/18 at 8:00 pm. third shift and frequer #13. NA #4 stated Re received incontinence am, at a minimum and change. She indicated never saturated his be but that he got a little computer equipment i room hot. A phone interview wa 12/19/18 at 8:21 PM.	s whole bed because he om just below his shoulders 3 stated she found Resident e and feces before but this w his bed that soaked. NA nt #13 never refused A #3 recalled the bed spread arough and everything from pad to the washable pad ig up the bed, NA #3 stated osable) pad and placed the x pad on mattress and the with urine. NA #3 stated shift, she notified Nurse #2 bund Resident #13 and what his need for assistance not a 12:41 AM to 8:30 AM. NA Nurse #2 told Resident #13 was the one who nces and that Resident #13 about writing a grievance cause he said it was not ing treated. s conducted with NA #4 on NA #4 stated she worked tty worked with Resident	F 5	50			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 20/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ER		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	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	him. She further state given a suppository, t resident more often. S #13 did not get a supp 12/15/18. She further perception that Resid 1:30 am and 5:30 am his room, woke him u stated that Resident # that he hadn't been cl him and changed him reported any concern did not mention that s first shift regarding Re A phone interview wa on 12/20/18 at 6:50 A expected all residents respect and dignity ar requested. A phone interview wa on 12/20/18 at 9:13 A worked 7:00 am to 7:0 toward the end of her he wanted to file a gri changed him for an e: morning of 12/16/18. end of first shift NA #3 was very wet. She fur the information to the indicated that she did or file a grievance bee checked on Resident	m at 1:30 AM and change ed that if Resident #13 was he NA's went to change the She indicated that Resident pository during 2nd shift on indicated that it was her ent #13 rang his call bell at and both times went into p and changed him. She #13 had been telling 1st shift hanged, so the NAs woke between the oncoming shift. She the reported any concerns to esident #13 on 12/16/18. Is conducted with the DON M. She indicated that she so conducted with the DON M. She indicated that she so conducted with Nurse #2 M. She indicated that she so conducted that the so conducted that that shift, Resident #13 told her evance because no one xtended time the early She stated that towards the 3 confirmed Resident #13 ther stated that she reported night shift Nurse #7. She not notify the social worker cause the social worker	F 55	50			
	Worker on 12/20/18 a						

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 01/31/2019 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING _			_		C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R			414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550 F 584 SS=E	of any concerns involve further indicated that it complained about beit previous Director of N at the facility which was She revealed that she #13 filing any recent of An interview was cond Administrator on 12/2 12:25 PM. She stated to be treated with digr to every staff member at the facility on 11/26 expected concerns to could be done. She in supposed to care for the problem of dignity if ca- indicated again she sl the incident, so she ca- Safe/Clean/Comfortat CFR(s): 483.10(i)(1)-(§483.10(i) Safe Enviro The resident has a rig comfortable and home but not limited to rece supports for daily livin The facility must provi §483.10(i)(1) A safe, of homelike environment use his or her persona possible. (i) This includes ensur-	 th, 2018 and wasn't aware ving Resident #13. She in the past, Resident #13 ing soaked in urine when the lursing (DON) was working as before December 2018. e didn't remember Resident grievances. ducted with the 0/18 from 11:14 AM to d she expected all residents inity and respect and told this when she started working w/18. She further stated she be reported so follow-up idicated staff were residents and it was a are was not given. She nould have been told about build fix the problem. ble/Homelike Environment 7) onment. th to a safe, clean, elike environment, including iving treatment and g safely. 		550				1/18/19

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HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
	1 ° <i>î</i>		(X3) DATE SURVEY COMPLETED C
345307	B. WING		12/20/2018
		STREET ADDRESS, CITY, STATE, ZIP CODE	1
2		4414 WILKINSON BLVD GASTONIA, NC 28056	
MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
es not pose a safety risk. ercise reasonable care for sident's property from loss eping and maintenance maintain a sanitary, orderly, or; d and bath linens that are loset space in each iffied in §483.90 (e)(2)(iv); e and comfortable lighting ble and safe temperature y certified after October 1, temperature range of 71 to naintenance of comfortable is not met as evidenced s and staff interviews the ean linens in a room free repair for one of one clean AM an observation was ean linen closet which was set within the facility.	F 58	 4 1. The Laundry Supervisor moved the clean linen from the closet to an appropriate location 12/20/18. The Director of Maintenance replaced the stained tiles on 12/20/18. 2. The Maintenance Director will contribute to check the facility for any other areas stained, bulging ceiling tiles, replacin any stained. 	nue as for
	IEDICAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	EDICAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIP A. BUILDING 345307 B. WING	IEDICAID SERVICES X1) PROVIDERSUPPLERUCLIA IDENTIFICATION NUMBER: 345307 B WING 345307 B WING G IDENTIFICATION NUMBER: A B WING G IDENTIFICATION NUMBER: B WING G IEDICT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION) TA Stant pose a safety risk. rcident's property from loss eping and maintenance maintain a sanitary, orderly, vr. rd oset space in each iffed in §483.90 (e)(2)(iv); e and comfortable lighting bible and safe temperature r certified after October 1, temperature range of 71 to naintenance of comfortable is not met as evidenced s and staff interviews the ean linens in a room free repair for one of one clean Proble con 12/20/18. The Director of Maintenance Director will conting to check the facility for any other area

Facility ID: 923314

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		ND HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 01/31/20′ RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	PLE CONSTRUCTION		TE SURVEY MPLETED
		345307	B. WING		1	C 2/20/2018
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COD	E	
		FB		4414 WILKINSON BLVD		
WEADOW	WOOD NURSING CENT	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 584	stains were observed	e 8 nd/or bulging. Brown, dried I on the wall and extended e floor. Inside the linen	F 58	Maintenance Director and En Supervisor regarding the regu components of the facility phy	llation	
	closet were six open various linens, dispos resident equipment. approximately three t	shelving units housing sable incontinence briefs and		environment of the regulations 12/20/18. The education of the physical environment of the re will be included in subsequent orientations.	s on e facility egulations	
	brown stains which a color as the stained o broken pieces of ceili top shelf near these t	ppeared to be the same ceiling tiles. In addition, ing tile were observed on the three sheets. A nursing		4. The Maintenance Director w responsible for monitoring this the Plan of Correction. The M	s aspect of aintenance	
	stated this was the cl linen for resident use			Director will observe facility commonthly x 4 months to assess water damage as evidence by bulging tiles. Any noted will be	for any v stained and e	
		AM a nursing assistant was of the clean linen closet with and.		documented on the Maintenau replaced and reported for the Administrator to sign off to en- compliance.		
	director stated after t had been leaking from parts of the facility which closet. The maintenan the white acoustic cee brown and bulged. T stated the dried brow clean linen closet we the acoustic ceiling ti maintenance director ongoing issues with a	AM the maintenance the recent heavy snow there in the roof and it affected hich included the clean linen ance director stated when illing tiles got wet they turned the maintenance director in stains on the walls of the re from water leaking from les when they got wet. The stated there had been a roof leak for years and the cess of trying to get repairs	aintenance leavy snow there and it affected ed the clean linen or stated when of wet they turned hance director the walls of the the walls of the the leaking from hey got wet. The re had been for years and the ng to get repairs		ittee at the ance ommittee thly audit e reported to and or new	
	stated the three stain the linen closet had b	AM the laundry director ed sheets on the top shelf of been put in place to absorb re leaks from the ceiling.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2019 APPROVED D: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER			E CONSTRUCTION			LETED
		345307	B. WIN	G		_		C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
				4	4414 WILKINSON BLVD			
WEADOW	WOOD NURSING CENTE	EK		0	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRE	D EFIX AG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From page	e 9		F 584	L			
	been an ongoing prob she tried to move the	stated the ceiling leak had blem and, when it leaked clean linens to areas with not affected by the ceiling						
	observed moving line because of the start of the observation.) The every time it rained sl because of leaks in the time of the observation acoustic ceiling tiles r a brown color, were be brown stains were ob extended from the ce broken tile remained clean linen room. An was stored inside the laundry director noted	AM the laundry director we ens within the linen closet of heavy rain (at the time of the laundry director stated the had to move the linen the clean linen closet. At the top seven of 12 white remained badly stained we proken or bulging and drie beserved on the wall which illing to the floor. Pieces of on the top shelf within the empty, rolling clothing can be clean linen closet and the d it had to be rolled out of if resident clothing was	of he ith id of e irt e					
F 600	she had just recently and, after the last sno leaks in the clean line stated she contacted inform him of the leak director to remove all closet and distribute t clean linen carts until clean linen room. Th was not aware the ite had not been remove Free from Abuse and	Neglect	e e e e e	F 600				1/18/19
SS=G	CFR(s): 483.12(a)(1)							
FORM CMS-256	7(02-99) Previous Versions Obs	solete Eve	nt ID: IMMS11	Fa	acility ID: 923314	If continu	ation shee	t Page 10 of 94

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		345307	B. WING				C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	B		4	414 WILKINSON BLVD		
	WOOD NURSING CENTE	-1		G	GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	9 10	F	600			
	Exploitation The resident has the ineglect, misappropria and exploitation as deincludes but is not limic corporal punishment, any physical or chemit treat the resident's mark §483.12(a) The facility §483.12(a)(1) Not use physical abuse, corporinvoluntary seclusion; This REQUIREMENT by: Based on observation resident interviews, w and hospice nurse int neglected to acknowle and failed to provide in hour time frame from of 5 residents depend care (Resident #13); fa s scheduled and ensions consistent with physic sampled residents revi infection (Resident #1 pressure ulcer treatm scheduled for 3 days residents reviewed fo Findings include: 1. Resident #13 was 04/04/17 with an origi	involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced ms, record review, staff and round physician interview, erview, the facility staff edge a resident's call bell ncontinence care for 8 an 12:41 AM to 8:30 AM for 1 lent on staff for incontinence failed to provide treatments sure wound care was done cian orders for 1 of 1 viewed with a wound (); and failed to complete ent as ordered and (Resident #7) for 1 of 3			Resident #13- Incontinence was provide by a certified nursing assistant 12/16/12 Resident #1- Consistent wound care w provided by a licensed nurse beginning 12/18/18. Resident # 7- Consistent and correct wound care was provided by a licensed nurse on 12/19/18. 2.All residents requiring incontinence c have the potential to be affected with wounds. In order to ensure that other residents are not affected by the same alleged deficient practice, all residents requiring incontinence care were assessed for wounds 1/16/19 through 1/18/19 by the Registered Nurse/Interin Director of Nursing	8. as J d are	

Facility ID: 923314

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		D. 0938-03 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COM	PLETED
						С
		345307	B. WING		12	/20/2018
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	CODE	
	WOOD NURSING CENT	ED		4414 WILKINSON BLVD		
WEADOW	WOOD NORSING CENT	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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
F 600	Continued From page	e 11	F 60	0		
		er, history of urinary tract		3.Certified Nursing Assist	ant staff were	
		ressive episode, anxiety,		educated 1/16/19-1/18/19		
		and left hands, history of		of incontinence care by th		
	cellulitis of lower extr			Nurse/Interim Director of		
	unsteadiness of feet	and type 2 diabetes mellitus.		Nurses were educated by		
				nurse/ Interim Director of	0	
		#13's Annual Minimum Data		1/16/19-1/18/19 that they	-	
		/28/18, indicated he was		for completing wound car		
		was totally dependent on MDS further indicated		care nurse is on duty. The educated 1/16/19-1/18/19		
	-	ways incontinent of bowel		wound care procedures b		
		OS revealed that he displayed		Nurse and or Interim Dire		
		ard others but had no		Newly hired nursing staff	•	
	rejection of care.			educated during subsequ		
		ties of Daily Living (ADL)		4.Monitoring performance		
		rea Assessment (CAA) and		ensure compliance the Re		
		CAA associated with the		Supervisor and or Interim		
		Resident #13 needed		Nursing will be responsible		
		ing as the resident was and bladder and staff		of the Plan of Correction. Nurse Supervisor and or	-	
	provided incontinent			of Nursing will randomly of		
		or Symptom CAA revealed		compliance of Certified N		
		gression directed toward		providing incontinence ca	-	
	staff.			per week x 4 weeks, then		
				week x 4 weeks. The Reg		
		#13's care plan, dated		Supervisor and or the Inte		
		he resident had an ADL		Nursing will interview thre		
		e deficit and required		oriented residents per we	•	
		from staff for toileting In further indicated that		then 1 resident per week ensure compliance.	x 4 weeks lo	
		as provided routinely and as		ensure compliance.		
		#13 and that Resident #13		The Registered nurse Su	pervisor and or	
		se bell to call for assistance.		Interim DON will random		
		plan for Resident #13		compliance of Nurses pro		
		the potential to be verbally		documenting wound care		
		aregivers. The care plan,		orders- 5 residents per we		
		nt being verbally aggressive		then 2 residents per week	x 4 weeks.	
	toward caregivers, fu	irther revealed staff were to				1

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-03
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· /	·) ´c	OMPLETED
						С
		345307	B. WING			12/20/2018
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
	WOOD NURSING CENTI	- D		4414 WILKINSON BLVD		
	WOOD NURSING CENT	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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	Continued From page	e 12	F 60	0		
1 000		e resident's toileting needs	1 00	-	he reviewed at	
	-	I and the resident needed		The plan of correction will the next scheduled Quality		
		g, assistance to turn or		Performance Improvemen		
		ery 2 hours and more often		1/22/19.		
	as needed or request					
				All Plan of Correction mor	thly audit data	
1 re O re		ducted with Resident #13 on		will be reported to the QA		
		 The resident provided the 		reviewed by the Committe		
		unresponsiveness and lack		months and recommendat	-	
	of response on 12/16			order to help to ensure that	•	
		. He stated that on 12/16/18		stay in compliance and if o		
		laying in urine and feces and		identified the QA committe addition three months to a		
	his personal compute	light and pressed record on		maintaining compliance.	SSIST WITH	
		his room and turned the call		maintaining compliance.		
		king on him. He further				
		A, he turned his call light on				
	again and pressed re	cord on his personal				
	computer voice recor	der and his call light was				
	-	d no one responded to his				
		hat at 5:51 AM, he turned on				
		sed record on his voice				
		30 minutes before NA #2				
		th his recording pushed to				
	the play button, the s	the NA #2 and the response				
		/16/18 at 5:51 am. Upon				
	-	further indicated that NA #2				
		"You keep ringing the call				
		ed, huh?" Resident #13				
		"That should be obvious. I				
		l up all night." Resident #13				
		change his brief, then left				
		and turned off his light. At				
		13 indicated that he pressed				
		he was soaked with urine				
		een laying there all night				
		d up and pressed record on				

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	MENT OF HEALTH AN					FORM	2: 01/31/2019 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMP	SURVEY LETED
		345307	B. WING			(12/2	C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
			4	414 WILKINSON BLVD			
MEADOW	WOOD NURSING CENTE	R	0	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 600	he told her that he had she stated that she was someone to the hospi come in to help. Then room and did not retu Resident #13 revealed again and NA # 3 can cleaned him, and she and the under pad was soaked up the urine at tobacco. Resident #13 hurt because staff did An interview was cond Worker on 12/18/18 at there were no grievan December 2018. An interview was cond 12/18/18 at 3:01 PM. into Resident #13's ro and had to change his was wet with urine fro to his knee cap. NA # #13 soaked with urine was the worst she saw #3 stated that Reside incontinence care. NA was wet all the way th the chux (disposable) was brown. In cleanin she took a chux (disp cotton side of the chu chux pad was soaked that at the end of first of the condition she for he reported regarding	41 came into his room and d not been cleaned up and as "in the middle of sending tal and can't make the NA's , Nurse #1 left the resident's rn to his room. At 8:30 AM, d that he rang his call light he into his room and washed his bed 3 times is turned upside down and nd the pad looked like 3 tearfully reported he felt n't clean him up. ducted with the Social t 1:13 PM. She revealed toes filed for the month of She indicated that she went iom on 12/16/18 at 8:30 AM is whole bed because he m just below his shoulders 3 stated she found Resident e and feces before but this w his bed that soaked. NA	F 600				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/31/2019 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING					C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STAT	E, ZIP CODE	-	
MEADOW	WOOD NURSING CENTE	P		44	414 WILKINSON BLVD			
MEADOW				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	×	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 600	that the social worker addressed the grieval mentioned something regarding 3rd shift be- right how he was bein A phone interview wat 12/19/18 at 8:00 pm. third shift and frequen #13. NA #4 stated Re- received incontinence am, at a minimum and change. She indicated never saturated his be- but that he got a little computer equipment in room hot. A phone interview wat 12/19/18 at 8:21 PM. assistants who came to Resident #13's room him. She further state given a suppository, t resident more often. S #13 did not get a supp 12/15/18. She further perception that Resident # that he hadn't been ch him and changed him reported any concerna- did not mention that s first shift regarding Re-	Nurse #2 told Resident #13 was the one who nees and that Resident #13 about writing a grievance cause he said it was not ig treated. s conducted with NA #4 on NA #4 stated she worked itly worked with Resident esident #13 typically e care at 1:30 am and 5:30 d that was close to shift d that Resident #13 had ed due to his incontinence sweaty because he had in his room that made the s conducted with NA #2 on She stated that the nursing in at 11:00 PM typically went m at 1:30 AM and changed d that if Resident #13 was he NA's went to change the She indicated that Resident pository during 2nd shift on indicated that it was her ent #13 rang his call bell at and both times went into p and changed him. She #13 had been telling 1st shift hanged, so the NAs woke . She further stated that she is to the oncoming shift. She he reported any concerns to esident #13 on 12/16/18.		600	DEI	FICIENCY)		
	A phone interview wa	s conducted with the DON						

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CENTER	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	0: 01/31/2019 APPROVED 0: 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION				
		345307	B. WING		_		20/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, 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	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	expected all residents respect and dignity ar requested. A phone interview was on 12/20/18 at 9:13 A worked 7:00 am to 7:0 toward the end of her he wanted to file a gri changed him for an ex- morning of 12/16/18. end of first shift NA #3 very wet. She further information to the nigli indicated that she did or file a grievance bea checked on Resident An interview was cone Worker on 12/20/18 a that she did not talk to week of December 17 of any concerns invol- further indicated that is complained about bei previous Director of N at the facility which was She revealed that she #13 filing any recent of Administrator on 12/2 12:25 PM. She stated to be changed 2 times administrator thought but when he fell asleed didn't know he was be	M. She indicated that she a would be treated with ad care to be provided when s conducted with Nurse #2 M. She indicated that she 00 pm on 12/16/18 and that shift, Resident #13 told her evance because no one xtended time the early She stated that towards the 3 confirm Resident #13 was stated that she reported the ht shift Nurse #7. She not notify the social worker cause the social worker #13 daily. ducted with the Social t 9:39 AM. She indicated b Resident #13 during the 7th, 2018 and wasn't aware ving Resident #13. She in the past, Resident #13 ng soaked in urine when the lursing (DON) was working as before December 2018. e didn't remember Resident grievances. ducted with the 0/18 from 11:14 AM to I Resident #13 only wanted	F 600					

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	MENT OF HEALTH AN						FORM	D: 01/31/2019 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			-		C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STA	ATE, 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 PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	the room and changir were for residents to l ensure they were dry needed. The administ coming in the building and expected care to on all shifts and that s Saturday night during midnight and left at 1: be difficult to please, follow his care plan an him and all residents administrator revealed incident or that a gried expectation was that treated with dignity ar to every staff member at the facility on 11/26 expected concerns to could be done, and st for residents and it was care was not given. T again she should hav incident, so she could 2. Resident #1 was r 04/5/17 with an origin with the following diag infection, dementia wi disturbance, generaliz (itching), peripheral va 2 diabetes mellitus, lo subcutaneous tissue depressive disorder. A review of Resident f Set (MDS), dated 01/ severe cognitive impar	ing him and her expectations be checked every 2 hours to and to provide care if trator stated she was all shifts to check on care be provided to all residents she was in the building 3rd shift and arrived around 30 AM. Resident #13 could but she expected staff to and do rounds to check on throughout their shift. The d she was not aware of the vance had been filed. Her all residents were to be and respect and this was told when she started working 5/18. The administrator also be reported so follow-up traff were supposed to care as a problem of dignity if he administrator indicated e been told about the fix the problem. eadmitted to the facility on al admission on 01/10/17 gnoses: right hip wound	F	600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/31/2019 1 APPROVED 2: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _			(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(12/2	C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 WILKINSON BLVD ASTONIA, 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 (EACH CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	extensive assistance assistance for transfe and extensive assista assistance for person indicated that she was development but that A review of the Press Assessment (CAA) as MDS revealed Reside breakdown due to her assistance with positie admitted with multiple primarily to her legs a history of chronic prur A review of the Facilit Non-Pressure Ulcer S Wound Infection, date following wound meas (cm): 8.5 cm in length in depth and 8.1 cm u A review of the Facilit Non-Pressure Ulcer S Wound Infection, date following wound meas (cm): 4.2 cm in length in depth and 8.0 cm u A review of Resident a dated 12/05/18, revea 1. Cleanse Right hip dry, pack with Dakins cover with dry dressin needed. 2. Cleanse Right hip	and bladder and needed with 2 plus person physical rs, bed mobility, toileting, nce with 1-person physical al hygiene. The MDS also is at risk for pressure ulcer she had no pressure ulcer she had no pressure ulcer. ure Ulcer Care Area sociated with the 01/08/18 ent #1 was at risk for r incontinence and needed oning. Resident #1 was also e areas of breakdown nd buttocks and had a ritis (itching). y Skin Condition Record for Skin Conditions for Right Hip ed 11/24/18, indicated the surements in centimeters a x 1.4 cm in width x 1.2 cm undermining at 12 o'clock. y Skin Conditions for Right Hip ed 12/05/18, indicated the surements in centimeters a x 1.2 cm in width x 0.8 cm undermining at 12 o'clock. #1's Physician Orders,	F 600				

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		345307	B. WING				C 20/2018		
NAME OF PF	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE				
MEADOW	WOOD NURSING CENTE	ER			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 PREF TAG		(EACH CORRECTIVE ACTION SHOULD E	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 600	area to right hip or po development, dated 1 #1's pressure ulcer w and would remain free plan further indicated were in place for staff ordered and were mo dressing was monitor and adhering and sta to the treatment nurse moisturizer applied to A review of the Facilit Non-Pressure Ulcer S Wound Infection, date following wound meas (cm): 5.1 cm in length in depth and 4.8 cm u (progress: improved). A review of the Decer Administration Record resident's right hip dre periwound dressing c done on the following 12/10/18; & 12/17/18. A review of December following treatments f initialed as done the f 1. Apply zinc oxide to day. (not initialed on 12/10/18; & 12/17/18)	ay and as needed. Is an for the nonstageable thential for pressure ulcer 12/6/18, indicated Resident ould show signs of healing is from infection. The care the following interventions to administer treatments as initored for effectiveness, red to ensure it was intact ff to report loose dressings a, and the resident needed a her skin. Y Skin Condition Record for Skin Conditions for Right Hip ed 12/12/18, indicated the surements in centimeters a x 1.1 cm in width x 2.0 cm indermining at 3 o'clock mber 2018 Treatment d (TAR) revealed the essing change and hange was not initialed as dates: 12/07/18; 12/08/18; r 2018 TAR revealed the for Resident #1 were not following dates: o groin redness/area every 12/07/18; 12/08/18;	F	600					
	-	ight on 3pm-11 pm until all and then as needed. (not							

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/31/2019 1 APPROVED 2: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(12/2	C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			4	414 WILKINSON BLVD			
MEADOW	WOOD NURSING CENTE	R	G	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page initialed on 12/07/18; 12/15/18; 12/16/18; a 3. Eucerin Cream- ap Extremities twice daily 7am (not initialed on 7 4. Eucerin Unscented areas topically every 6 (not initialed on 12/07 12/17/18) 5. Ketoconazole Shar once a week for itch 6 on12/07/18 and 12/14 6. Vitamin A+D ointme A&D - apply topically day. (not initialed on 1 12/10/18; & 12/17/18) An observation of Res bed via Hoyer Lift was 2:30 pm with Nurse # time of the transfer, N skin assessment on th continuing observatio repositioning the resid change the dressing, undated. An interview with Nurs 12/17/18 from 2:45 Pl stated that the facility Tuesdays, Wednesda the week and a treatm and Sundays every of no treatment nurse or	e 19 12/8/18; 12/11/18; 12/14/18; nd 12/17/18) oply to Bilateral Lower y for 7am-7 pm and 7pm to 12/10/18 for 7am to 7 pm) d Cream- apply to affected day on upper extremities /18; 12/08/18; 12/10/18; & mpoo 2%- apply to scalp on 11 p-7p (not initialed 1/18) ent for Desitin Clear with Vit to buttocks and thighs every 12/07/18; 12/08/18; sident #1 being assisted to s conducted on 12/17/18 at 6 and NA #5 present. At the lurse #6 was performing a he resident. During n of Nurse #6 and NA #5 dent, the nurse did not	F 600				
	weeks ago and the fa Nurse #6 further indic	but as a bump about 2 cility had a wound doctor. ated the resident had tion of tissue extending					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(12/2) 20/2018
NAME OF P	ROVIDER OR SUPPLIER		Ś	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	was larger at its base the wound and it was She indicated that the was for the wound to a blue dry dressing. An interview was com Nurse on 12/18/18 at she knew nothing abo wound until Saturday; date she saw the wou further stated that the popped open and was undermining. She ind information in the faci Resident #1's right hij indicated that she init hip on 11/24/18. She not at work, the treatr consistently getting do the same dressings th from when she last we 12/05/18, she comple residents and, when s Tuesday; 12/11/18 sh dressing and the blue drainage, had no date not packed as ordered undermining of the wo An observation and in with the Treatment Nu PM to 1:35 PM. She we change on Resident # when the wound doct resident's right hip wo	so that the pressure ulcer than at the skin surface) of a decubitus pressure ulcer. e right hip wound treatment be packed and covered with ducted with the Treatment 8:52 AM. She stated that but Resident #1's right hip (11/24/18, which was the ind for the first time. She right hip wound had already s draining and developed icated that she documented lity doctor's book about b wound. She further iated treatment to the right stated that when she was nents on residents were not one because she would find hat she placed on residents orked. She indicated that on ted the treatments on all the she went back to work on e checked Resident #1's foam was saturated with e on it, and the wound because Resident #1 had	F 600				

Facility ID: 923314

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES				FORM): 01/31/2019 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(12//	C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			4	414 WILKINSON BLVD			
MEADOW	WOOD NURSING CENTE	:R	0	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	and he removed the of the wound which rever further stated that the decreased from 8 cer During continued obsis sponge was still noted and the periwound (sl was not covered with areas of thick yellow at the dressing. Further was no odor noted fro wound itself. The Treat dry dressing she remon not have been there to not follow the physicial been changed daily. S Resident #1 never ref scratch her right hip at caused the dressing to wound. The Treatment the dressing may com notify the hall nurses dressing because the needed also. She also responsible for doing An interview was cond 12/18/18 at 2:04 PM. change the dressing of She further stated that was not at the facility, responsible for chang indicated that she not Nurse #8, on 12/17/18 been done for Reside A phone interview was on 12/19/18 at 9:53 A	dead tissue off of the top of ealed the undermining. She undermining had timeters (cm) to 4 cm. ervation, the undated blue d on Resident #1's right hip kin surrounding the wound) a dressing and had 4 small adherent tissue surrounding observation indicated there on the old dressing or the atment Nurse stated that the oved from the wound should because the dressing did an's order and it should have She further stated that tused care, but she did and around the wound which o hang loosely off the nt Nurse stated that because he off, she told the Na's to and they could change the treatment order was as o stated that all nurses were a weekly skin assessment. ducted with Nurse #6 on She stated that she did not on 12/17/18 for Resident #1. It when the treatment nurse the hall nurses were ing the dressing. She ified oncoming 3rd shift, 8 that a treatment had not int #1.	F 600				
	the wound which rever further stated that the decreased from 8 cern During continued obsis sponge was still noted and the periwound (sl was not covered with areas of thick yellow a the dressing. Further was no odor noted fro wound itself. The Treat dry dressing she remon not have been there b not follow the physicial been changed daily. S Resident #1 never ref scratch her right hip a caused the dressing t wound. The Treatment the dressing may com notify the hall nurses dressing because the needed also. She also responsible for doing An interview was com 12/18/18 at 2:04 PM. change the dressing of She further stated that was not at the facility, responsible for chang indicated that she not Nurse #8, on 12/17/18 been done for Reside A phone interview was on 12/19/18 at 9:53 A	ealed the undermining. She undermining had timeters (cm) to 4 cm. ervation, the undated blue d on Resident #1's right hip kin surrounding the wound) a dressing and had 4 small adherent tissue surrounding observation indicated there on the old dressing or the atment Nurse stated that the boyed from the wound should because the dressing did an's order and it should have She further stated that fused care, but she did and around the wound which o hang loosely off the nt Nurse stated that because he off, she told the Na's to and they could change the treatment order was as o stated that all nurses were a weekly skin assessment. ducted with Nurse #6 on She stated that she did not on 12/17/18 for Resident #1. It when the treatment nurse the hall nurses were ing the dressing. She ified oncoming 3rd shift, 8 that a treatment had not int #1.					

Facility ID: 923314

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 MAPPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 20/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	with only one NA. A phone interview was on 12/19/18 at 10:07 12/08/18, she only pe on another resident, r A phone interview was on 12/19/18 at 10:27 worked with Resident PM to 7:00 AM, and of treatments on Reside An interview was cond Doctor on 12/19/18 at that when the regular working every day, the treatments being com- stated he was not sur her skin caused the in- further stated that Res- packing wet to moist of that the periwound de Care notes, dated 12/ insufficiency). He ind was ordered for the p- key to successful wou- the wound and that the be covering the woun A phone interview was on 12/19/18 at 11:55 with Resident #1 on 1 treatments were done A telephone interview	e was working by herself s conducted with Nurse #4 AM. She indicated that on rformed a dressing change not Resident #1. s conducted with Nurse #7 AM. She stated that she #1 on 12/17/18, from 11:00 lid not perform any nt #1. ducted with the Wound : 11:14 AM. He indicated treatment nurse was not ere was an issue with pleted as ordered. He e if Resident #1 scratching ifection of her right hip. He sident #1 needed wound dressings once a day and teriorated (per the Wound 12/18, due to venous icated that the Silvadene eriwound abrasion and the und healing was to protect e dressing was supposed to d. s conducted with Nurse #2 AM. She stated she worked 2/08/18 and that no s. was conducted with the	F 600				
	A telephone interview DON on 12/19/18 1:5						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345307	B. WING				C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MEADOW	WOOD NURSING CENT	ER			414 WILKINSON BLVD ASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	 followed, and treatments scheduled. An interview was con Administrator on 12/2 12:25 PM. The admir expected treatments the physician orders. was not aware treatments as scheduled but exp followed for type of the for treatments. Resident #7 admit 01/31/17 with multiple dementia, kyphosis (of the spine), age-related chronic pain. Review of a physiciar Resident #7 read in p protecting skin) to bilated and the spine) to bilated and the spine). 	ents completed as ducted with the 20/18 from 11:14 AM to histrator indicated that she to be done consistent with She further indicated she hents were not being done vected all orders to be eatment and schedule set	F	600			
	Set (MDS) dated 10/2 was moderately impa making and displayed the 7-day assessmen the MDS indicated Re	with activities of daily living					
	10/25/18, revealed R	n, with a revised date of esident #7 had the potential velopment related to needing					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345307	B. WING				C 2/ 20/2018
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	free from any signs of related to altered skin	ity, incontinence and with the goal she would be r symptoms of infections i integrity. The interventions dminister treatments as	F	600)		
	Resident #7 read in p ankle with wound clea Polymen Dressing (ty a mild cleaning agent	n's order dated 11/28/18 for art, "cleanse right outer anser, pat dry, apply pe of dressing that contains activated by moisture and to the wound area) 3 times a					
	for Resident #7's righ to be completed on M Friday during the hou There were no initials treatment to Resident completed on the sch	d (TAR) revealed treatment t outer ankle was scheduled londay, Wednesday and rs of 7:00 AM to 3:00 PM. on the TAR indicating the t #7's right outer ankle was eduled days of 12/03/18, t 12/17/18. Further review of initials indicating the tt #7's top of foot was					
	Wound Nurse (WN) e responsible for compl residents on the days Tuesdays, Wednesda week, and the hall nu completing wound tre	n 12/18/18 at 8:35 AM, the explained she was eting wound treatments for she worked, which were ays and Thursdays each rses were responsible for atments the remaining days. nging the dressing on					

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 01/31/2019 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING					C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP C	ODE		
MEADOW	WOOD NURSING CENTE	R			414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD B		(X5) COMPLETION DATE
F 600	the next dressing cha and 12/10/18. She st work on 12/11/18, the dated 12/05/18 with h hanging off the wound did not work on 12/03 and stated it was an of treatments were not b nurses on the days st work. She added she the day she returned done by the hall nurse An observation was n wound care on 12/18, washed her hands an old dressing from the she stated the dressin Polymen which was the dressing was dated 1 Nurse #5. The skin of foot was intact with no noticed. The WN indit was preventative and replaced to protect the her hands and as she (foot/heal protector) for there was no dressing ankle and the wound wound was red with a slough (dead tissue) a wound bed was a dar cleaned the ankle with	ter ankle on 12/05/18 with nges scheduled on 12/07/18 ated when she returned to dressing in place was er initials, smelled and was d. The WN confirmed she /18, 12/07/18 or 12/10/18 ongoing issue that wound being completed by the hall he was not scheduled to e completed treatments on if she noticed they were not es on the day scheduled.	F	600				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· /				PRINTED: 01/31/2 FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED C		
		345307	B. WING					20/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE	, ZIP CODE			
MEADOW	WOOD NURSING CENTE	ĨR			414 WILKINSON BLVD GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE	
F 600	PM, Nurse #1 confirm nurse on 12/07/18 and treatment to Resident explained she was ne wound treatments and dressing when it fell of never informed she not treatments on the day scheduled.	terview on 12/18/18 at 1:23 ned she worked as a hall d did not complete wound t #7's right outer ankle. She ever shown how to complete d only reapplied a resident's off. Nurse #1 added she was eeded to complete	F	600					
	to provide care to Res Nurse #4 stated she of treatment to Resident any other resident as never trained to provide explained the facility h the treatments for all informed she needed when the WN was not	sident #7 on 12/03/18. did not complete the wound t #7's right outer ankle or signed because she was de wound care. Nurse #4 had a WN who completed residents and was never to complete the treatments t scheduled.							
	PM, Nurse #5 confirm treatment to Resident she must have forgott completed. Nurse #5 (HN) was present dur Nurse #5 explained st bandage on the top of applied Tegaderm (tra cover and protect wor to her right outer ankli reviewed the TAR prior was unable to explain	terview on 12/18/18 at 3:31 ned she provided wound t #7 on 12/17/18 and stated ten to initial the TAR when added the Hospice Nurse ring the wound treatment. he put a 4 inch (in) by 4 in f Resident #7's left foot and ansparent dressing used to und) and Polymen dressing e. Nurse #5 added she or to providing treatment and n why there was no dressing t outer ankle or why the							

Facility ID: 923314

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, ST	ATE, 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	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	foot.	applied to the top of her left	F 600				
	PM, the HN confirmed Nurse #5 provided wo #7 on 12/17/18. The observed the treatme ulcer on Resident #7's not familiar with the tr of her foot. She state wound treatment orde and a non-adhesive F Resident #7's right ou out of the adhesive P	iter ankle since Hospice was olymen dressing they added it was possible the					
	Wound Physician (WI been providing wound past 3 weeks and was was an issue with wo completed as ordered a resident was on Hos dressing changes to a discomfort. The WP Resident #7's wound showed improvement and no changes were treatment as ordered unaware a dressing w	stated when he treated earlier that morning, it with no signs of infection made to the current by Hospice. He was vas not observed on on 12/18/18 and stated a been applied and the					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345307	B. WING				C 20/2018
NAME OF PF	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	28	F	600			
	PM the Director of Nu nursing staff were info providing wound treat description. The DOM	ment was a part of their job N stated she would expect nplete wound treatments as					
	AM, Nurse #2 confirm assigned to provide c 12/10/18. Nurse #2 s the wound treatment	tated she did not complete to Resident #7's right outer ceived Hospice services					
F 656 SS=G	Administrator was una were not being compl when the WN was no stated she was aware the building and felt th training in wound care expectation wound tra scheduled and consis orders. Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe		F	656			1/18/19
	implement a compreh care plan for each res	ility must develop and lensive person-centered sident, consistent with the th at §483.10(c)(2) and					

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						NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED	
			A. BUILDING	<u> </u>		0	
		345307	B. WING		C		
		345307				2/20/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
MEADOW	WOOD NURSING CENT	ER		4414 WILKINSON BLVD			
				GASTONIA, NC 28056			
(X4) ID			ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETIO DATE	
F 656	Continued From page	e 29	F 65	56			
	§483.10(c)(3), that in						
		ames to meet a resident's					
	medical, nursing, and	d mental and psychosocial					
		fied in the comprehensive					
		mprehensive care plan must					
	describe the following	0					
		are to be furnished to attain					
		ent's highest practicable					
		by psychosocial well-being as					
		24, §483.25 or §483.40; and would otherwise be required					
		.25 or §483.40 but are not					
		esident's exercise of rights					
		ding the right to refuse					
	treatment under §483						
		services or specialized					
		s the nursing facility will					
	provide as a result of	PASARR					
		a facility disagrees with the					
		RR, it must indicate its					
	rationale in the reside						
		th the resident and the					
	resident's representa						
		als for admission and					
	desired outcomes.	eference and potential for					
		cilities must document					
		's desire to return to the					
		essed and any referrals to					
	-	es and/or other appropriate					
	entities, for this purpo						
		in the comprehensive care					
		in accordance with the					
		h in paragraph (c) of this					
	section.						
		I is not met as evidenced					
	by:						
	Deced on choon of in		1			1	
	interviews, staff inter	ons, record review, resident		1. Resident #1 and #11 care updated 1/17/19 with accurate			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
		345307	B. WING			C 12/20/2018
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD		
MEADOW	WOOD NURSING CENT	ER		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 PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 656	Continued From page	e 30	F 65	6		
F 030	 Continued From page 30 interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #11); failed to implement the care plan for treating wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #7); and failed to implement the care plan for activities of daily living (ADLs) for 2 of 5 residents reviewed for ADLs (Residents #1 and #13). The findings included: Resident #13 was readmitted to the facility on 04/04/17 with an original admission on 10/08/09 with the following diagnoses: neuromuscular dysfunction of bladder, history of urinary tract infections, major depressive episode, anxiety, contractures of right and left hands, history of cellulitis of lower extremities with sepsis, unsteadiness of feet and type 2 diabetes mellitus. A review of Resident #13's Annual Minimum Data Set (MDS), dated 02/28/18, indicated he was 		F 65	 descriptions by the Interim Di Nursing/Regional RN. Reside #7 care plans regarding wour implemented 12/19/18 by the nurse. 2.In order to ensure that othe are not affected by the allege practice the care plans have I revamped by the Registered I Interim Director of nursing as in which to help to identify spe of the residents. The care plans regarding ADI residents #1 nail care was im by the Certified Nursing Assis 12/20/2018 In regards to resident #13 inc care was performed by the Certified Nursing Assis 	In order to ensure that other residents re not affected by the alleged deficient ractice the care plans have been examped by the Registered Nurse/ iterim Director of nursing as of 12/20/18 which to help to identify specific needs if the residents. the care plans regarding ADL care of esidents #1 nail care was implemented y the Certified Nursing Assistant on 2/20/2018 a regards to resident #13 incontinence are was performed by the Certified iursing Assistant on 12/19/18. Resident	
	staff for toileting. The Resident #13 was alv and bladder. A review of the Activit Rehabilitation Care A	was totally dependent on e MDS further indicated ways incontinent of bowel ties of Daily Living (ADL) and CAA) and		him to ensure call-lights are b addressed in a timely manner being changed when needed. The Nurse and or Interim Dor least three (3) cognitively resi	eing - and he is - n will audit at dents	
	02/28/18 MDS noted assistance with toileti incontinent of bowel a provided incontinent needed. A review of Resident			regarding ADL care weekly x then weekly x 2 weeks. The care plans of residents w were audited 1/16/19 and 1/1 Regional RN for accurate des and corrected. The wound care nurse's sche been changed effective 1/15/	ith wounds 7/19 by the scriptions dule has	

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F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
CORRECTION	IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	I ` /	TE SURVEY MPLETED
		A. BUILDIN	1G			
	345307	B WING				С
	545507				1	2/20/2018
OVIDER OR SUPPLIER						
VOOD NURSING CENTE	ER					
				·		()(5)
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		((EACH CORRECTIVE ACTION SHOULD E	3E	(X5) COMPLETIOI DATE
Continued From page	e 31	F 6	56			
				Monday-Friday to complete daily		
extensive assistance	from staff for toileting			coverage.		
				3 Education was provided to the nursi	na	
was encouraged to us	se bell to call for assistance.					
· ·				wound nurse is not working.		
An interview was con	ducted with Resident #13 on					
12/18/18 at 10:30 AM	 The resident provided the 			In-Service was also provided to the		
-	-			nursing staff 1/16/19-1/18/19 in the		
•						
				· · ·	•	
					in	
				subsequent new-nire orientations.		
				4 Monitoring To ensure compliance the	2	
				-		
					tor	
turned off by staff and	d no one responded to his			of Nursing will randomly check		
					ence	
-	-			-		
					us	
-						
				The registered nurse/ Interim director	of	
				Nursing will randomly check the		
				compliance of Nurses providing and		
	-				S,	
	-			then 2 residents per week x 4 weeks.		
-						
					d at	
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page self-care performance extensive assistance needs. The care plan incontinence care wa needed for Resident i was encouraged to u An interview was con 12/18/18 at 10:30 AM recordings of call bell of response on 12/16 resident's statements at 12:41 AM, he was he turned on his call his personal compute someone came in to light off without check stated that at 4:41 AM again and pressed re computer voice recor turned off by staff and needs. He indicated th his call light and press recorder and it took 3 came to his room.Wit the play button, the s statements made by by the resident on 12 entering his room, he asked Resident #13, bell? What do you ne stated he responded, haven't been cleaned stated NA #2 did not Resident #13's room 7:30 AM, Resident #7 his call light because and feces and had be	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 self-care performance deficit and required extensive assistance from staff for toileting needs. The care plan further indicated that incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance. An interview was conducted with Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell unresponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12:41 AM, he was laying in urine and feces and he turned on his call light and pressed record on his personal computer voice recorder and someone came in to his room and turned the call light off without checking on him. He further stated that at 4:41 AM, he turned his call light on again and pressed record on his personal computer voice recorder and his call light on again and pressed record on his voice recorder and it took 30 minutes before NA #2 came to his room. With his recording pushed to the play button, the surveyor heard the statements made by the NA #2 and the response by the resident on 12/16/18 at 5:51 am. Upon entering his room, he further indicated that NA #2 asked Resident #13, "You keep ringing the call bell? What do you need, huh?" Resident #13 stated he responded, "That should be obvious. I haven't been cleaned up all night." Resident #13 stated ha #2 did not change his brief, then left Resident #13's room and turned off his light. At 7:30 AM, Resident #13 indicated that he pressed his call light because he was soaked with urine and feces and had been laying there all night without being cleaned up and pressed record on	OVIDER OR SUPPLIER VOOD NURSING CENTER Image: Supprise of the second the second of the second of the second the second the se	OVIDER OR SUPPLIER \$ VOOD NURSING CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 31 F 656 self-care performance deficit and required extensive assistance from staff for toileting needs. The care plan further indicated that incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance. An interview was conducted with Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell unresponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12:41 AM, he was laying in urine and feces and he turned on his call light and pressed record on his personal computer voice recorder and someone came in to his room and turned the call light off without checking on him. He further stated that at 4:41 AM, he turned his call light on again and pressed record on his personal computer voice recorder and his call light was turned off by staff and no one responded to his needs. He indicated that at 5:51 AM, he turned on his call light and pressed record on his voice recorder and it took 30 minutes before NA #2 came to his room. With his recording pushed to the play button, the surveyor heard the statements made by the NA #2 and the response by the resident on 12/16/18 at 5:51 am. Upon entering his room, he further indicated that NA #2 asked Resident #13, "You keep ringing the call bell? What do you need, huh? Resident #13 stated NA #2 did not change his brief, then left Resident #13 sroom and turned off his light. At 7:30 AM, Resident #13 indicated that he pressed his call light because he was soake	DUDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE VOOD NURSING CENTER STREET ADDRESS, CITY, STATE, ZP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY RUST BE PRECIDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) ID PREFIX Continued From page 31 self-care performance deficit and required extensive assistance from staff for toileiting incontinence care was provided for thineling incontinence care was provided for thineling incontinence care was provided to that Resident #13 on 12/18/18 at 10:30 AM. The resident provided the recordings of call bell uncesponsiveness and lack of response on 12/16/18 that verified the resident's statements. He stated that on 12/16/18 at 12/41 AM, he was laiving in urine and feces and bis personal computer voice recorder and someone came in to his room and turned the call light off without checking on him. He further oumputer voice recorder and someone came in to his room and turned the call light off by staff and no one responded to his anal pressed record on his voice recorder and it lock30 minutes before NA #2 came to his room With his recording pushed to the play button, the surveyor heard the state that at 5.51 AM, he turned on his call light and pressed record on his voice recorder and it lock 30 minutes before NA #2 came to his room With his recording pushed to the play button, the surveyor heard the stated that at 5.51 AM, he turned on his call light and pressed record on his voice recorder and it lock 30 minutes before NA #2 came to his room With his recording pushed to his call light and pressed record on his voice recorder and it lock 30 minutes before NA #2 came to his room With his recording pushed to his call light at at 5.51 AM, he turned on netering his crom, With Wite recording pushed to his call light and pressed recording main the vertice the recorder and it lock 30 m	OWDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZP CODE YOOD NURSING CENTER STREET ADDRESS. CITY, STATE, ZP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REDULATORY OR LS DEENTFYING INFORMATION) ID PREPRY TAC PROVDER'S PLAN OF CORRECTION (EACH COMRCIPUE ADDRESS PLAN OF CORRECTION (EACH COMRCIPUE ADDRESS) (CONSTRET) CONTINUES ADDRESS PLAN OF CORRECTION (CAUSA PLAN OF CORREC

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			()(0) 1			O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY IPLETED
			A. BUILDING	3		
		345307	B. WING			С
		545507				2/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	JODE	
MEADOW	WOOD NURSING CENT	ER		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 PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 32	F 65	6		
	his personal compute	er voice recorder. He further		Improvement Committee m	neeting 1/22/19	
		#1 came into his room and		in which all monthly audit w	-	
	he told her that he ha	ad not been cleaned up and		by each auditor to subsequ		
		as "in the middle of sending		Quality Assurance Perform	ance	
		ital and can't make the NA's		Committee for review and		
		n, Nurse #1 left the resident's		recommendations in order	to stay in	
		urn to his room. At 8:30 AM,		compliance.		
		ed that he rang his call light				
	again and NA # 3 car					
		e washed his bed 3 times as turned upside down and				
		and the pad looked like				
	-	3 tearfully reported he felt				
	hurt because staff did					
	An interview was con	ducted with NA #3 on				
	12/18/18 at 3:01 PM.	She indicated that she went				
	into Resident #13's ro	oom on 12/16/18 at 8:30 AM				
		is whole bed because he				
		om just below his shoulders				
		#3 stated she found Resident				
		e and feces before but this				
		w his bed that soaked. NA				
	#3 stated that Reside					
		A #3 recalled the bed spread				
		hrough and everything from) pad to the washable pad				
		ng up the bed, NA #3 stated				
		posable) pad and placed the				
		ix pad on mattress and the				
		d with urine. NA #3 stated				
		t shift, she notified Nurse #2				
		ound Resident #13 and what				
	he reported regarding	g his need for assistance not				
	being addressed from	n 12:41 AM to 8:30 AM. NA				
		Nurse #2 told Resident #13				
	that the social worker					
		nces and that Resident #13				
	mentioned something					

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8				F	NTED: 01/31/2019 ORM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
	345307	B. WING			C 12/20/2018
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, Z	IP CODE	
MEADOWWOOD NURSING CENT	ſER		414 WILKINSON BLVD GASTONIA, NC 28056		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE
right how he was be A phone interview w Director of Nursing (PM. She stated that for ADL's be followe An interview was co Administrator on 12/ 12:25 PM. She state be accurate and exp followed in terms of treatments or ADLs. 2. Resident #1 was 04/5/17 with an origi with the following dia behavioral disturban disorder, pruritus (ito peripheral vascular of diabetes mellitus, lo subcutaneous tissue depressive disorder. 2a. A review of Resi dated 12/05/18, reve 1. Cleanse Right hip dry, pack with Dakin cover with dry dress 2. Cleanse Right hip cleanser, pat dry, ap dry dressing every of A review of the care area to right hip or p	ecause he said it was not ing treated. as conducted with the [DON] on 12/19/18 at 1:53 she expected all care plans d. nducted with the '20/18 from 11:14 AM to ed she expected care plans to bected interventions to be care whether it was care for readmitted to the facility on inal admission on 01/10/17 agnoses: dementia without ice, generalized anxiety ching), right hip infection, disease, (PVD), type 2 cal infection of the skin and e (onset 01/11/17), and major dent #1's Physician Orders, ealed the following: with wound cleanser, pat is' soaked Kling gauze, and ing every day and as needed. periwound with wound oply Silvadene and cover with	F 656			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		- D		4414 WILKINSON BLVD			
WEADOW	WOOD NURSING CENTE	:K		GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	plan further indicated were in place for staff ordered and were mo dressing was monitor and adhering and staft to the treatment nurse moisturizer applied to A review of Resident a Set (MDS), dated 01// severe cognitive impa symptoms of scratchin incontinent of bowel a extensive assistance assistance for transfe and extensive assistance assistance for person indicated that she was development but that A review of the Press Assessment (CAA) as MDS revealed Reside breakdown due to her assistance with positio admitted with multiple primarily to her legs a chronic pruritis (itchin she was prone to self A review of the Decer Administration Record resident's Right hip dr periwound dressing c	e from infection. The care the following interventions to administer treatments as nitored for effectiveness, ed to ensure it was intact ff to report loose dressings e, and the resident needed her skin. #1's Annual Minimum Data 08/18, indicated she had irment, she had behavioral ng herself, she was always and bladder and needed with 2 plus person physical rs, bed mobility, toileting, nce with 1-person physical al hygiene. The MDS also is at risk for pressure ulcer she had no pressure ulcer she had no pressure ulcer. ure Ulcer Care Area sociated with the 01/08/18 ent #1 was at risk for incontinence and needed oning. Resident #1 was also a areas of breakdown nd buttocks with a history of g). The CAA also revealed -inflict scratches. mber 2018 Treatment d (TAR) revealed the ressing change and hange was not initialed as dates:12/07/18; 12/08/18;	F 65		DEFICIENCY)		
		r 2018 TAR revealed the					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _			(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(12/)	C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	: 35	F 656				
F 656	 initialed as done the fi Apply zinc oxide day. (not initialed on 1 12/10/18; & 12/17/18) Doxepin Cream 5 with abrasion every ni areas are healed initialed on 12/07/18; 12/15/18; 12/16/18; ai Eucerin Cream- a Extremities twice daily 7am (not initialed on 12/07 12/17/18) Ketoconazole Sh once a week for itch of 12/07/18 and 12/14/18 Vitamin A+D ointive Vit A&D - apply topicate every day. (not initialed 12/10/18; & 12/17/18) An observation of Respective day. An observation of Respective day. with Nurse # time of the transfer, N skin assessment on the continuing observation repositioning the reside change the dressing, undated. 	or Resident #1 were not ollowing dates: to groin redness/area every 12/07/18; 12/08/18; 5%- apply to all body parts ight on 3pm-11 pm until all and then as needed. (not 12/8/18; 12/11/18; 12/14/18; nd 12/17/18) apply to Bilateral Lower y for 7am-7 pm and 7pm to 12/10/18 for 7am to 7 pm) ed Cream- apply to affected day on upper extremities /18; 12/08/18; 12/10/18; & ampoo 2%- apply to scalp on 11 p-7p (not initialed on 8) ment for Desitin Clear with illy to buttocks and thighs ed on 12/07/18; 12/08/18; - sident #1 being assisted to a conducted on 12/17/18 at 6 and NA #5 present. At the urse #6 was performing a ne resident. During n of Nurse #6 and NA #5 dent, the nurse did not as the dressing was	F 656				
	12/17/18 from 2:45 PI stated that the facility	se #6 was conducted on M to 3:00 PM. Nurse #6 had a treatment nurse on ys, and Thursdays during					

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HUMAN SERVICES EDICAID SERVICES				FORM	: 01/31/2019 APPROVED . 0938-0391
(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. /			(X3) DATE : COMPI	SURVEY LETED
345307	B. WING				; 20/2018
	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
	4	414 WILKINSON BLVD			
	G	GASTONIA, NC 28056			
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	TIVE ACTION SHOULD BE		(X5) COMPLETION DATE
36 ant nurse on Saturdays er weekend but there was Mondays and Fridays. the wound on Resident t as a bump about 2 lity had a wound doctor. ted the resident had on of tissue extending that the pressure ulcer an at the skin surface) of decubitus pressure ulcer. ight hip wound treatment to packed and covered with to tee with the Treatment to 2 AM. She stated that t Resident #1's right hip 1/24/18, which was the d for the first time. She ght hip wound had already draining and developed ated that she documented y doctor's book about wound. She further ted treatment to the right ated that when she was ents on residents were not be because she would find t she placed on residents ked. She indicated that on d the treatments on all the e went back to work on checked Resident #1's bam was saturated with on it, and the wound was She said the wound ecause Resident #1 had	F 656				
	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345307 EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) 66 and nurse on Saturdays er weekend but there was Mondays and Fridays. the wound on Resident t as a bump about 2 lity had a wound doctor. ed the resident had in of tissue extending that the pressure ulcer an at the skin surface) of decubitus pressure ulcer. ight hip wound treatment a packed and covered with acted with the Treatment 52 AM. She stated that t Resident #1's right hip 1/24/18, which was the d for the first time. She ght hip wound had already draining and developed ated that she documented y doctor's book about wound. She further the d treatment to the right ated that when she was ents on residents were not e because she would find t she placed on residents ked. She indicated that on d the treatments on all the e went back to work on checked Resident #1's pam was saturated with on it, and the wound was She said the wound	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING 345307 B. WING 345307 B. WING 345307 B. WING S 4 C C S Model MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) PREFIX TAG 76 F 656 revealed but there was Mondays and Fridays. the wound on Resident t as a bump about 2 lity had a wound doctor. ed the resident had no f tissue extending that the pressure ulcer han at the skin surface) of decubitus pressure ulcer. ight hip wound treatment e packed and covered with Accedent #1's right hip 1/24/18, which was the d for the first time. She ght hip wound had already draining and developed ated that she documented y doctor's book about wound. She further here the treatment to the right ated that when she was ents on residents were not e because she would find t she placed on residents ked. She indicated that on d the treatments on all the e went back to work on checked Resident #1's baam was saturated with on it, and the wound was She said the wound ecause Resident #1 had	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 345307 B. WING 345307 B. WING STREET ADDRESS, CITY, STA 4414 WILKINSON BLVD GASTONIA, NC 28056 IMENT OF DEFICIENCIES INUST BE PRECEDED BY FULL DEENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S I (EACH CORREC CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-CROSS-REFERENCE CROSS-CROSS-REFERENCE CROSS-REFERENCE CROSS-CROSS	HUMAN SERVICES EDICAD SERVICES (C) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: 345307 (2) MULTIPLE CONSTRUCTION A BUILDING 345307 (2) MULTIPLE CONSTRUCTION A BUILDING 345307 (2) MULTIPLE CONSTRUCTION A BUILDING 414 WILKINSON BLVD GASTONIA, NC 28056 EMENT OF DEFICIENCIES USE PRECEDED BY FULL DENTIFYING INFORMATION) FROM DEPROCEDED BY FULL DENTIFYING INFORMATION) FROM DEPROCEDED BY FULL DEFICENCY 66 rt nurse on Saturdays er weekend but there was Mondays and Fridays. the wound on Resident t as a bump about 2 ity had a wound doctor. ed the resident had n of tissue extending that the pressure ulcer that the theressure ulcer but at the skin surface) of decubitus pressure ulcer but at the skin surface) of decubitus pressure ulcer but at the skin surface) of decubitus pressure ulcer but at the skin surface) of decubitus pressure ulcer but at the skin surface) of decubitus pressure ulcer but at the skin surface but that the cound reatment but at the there that the packed and covered with but at the there that the packed and covered with but at the there that the packed on residents tated that the documented y doctor's book about wound. She further te du the restments on all the te went back to work on checked Resident #1's amm was saturated with on it, and the wound cause Resident #1 had	HUMAN SERVICES FOOME NO DICAID SERVICES OMB NO JUENTFICATION NUMBER: A BUILDING 345307 b. WING 345307 b. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILLINSON BLVD CASTONIA, NC 28056

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING				(12/2) 20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE	E, ZIP CODE		
	MEADOWWOOD NURSING CENTER			4	414 WILKINSON BLVD			
	WOOD NURSING CENTE	IR		G	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	9 37	F	656				
	with the Treatment Nu PM to 1:35 PM. She with change on Resident # when the wound doct resident's right hip wo stated that the wound and he removed the of the wound which rever further stated that the decreased from 8 cer During continued obs sponge was still noted and the periwound (sl was not covered with areas of thick yellow at the dressing. Further was no dor noted from wound itself. The Treat dry dressing she remonent not have been there the not follow the physicial been changed daily. S Resident #1 never ref scratch her right hip at caused the dressing the wound. The Treatmer the dressing because the needed also. She also responsible for doing An interview was com- 12/18/18 at 2:04 PM. change the dressing of	Attimeters (cm) to 4 cm. ervation, the undated blue d on Resident #1's right hip kin surrounding the wound) a dressing and had 4 small adherent tissue surrounding observation indicated there on the old dressing or the atment Nurse stated that the oved from the wound should because it the dressing did an's order and it should have She further stated that fused care, but she did and around the wound which o hang loosely off the nt Nurse stated that because he off, she told the Na's to and they could change the treatment order was as o stated that all nurses were a weekly skin assessment. ducted with Nurse #6 on She stated that she did not on 12/17/18 for Resident #1. it when the treatment nurse						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(12/2) 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 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	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	Nurse #8, on 12/17/18 been done for Reside A phone interview wa on 12/19/18 at 9:53 A did not do the treatment 12/17/18 because she with only one NA. A phone interview wa on 12/19/18 at 10:07 12/08/18, she only per on another resident, r A phone interview wa on 12/19/18 at 10:27 worked with Resident PM to 7:00 AM, and of treatments on Reside An interview was comported that when the regular working every day, the treatments being com- stated he was not sur her skin caused the in- further stated that Res- packing wet to moist of that the periwound de Care notes, dated 12/ insufficiency). He indi- was ordered for the p- key to successful would a stated would be to moist of the stated would be the p- key to successful would be care notes for the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be to moist of the p- key to successful would be care notes would be to moist of the p- key to successful would be to moist of the p- the p-	ing the dressing. She ified oncoming 3rd shift, 8 that a treatment had not int #1. s conducted with Nurse #8 M. She indicated that she ents on Resident #1 on e was working by herself s conducted with Nurse #4 AM. She indicated that on erformed a dressing change not Resident #1. s conducted with Nurse #7 AM. She stated that she f #1 on 12/17/18, from 11:00 did not perform any nt #1. ducted with the Wound t 11:14 AM. He indicated treatment nurse was not ere was an issue with upleted as ordered. He f if Resident #1 scratching infection of her right hip. He sident #1 needed wound dressings once a day and eteriorated (per the Wound t/12/18, due to venous cated that the Silvadene eriwound abrasion and the und healing was to protect the dressing was supposed to	F 656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	on 12/19/18 at 11:55. treatments were done 12/08/18. She further only changed another Resident #1. A telephone interview DON on 12/19/18 1:5 Resident #1's treatme followed, and treatme scheduled. An interview was con Administrator on 12/2 12:25 PM. The admin treatment orders shou completed as schedu 2b. A review of Care I at the facility for nursi resident specific need she was supposed to needed. Review of the and nail care sheet for nail care was docume A review of Resident Set (MDS), dated 01// severe cognitive impa symptoms of scratchi incontinent of bowel a extensive assistance and extensive assistance assistance for person indicated that she was	s conducted with Nurse #2 AM. She stated that no e on Resident #1 on stated that on 12/10/18, she r resident's dressing, not was conducted with the 3 PM. She stated that ent orders should be onts completed as ducted with the 0/18 from 11:14 AM to istrator stated that uld be followed and led. Kardex (the system in place ng assistants to know ds) for Resident #1 revealed get nail care daily and as e December 2018 bed baths or Resident #1 indicated no	F 656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(12/:) 20/2018
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, ST	ATE, 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	MDS revealed Reside with multiple areas of legs and buttocks with (itching). The CAA als to self-inflict scratches A review of ADL Func- associated with the 0 Resident #1 had a dia CAA further revealed assistance with perso- assist with basic hygin physical assistance with physical assistance with physical assistance with physical assistance with and wound would sho remain free from infec- revealed the following for potential for pressure indicated Resident #1 and wound would sho remain free from infec- revealed the following for potential for pressu- to make sure fingerna and had no jagged ec- treatments as ordered monitored for effective An observation of Res bed via Hoyer Lift was 2:30 pm with Nurse # Resident #1's nails or to be dirty with a brow under her fingernails length and the fingerr the right hand had a ja	ure Ulcer Care Area sociated with the 01/08/18 ent #1 was also admitted breakdown primarily to her in a history of chronic pruritis so revealed she was prone is. tional/Potential CAA 1/08/18 MDS revealed agnosis of dementia. The she required extensive mal hygiene but was able to ene with setup and needed with bathing or showering. Nan, dated 01/08/18, for the e Ulcer Development 's self-inflicted scratches bw signs of healing and ction. The care plan also g interventions were in place ure ulcer development: staff als were clean, trimmed, lges and staff to administer d and treatments were eness. sident #1 being assisted to s conducted on 12/17/18 at 6 and NA #5 present. n both hands were observed which red colored substance and the nails were ¼ inch in hail on the second digit of	F 65				

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, 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 (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 656	stated that the residen nail care and NA's we when they gave her a Resident #1 did not re An interview with NA 12/17/18 at 3:00 PM. Resident #1 was sup during her shower and refuse care. An observation conducted conducted on 12/18/1 The observation of the dressing changed rev both hands were still colored substance un nails were ¼ inch in le the second digit of the edge. An interview was cont 12/19/18 at 8:55 AM. 3rd shift and did not of because that was dor An observation of Res 12/19/18 at 12:40 PM Resident #1's nails or with a brownish red co fingernails and the na and the fingernail on the hand had a jagged ec right hand in her mou	At definitely needed good are supposed to cut her nails a shower and also stated that efuse care. #5 was conducted on NA #5 indicated that bosed to have her nails cut d that Resident #1 was 8 from 1:15 PM to 1:35 PM. e resident during the ealed Resident #1's nails on dirty with a brownish red der her fingernails and the ength and the fingernail on e right hand had a jagged ducted with NA #4 on She stated that she worked to nail care on Resident #1 he on day shift. sident #1 was conducted on . During the observation, n both hands were still dirty olored substance under her ils were ¼ inch in length the second digit of the right lege and the resident put her th.	F 656				

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DEPARTMENT OF HEALTH AND HU CENTERS FOR MEDICARE & MED					FORM	0: 01/31/2019 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	345307	B. WING		_		C 20/2018
NAME OF PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MEADOWWOOD NURSING CENTER			414 WILKINSON BLVD GASTONIA, NC 28056			
PREFIX (EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 F 656 Continued From page 42 that the resident's nails net then left the resident's room nail care. An observation of Residen Room was conducted on 1 Resident #1's nails on both with a brownish red colore fingernails and the nails we and the fingernail on the set hand had a jagged edge. A telephone interview was DON on 12/19/18 1:53 PM expectation was that every shower their nails should b checked daily to determine cleaned or trimmed and th have been followed. An interview was conducte Administrator on 12/20/18 12:25 PM. The administrat should have been done co of care. 2c. A review of Resident # Data Set (MDS), dated 01/ had severe cognitive impa behavioral symptoms of so was always incontinent of needed extensive assistant physical assistance for trait toileting, and extensive assistant physical assistance for per MDS also indicated that sh pressure ulcer development pressure ulcer. 	m without performing t #1 in the Activity 12/20/18 at 10:35 AM. In hands were still dirty d substance under her ere 1⁄4 inch in length econd digit of the right conducted with the I. She stated that her v time residents got a be checked and e if they needed to be e care plan should ed with the from 11:14 AM to from stated that nail care insistent with the plan 1's Annual Minimum (08/18, indicated she irment, she had cratching herself, she bowel and bladder and ice with 2 plus person insfers, bed mobility, sistance with 1-person sonal hygiene. The ne was at risk for	F 656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING					C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R			414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 656	MDS revealed Reside with multiple areas of legs and buttocks with (itching). The CAA als to self-inflict scratches A review of the care p area to right hip or po development, dated 1 #1's pressure ulcer w and would remain free An interview was com on 12/19/18 at 12:26 had to clarify with the 12/19/18 because she documented the right ulcer on the 12/06/18 11/28/18, it was mark Wound Tracking Repo the wound stages por A telephone interview DON on 12/19/18 1:5 Resident #1's wound was incorrectly staged expectation was the v staged correctly. A follow-up interview MDS nurse on 12/19/ that the Unstageable have been listed on F	ure Ulcer Care Area sociated with the 01/08/18 ent #1 was also admitted breakdown primarily to her is a history of chronic pruritis to revealed she was prone s. Wan for the nonstageable tential for pressure ulcer 2/6/18, indicated Resident ould show signs of healing e from infection. ducted with the MDS nurse PM. She indicated that she treatment nurse on e didn't know why she hip unstageable pressure care plan other than on ed Unstaged on the facility ort and had an X through tion of the report. Was conducted with the 3 PM. She stated that was not unstageable and d on the Care Plan and her yound should have been was conducted with the 18 at 3:52 pm. She revealed Pressure Ulcer should not tesident #1's 12/06/18 care and was an infection, not a	F 6	56				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345307	B. WING _				C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MEADOW	WOOD NURSING CENTE	ER			414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	 12:25 PM. The admin should be an accurate wound. 3. Resident #7 admit 01/31/17 with multiple dementia, kyphosis (e of the spine), age-rela chronic pain. Review of the signific Set (MDS) dated 10/2 was moderately impa making and displayed the 7-day assessmen the MDS indicated Re extensive assistance and had 2 unhealed p Review of a care plan 10/25/18, revealed Re for pressure ulcer dev assistance with mobil decreased oral intake free from any signs of related to altered skin included for staff to ac ordered and monitor for Review of a physiciar Resident #7 read in p ankle with wound clea Polymen Dressing (ty 	20/18 from 11:14 AM to histrator stated the care plan e reflection of Resident #1's ted to the facility on e diagnoses that included excessive outward curvature ated osteoporosis, and ant change Minimum Data 24/18 revealed Resident #7 ired for daily decision d no rejection of care during it period. Further review of esident #7 required with activities of daily living pressure ulcers. h, with a revised date of esident #7 had the potential velopment related to needing ity, incontinence and e with the goal she would be r symptoms of infections n integrity. The interventions diminister treatments as for effectiveness.	F	356			
	Polymen Dressing (ty a mild cleaning agent						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	PLETED	
		345307	B. WING			C 12/20/2018		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•		
MEADOW	WOOD NURSING CENT	ER			414 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 656	week."		F	656				
	for Resident #7's righ to be completed on M Friday during the hou There were no initials treatment to Resident	d (TAR) revealed treatment t outer ankle was scheduled londay, Wednesday and irs of 7:00 AM to 3:00 PM. s on the TAR indicating the t #7's right outer ankle was reduled days of 12/03/18,						
	Wound Nurse (WN) eresponsible for completing residents on the days Tuesdays, Wednesday week, and the hall nur completing wound tree The WN recalled cha Resident #7's right out the next dressing cha and 12/10/18. She st work on 12/11/18, the dated 12/05/18 with the hanging off the wound did not work on 12/03 and added it was and treatments were not the she was not schedule completed treatments	leting wound treatments for s she worked, which were ays and Thursdays each rises were responsible for eatments the remaining days. nging the dressing on uter ankle on 12/05/18 with inges scheduled on 12/07/18 tated when she returned to e dressing in place was her initials, smelled and was d. The WN confirmed she 8/18, 12/07/18 or 12/10/18 ongoing issue that wound being completed on the days ed to work. She added she is on the day she returned to ey were not done by the hall						
		terview on 12/18/18 at 1:23 ned she worked as a hall						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, 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	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	treatment to Resident explained she was ner wound treatments and dressing when it fell on never informed she ner treatments on the day scheduled. During an interview of Nurse #4 confirmed s to provide care to Res Nurse #4 stated she of treatment to Resident any other resident ass never trained to provide explained the facility fi the treatments for all fi informed she needed when the WN was not During a telephone in PM the Director of Nu nursing staff were infor providing wound treat description. The DON expectation nursing s #7's care plan and pro scheduled and ordered During a telephone in AM, Nurse #2 confirm assigned to provide c 12/10/18. Nurse #2 s the wound treatment fi	d did not complete wound #7's right outer ankle. She ever shown how to complete d only reapplied a resident's off. Nurse #1 added she was eeded to complete rs the WN was not n 12/18/18 at 3:00 PM, he was the nurse assigned sident #7 on 12/03/18. did not complete the wound #7's right outer ankle or signed because she was de wound care. Nurse #4 had a WN who completed residents and was never to complete the treatments t scheduled. terview on 12/19/18 at 2:03 irrsing (DON) explained ormed upon hire that ment was a part of their job N stated it was her taff would follow Resident ovide wound treatment as ed.	F 656				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345307	B. WING				C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R			1414 WILKINSON BLVD GASTONIA, 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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	Continued From page and the Hospice Nurs	e 47 se provided wound care.	F	656			
	Administrator was una were not being compl when the WN was no stated she was aware the building and felt th training in wound care expectation wound tra	n 12/20/18 at 11:14 AM, the aware wound treatments eted by the hall nurses t scheduled to work. She of all the training needs in ne nurses needed more e. She stated it was her eatments were completed as ed and staff provided care dent's care plan.					
	11/21/18 revealed an Resident #11 had pot development related to incontinence and had his coccyx and left hip pressure ulcer on his Resident #11 would bo pressure ulcer develop address problem were administer treatments effectiveness. Staff we monitor/document/rep in skin status (appear signs and symptoms of stage).	a stage II pressure ulcer on o and had a stage III right heel. The goal was e free from any further pment. Interventions to e as follows: Staff were to a sordered and monitor for ere to bort as needed any changes ance, color, wound healing, of infection, wound size, and					
	11/29/18 indicated Re	physician's note dated sident #11 had an sulcer to coccyx, right hip,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345307	B. WING				C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	ER			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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	right heel, and right m A review of hospital w 12/07/18 indicated Re pressure ulcer to left right heel, pressure u that was not staged, p left knee, and right he	nedial ankle. yound discharge sheet dated esident #11 had stage I heel and deep tissue injury lcer to right medial ankle pressure ulcer to sacrum, ead that was unstageable,	F	656	5		
	staged. A review of the Admis (ANA) dated 12/07/18 an unstageable press sacrum, right head, a	right hip that was not ssion Nursing Assessment 3 revealed Resident #11 had sure ulcer to buttock, nd left knee and a stage I heel, and deep tissue injury					
	12/12/2018 indicated unstageable pressure right heel, left heel, an to right medial ankle. On 12/19/18 at 10:36 conducted with the M nurse who stated she	AM an interview was inimum Data Set (MDS)					
	location and stage for nurse stated she was pressure ulcers but h physician notes for 1 ² location and stage of ulcers. She stated sh admission nursing as and hospital discharg 12/07/18 for pressure and had not reviewed	r Resident #11. The MDS aware Resident #11 had ad not reviewed the wound 1/29/18 that indicated Resident #11's pressure e had not reviewed the sessment dated 12/07/18					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		CONSTRUCTION		PLETED
		345307	B. WING				C 20/2018
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R			414 WILKINSON BLVD ASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 F 677 SS=G	Resident #11's care p ulcer location and sta pulled from performin to administer medicat the facility. On 12/19/18 at 10:53 conducted with the Ac MDS nurse was respond Resident #11's care p pressure ulcers and lo expectation was that to updated the care plan had pressure ulcer an On 12/19/2018 at 2:3 was conducted with the stated it was her expect would have updated to stage and location of #11. ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain of personal and oral hyon This REQUIREMENT by: Based on observation and staff interviews, to toileting assistance for reviewed for Activities (Resident #13) and fat	e stated she did not update lan to indicate pressure ge because she had been g her duties as MDS nurse ions and admit residents to AM an interview was dministrator who stated the onsible for updating lan to indicate stage of ocation. She stated her the MDS nurse would have to indicate Resident #11 eas. 5 PM a telephone interview he Director of Nursing who ectation that the MDS nurse he care plan to indicate pressure ulcers for Resident or Dependent Residents ent who is unable to carry iving receives the necessary good nutrition, grooming, and		556	 1.Incontinence care was provided to Resident #13 by a certified nursing assistant 12/16/18. Nail care was provided to Resident # 1 12/20/18 by th Certified Nursing Assistant. 2.The Registered Nurse/Interim Director 		1/18/19
	(Resident #13) and fa 2 of 5 dependent resid	iled to provide nail care for			Certified Nursing Assistant.		

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				LE CONSTRUCTION		<u>10. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED
			A. BUILDING	·		С
		345307	B. WING			2/20/2018
NAME OF P	ROVIDER OR SUPPLIER	0.0001		STREET ADDRESS, CITY, STATE, ZIP CO		2/20/2018
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTI	ER		GASTONIA, NC 28056		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	· · · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION
F 677	Continued From page	e 50	F 67	7		
				of Nursing completed an auc		
	The findings included	:		-1/18/19 to assess for advers		
				other residents with none ob	served.	
		readmitted to the facility on		2 The purging stoff wore edu	aatad by tha	
	-	inal admission on 10/08/09 gnoses: neuromuscular		3.The nursing staff were edu Registered Nurse/Interim Dir	-	
		er, history of urinary tract		Nursing 1/16-1/18/19 in prop		
		ressive episode, anxiety,		including nail and incontinen		
		and left hands, history of		residents requiring assistance		
	cellulitis of lower extr	-		education will be included in	subsequent	
	unsteadiness of feet	and type 2 diabetes mellitus.		new-hire orientation.		
	A review of Resident	#13's Annual Minimum Data		4.The Director of Nursing/Int	erim Director	
	Set (MDS), dated 02/	28/18, indicated he was		of Nursing will be responsible		
		was totally dependent on		aspect of the Plan of Correct		
		MDS further indicated		The Registered Nurse will ra		
		vays incontinent of bowel		compliance of Certified Nurs		
	of care.	S revealed had no rejection		providing ADL care including care and nail care- 5 resider		
				x 4 weeks, then 2 residents		
	A review of the Activit	ties of Daily Living (ADL)		weeks.		
		rea Assessment (CAA) and				
	Urinary Incontinence	CAA associated with the		The Plan of Correction will b	e reviewed at	
		Resident #13 needed		the next scheduled Quality A		
		ng as the resident was		Performance Improvement C		
	incontinent of bowel a			1/22/19. The committee inclu		
	provided incontinent needed.	care routinely and as		Medical Director, Administration of Nursing, Registered Nurse		
				Services, Dietary, Medical	, 300iai	
	A review of Resident	#13's care plan, dated		Records/Human Resource D	irector,	
		ne resident had an ADL		Maintenance Director, and li		
	-	e deficit and required		member.		
		from staff for toileting				
	-	further indicated that		All Plan of Correction month		
		s provided routinely and as #13 and that Resident #13		will be reported by each aud		
		se bell to call for assistance.		subsequent monthly Quality Performance Committee for		
	A review of the care			recommendations and updat		
		the potential to be verbally		to ensure continuous complia		

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		MEDICAID SERVICES				<u>10. 0938-039</u> TE SURVEY
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	· · · ·	MPLETED
			A. BOILDING			С
		345307	B. WING		1	2/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		2/20/2010
				4414 WILKINSON BLVD	_	
MEADOW	WOOD NURSING CENT	ER		GASTONIA, NC 28056		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO
F 677	Continued From page	e 51	F 67	7		
		aregivers. The care plan,	1.07			
		t being verbally aggressive				
		in ther revealed staff were to				
		e resident's toileting needs .				
		ducted with Resident #13 on				
		1. The resident provided the				
	of response on 12/16	I unresponsiveness and lack				
		s. He stated that on 12/16/18				
		laying in urine and feces and				
		light and pressed record on				
	his personal compute					
	someone came in to	his room and turned the call				
		king on him. He further				
		M, he turned his call light on				
	again and pressed re	-				
	-	der and his call light was d no one responded to his				
		that at 5:51 AM, he turned on				
		sed record on his voice				
	• ·	30 minutes before NA #2				
		ith his recording pushed to				
	the play button, the s	urveyor heard the				
		the NA #2 and the response				
		2/16/18 at 5:51 am. Upon				
	-	further indicated that NA #2				
		"You keep ringing the call				
		ed, huh?" Resident #13 , "That should be obvious. I				
		d up all night." Resident #13				
		change his brief, then left				
		and turned off his light. At				
		13 indicated that he pressed				
	his call light because	he was soaked with urine				
		een laying there all night				
		d up and pressed record on				
	his personal compute	er voice recorder. He further				
		#1 came into his room and				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2019 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
MEADOW	WOOD NURSING CENTE	P		4	414 WILKINSON BLVD			
MEADOW				G	SASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	she stated that she w someone to the hospic come in to help. Then room and did not retu Resident #13 reveale again and NA # 3 can cleaned him, and she and the under pad wa soaked up the urine a tobacco. Resident #11 hurt because staff did An interview was con Worker on 12/18/18 a there were no grievan December 2018. An interview was con 12/18/18 at 3:01 PM. into Resident #13's ro and had to change his was wet with urine fro to his knee cap. NA # #13 soaked with urine was the worst she say #3 stated that Reside incontinence care. NA was wet all the way th the chux (disposable) was brown. In cleanin she took a chux (disp cotton side of the chu chux pad was soaked that at the end of first of the condition she for	d not been cleaned up and as "in the middle of sending tal and can't make the NA's a, Nurse #1 left the resident's rn to his room. At 8:30 AM, d that he rang his call light ne into his room and washed his bed 3 times as turned upside down and and the pad looked like 3 tearfully reported he felt n't clean him up. ducted with the Social at 1:13 PM. She revealed aces filed for the month of beindicated that she went bom on 12/16/18 at 8:30 AM s whole bed because he om just below his shoulders 3 stated she found Resident e and feces before but this w his bed that soaked. NA	F	677		DEFICIENCY)		
	he reported regarding being addressed from							

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/31/2019 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING					C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ĒR			414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 677	mentioned something regarding 3rd shift be right how he was bein A phone interview wa 12/19/18 at 8:00 pm. third shift and frequer #13. NA #4 stated Re received incontinence am, at a minimum and change. She indicated never saturated his be but that he got a little computer equipment room hot. A phone interview wa 12/19/18 at 8:21 PM. assistants who came to Resident #13's roo him. She further state given a suppository, t resident more often. \$ #13 did not get a sup 12/15/18. She further perception that Resid 1:30 am and 5:30 am his room, woke him u stated that Resident # that he hadn't been ch him and changed him reported any concern did not mention that s first shift regarding Re	was the one who nces and that Resident #13 about writing a grievance cause he said it was not ng treated. s conducted with NA #4 on NA #4 stated she worked ttly worked with Resident	F	577				

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/31/2019 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345307	B. WING		_	(12/2) 20/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			4	414 WILKINSON BLVD			
MEADOW	WOOD NURSING CENTE	:R	G	ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	2 54	F 677				
		would be treated with nd care to be provided when					
	on 12/20/18 at 9:13 A worked 7:00 am to 7: toward the end of her he wanted to file a gri changed him for an e morning of 12/16/18. end of first shift NA #: very wet. She further information to the nig indicated that she did or file a grievance bee checked on Resident	not notify the social worker cause the social worker #13 daily.					
	Worker on 12/20/18 a that she did not talk t week of December 17 of any concerns invol further indicated that complained about bei previous Director of N at the facility which w She revealed that she #13 filing any recent of An interview was con Administrator on 12/2 12:25 PM. She states to be treated with dig to every staff member at the facility on 11/20	ducted with the 0/18 from 11:14 AM to d she expected all residents nity and respect and told this r when she started working S/18. She further stated she b e reported so follow-up					
		residents and it was a					

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DEPARTMENT OF HEAL CENTERS FOR MEDICA							FORM	D: 01/31/2019 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING					C 20/2018
NAME OF PROVIDER OR SUPPLIE	R			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MEADOWWOOD NURSING		D		4	414 WILKINSON BLVD			
		-1		G	ASTONIA, NC 28056			
PREFIX (EACH DEF	ICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA FFICIENCY)		(X5) COMPLETION DATE
 indicated again the incident, so 2. Resident #1 • 04/5/17 with an with the followir behavioral distudisorder, prurituperipheral vasc diabetes mellitus subcutaneous to depressive diso A review of Ress Set (MDS), data severe cognitive symptoms of so incontinent of bextensive assistance for trand extensive assistance for prindicated that sidevelopment but A review of the Assessment (Crisk for breakdown primhad a history of also revealed siscratches. A review of ADL 	ity if c she s she c origin g diag irbanc is (itch ular di s, loca is (e 55 are was not given. She hould have been told about ould fix the problem. eadmitted to the facility on al admission on 01/10/17 gnoses: dementia without e, generalized anxiety hing), Right hip infection, sease, (PVD), type 2 al infection of the skin and (onset 01/11/17), and major #1's Annual Minimum Data 8/18, indicated she had hirment, she had behavioral ng herself, she was always and bladder and needed with 2 plus person physical rs, bed mobility, toileting, nce with 1-person physical al hygiene. The MDS also is at risk for pressure ulcer she had no pressure ulcer. ure Ulcer Care Area evealed Resident #1 was at e to her incontinence and th positioning. Resident #1 h multiple areas of o her legs and buttocks and hic pruritis (itching). The CAA is prone to self-inflict	F	677		EFICIENCY)		

Facility ID: 923314

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 01/31/2019 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_	(12/:	C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	extensive assistance was able to assist with Resident #1 also need bathing or showering. A review of the care p Pressure Ulcer Devel #1's self-inflicted scra revealed the following for potential for pressi to make sure fingerna and had no jagged ed treatments as ordered monitored for effective A review of Care Kard she was supposed to needed and the Dece nail care sheet indicat documented. An observation of Res bed via Hoyer Lift was 2:30 pm with a nurse present. Nurse #6 was assessment on the re on both hands were do colored substance un nails were ¼ inch in le the second digit of the edge. An interview with Nurs 12/17/18 from 2:45 Pl stated that the resider nail care and NA's we	urther revealed she required with personal hygiene but h basic hygiene with setup). ded physical assistance with lan for the Potential for opment indicated Resident tches. The care plan also g interventions were in place ure ulcer development: staff als were clean, trimmed, liges and staff to administer d and treatments were eness. dex for Resident #1 revealed get nail care daily and as imber 2018 bed baths and ted no nail care was sident #1 being assisted to as conducted on 12/17/18 at and nursing assistant s performing a skin sident. Resident #1's nails lirty with a brownish red der her fingernails and the ength and the fingernail on e right hand had a jagged se #6 was conducted on M to 3:00 PM. Nurse #6 int definitely needed good ere supposed to cut her nails shower and also stated that	F 677				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M					FORM): 01/31/2019 APPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	345307	B. WING		_	(12/2) 20/2018
NAME OF PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
MEADOWWOOD NURSING CENTE	R		1414 WILKINSON BLVD GASTONIA, NC 28056			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 with Nurse #6 regardine An observation and interview was conditioned and the fingernail on the fingern	efuse care. NA #5 concurred ing Resident #1's nail care. terview were conducted irse on 12/18/18 from 1:15 vas performing a dressing e1's right hip. Further ident during the dressing sident #1's nails on both with a brownish red colored ingernails and the nails and the fingernail on the ht hand had a jagged edge. stated that because the ff, she told the Na's to notify ey could change the treatment order is as to stated that all nurses were a weekly skin assessment. ducted with NA #4 on She stated that she did not ent #1 because that was sident #1 was conducted on . During the observation, a both hands were still dirty olored substance under her ils were ¼ inch in length he second digit of the right ge and the resident put her th.	F 677				

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ATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY PLETED
D PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		CON	C
		345307	B. WING		12	2/20/2018
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
IEADOW	WOOD NURSING CENT	ER		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 PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677	Continued From page	e 58	F 677	,		
	then left the resident' nail care.	s room without performing				
	DON on 12/19/18 1.5 expectation was that shower their nails sho checked daily to dete	was conducted with the 53 PM. She stated that her every time residents get a ould be checked and ermine if they needed to be and the care plan should				
	Room was conducted Resident #1's nails o with a brownish red of fingernails and the na	esident #1 in the Activity d on 12/20/18 at 10:35 AM. n both hands were still dirty colored substance under her ails were ¼ inch in length the second digit of the right dge.				
	12:25 PM. The admir nails to be cleaned e stated NAs should be have time to do this of indicated that she tal care in particular for contractures. She fu should have been do of care. The administ care plans to be accu interventions to be fo whether it was care f	20/18 from 11:14 AM to histrator stated she expected very day by NAs. She further e able to do this and should during AM care. She ked with the NAs about nail residents that had rther indicated that nail care ine consistent with the plan trator stated she expected				
F 684 SS=D	Quality of Care CFR(s): 483.25		F 684	L		1/18/19
	§ 483.25 Quality of c Quality of care is a fu	are Indamental principle that				

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	NO. 0938-039
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CO	MPLETED
		345307	B. WING			C 2/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		2/20/2010
MEADOW	WOOD NURSING CENTI	ER		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 PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page	e 59	F 68	34		
	applies to all treatme	nt and care provided to		-		
	-	ed on the comprehensive				
		dent, the facility must ensure treatment and care in				
		essional standards of				
	-	nensive person-centered				
	care plan, and the rea	•				
	This REQUIREMENT	Γ is not met as evidenced				
	by:					
		ons, record review, staff		1.Resident #1 wound care I		
		cian interviews, the facility ments as scheduled and		provided consistently by the nurse.	licensed	
		vas done consistent with		nuise.		
		1 of 1 sampled residents		2.In order to ensure other re	sidents are	
		nd infection (Resident #1).		not affected by the alleged of practice the wound care nur		
	The findings included			schedule has been changed 1/15/19 to Monday-Friday to	complete	
		dmitted to the facility on		daily coverage and all nurse		
	-	nal admission on 01/10/17 gnoses: right hip wound		informed that when the treat off they are to perform wour		
	infection, dementia w			wound care nurse absence.		
		zed anxiety disorder, pruritus				
		ascular disease, (PVD), type		3.Education was provided to	o the nursing	
		ocal infection of the skin and		staff 1/16-1/18/19 by the Re		
		(onset 01/11/17), and major		Nurse/Interim Director of Nu		
	depressive disorder.			regarding their role to provid		
	A review of Resident	#1's Annual Minimum Data		in the event the wound nurs working. They were also edu		
		/08/18, indicated she had		1/16-1/18/19 regarding would		
		airment, she had behavioral		procedures by the Registere		
	symptoms of scratchi	ing herself, she was always		Nurse/Interim Director of Nu	ırsing.	
		and bladder and needed		Newly hired nursing staff wil		
		with 2 plus person physical ers, bed mobility, toileting,		during subsequent orientation	on events.	
		ance with 1-person physical		4.Monitoring to ensure comp	pliance the	
	assistance for persor	nal hygiene. The MDS also		Registered Nurse/Interim Di	rector of	
		is at risk for pressure ulcer		Nursing will be responsible f	for this aspect	
	development but that	she had no pressure ulcer.		of the Plan of Correction.		

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 09 (X3) DATE SURV	
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:			COMPLETE	D
					С	
		345307	B. WING		12/20/2	018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	ER		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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COM	(X5) MPLETIOI DATE
F 684	Continued From page	e 60	F 684			
	A review of the Press Assessment (CAA) as MDS revealed Reside breakdown due to he assistance with positi admitted with multiple primarily to her legs a chronic pruritis (itchin A review of the Facilit Non-Pressure Ulcer S Wound Infection, date following wound mea (cm): 8.5 cm in length in depth and 8.1 cm u A review of the Facilit Non-Pressure Ulcer S Wound Infection, date following wound mea (cm): 4.2 cm in length in depth and 8.0 cm u A review of Resident dated 12/05/18, revea 1. Cleanse Right hi dry, pack with Dakins cover with dry dre needed. 2. Cleanse Right hi cleanser, pat dry, app dry dressing every A review of the care p area to right hip or po	ure Ulcer Care Area ssociated with the 01/08/18 ent #1 was at risk for r incontinence and needed oning. Resident #1 was also e areas of breakdown and buttocks with a history of g). by Skin Condition Record for Skin Conditions for Right Hip ed 11/24/18, indicated the surements in centimeters in x 1.4 cm in width x 1.2 cm undermining at 12 o'clock. by Skin Conditions for Right Hip ed 12/05/18, indicated the surements in centimeters in x 1.2 cm in width x 0.8 cm undermining at 12 o'clock. with the surements in centimeters in x 1.2 cm in width x 0.8 cm undermining at 12 o'clock. #1's Physician Orders,		The Registered Nurse will random the compliance of Nurses providin consistent wound care according t orders- 5 residents per week x 4 then 2 residents per week x 4 wee The Plan of Correction will be revie the next scheduled Quality Assura Performance Improvement Comm 1/22/19. All Plan of Correction mon audit data will be reported by each to subsequent monthly Quality Ass Performance Committee for review recommendations to continue the achievement of compliance.	g o MD weeks, ks. ewed at nce ttee nthly auditor surance	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		345307	B. WING				C /20/2018		
NAME OF P	ROVIDER OR SUPPLIER	•	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-			
MEADOW	WOOD NURSING CENTE	ĒR		4414 WILKINSON BLVD GASTONIA, NC 28056					
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				3E	(X5) COMPLETION DATE			
F 684	plan further indicated were in place for staff ordered and were mo dressing was monitor and adhering and sta to the treatment nurse moisturizer applied to A review of the Facilit Non-Pressure Ulcer S Wound Infection, date following wound meas (cm): 5.1 cm in length in depth and 4.8 cm u (progress: improved). A review of the Decer Administration Record resident's Right hip du periwound dressing c done on the following 12/10/18; & 12/17/18. A review of Decembe following treatments f initialed as done the f 1. Apply zinc oxide day. (not initialed on 12/10/18; & 12/17/18; 2. Doxepin Cream s with abrasion every n areas are healed initialed on 12/07/18; 12/15/18; 12/16/18; a 3. Eucerin Cream-a Extremities twice daily 7am (not initialed on 4. Eucerin Unscent	the following interventions to administer treatments as nitored for effectiveness, ed to ensure it was intact ff to report loose dressings e, and the resident needed ther skin. y Skin Condition Record for Skin Conditions for Right Hip ed 12/12/18, indicated the surements in centimeters of x 1.1 cm in width x 2.0 cm indermining at 3 o'clock mber 2018 Treatment d (TAR) revealed the ressing change and hange was not initialed as dates: 12/07/18; 12/08/18; r 2018 TAR revealed the for Resident #1 were not following dates: to groin redness/area every 12/07/18; 12/08/18; 5%- apply to all body parts ight on 3pm-11 pm until all and then as needed. (not 12/8/18; 12/11/18; 12/14/18;	F	684					

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	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3)	3) DATE SURVEY COMPLETED
345307 B. WING	C 12/20/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MEADOWWOOD NURSING CENTER 4414 WILKINSON BLVD GASTONIA, NC 28056	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
 F 684 Continued From page 62 (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18) 5. Ketoconazole Shampoo 2%- apply to scalp once a week for itch on 11 p-7p (not initialed on 12/07/18 at 02/14/18) 6. Vitamin A+D ointment for Desitin Clear with Vit A&D - apply topically to buttocks and thighs every day. (not initialed on 12/07/18; 12/08/18; 12/10/18; & 12/17/18) An observation of Resident #1 being assisted to bed via Hoyer Lift was conducted on 12/17/18 at 2:30 pm with Nurse #6 and NA #5 present. At the time of the transfer, Nurse #6 was performing a skin assessment on the resident. Luring continuing observation of Nurse #6 and NA #5 repositioning the resident, the nurse did not change the dressing, as the dressing was undated. An interview with Nurse #6 was conducted on 12/17/18 from 2:45 PM to 3:00 PM. Nurse #6 stated that the facility had a treatment nurse on Tuesdays, Wednesdays, and Thursdays during the week and a treatment nurse on Saturdays and Sundays every other weeked but there was no treatment nurse on Mondays and Fridays. Nurse #6 indicated that the resident the resident #1* right hip started out as a bump about 2 weeks ago and the facility had a wound doctor. Nurse #6 further indicated the resident had undermining (destruction of fusue extending under the skin edges so that the pressure ulcer was larger at its base than at the skin surface) of the wound not ti was a decublus pressure ulcer. She indicated that the right hip wound treatment was for the wound to be packed and covered with a blue dry dressing. 	

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2019 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345307	B. WING					C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP COI	DE		
				4	414 WILKINSON BLVD			
MEADOW	WOOD 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 PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD B E APPROPRI/		(X5) COMPLETION DATE
F 684	Nurse on 12/18/18 at she knew nothing abo wound until Saturday date she saw the wou further stated that the popped open and was undermining. She ind information in the faci Resident #1's right hij indicated that she init hip on 11/24/18. She not at work, the treatr consistently getting du the same dressings th from when she last w 12/05/18, she complet residents and, when s Tuesday; 12/11/18 sh dressing and the blue drainage, had no date not packed as ordered undermining of the wo An observation and in with the Treatment Nu PM to 1:35 PM. She change on Resident # when the wound doct resident's right hip wo stated that the wound and he removed the of the wound which reve further stated that the decreased from 8 cer During continued obs sponge was still noted	ducted with the Treatment 8:52 AM. She stated that but Resident #1's right hip (11/24/18, which was the and for the first time. She right hip wound had already s draining and developed icated that she documented lity doctor's book about p wound. She further iated treatment to the right stated that when she was ments on residents were not one because she would find hat she placed on residents orked. She indicated that on the checked Resident #1's e foam was saturated with e on it, and the wound was d. She said the wound because Resident #1 had bund. hterview were conducted urse on 12/18/18 from 1:15 was performing a dressing #1's right hip. She stated that or first came to assess the bund after it opened up, he l looked like a bad infection dead tissue off of the top of ealed the undermining. She	F	684				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/31/2019 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			-		C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R			414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	areas of thick yellow a the dressing. Further was no odor noted fro wound itself. The Tread dry dressing she remo- not have been there to not follow the physicial been changed daily. S Resident #1 never ref scratch her right hip a caused the dressing to wound. The Treatmer the dressing may com- notify the hall nurses dressing because the needed also. She also responsible for doing An interview was com- 12/18/18 at 2:04 PM. change the dressing of She further stated that was not at the facility, responsible for chang indicated that she not Nurse #8, on 12/17/18 been done for Reside A phone interview wa on 12/19/18 at 9:53 A did not do the treatment 12/17/18 because she with only one NA. A phone interview wa on 12/19/18 at 10:07	a dressing and had 4 small adherent tissue surrounding observation indicated there om the old dressing or the atment Nurse stated that the oved from the wound should because it the dressing did an's order and it should have She further stated that fused care, but she did and around the wound which o hang loosely off the it Nurse stated that because the off, she told the Na's to and they could change the treatment order was as o stated that all nurses were a weekly skin assessment. ducted with Nurse #6 on She stated that she did not on 12/17/18 for Resident #1. it when the treatment nurse the hall nurses were ing the dressing. She ified oncoming 3rd shift, 8 that a treatment had not int #1. s conducted with Nurse #8 M. She indicated that she ents on Resident #1 on e was working by herself s conducted with Nurse #4 AM. She indicated that on rformed a dressing change	F	;84				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMP	SURVEY LETED
		345307	B. WING		-	(12/:	C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	9 65	F 684				
	on 12/19/18 at 10:27 worked with Resident PM to 7:00 AM, and of treatments on Reside An interview was come Doctor on 12/19/18 at that when the regular working every day, the treatments being come stated he was not sur her skin caused the in further stated that Res packing wet to moist of that the periwound de Care notes, dated 12/ insufficiency). He indii was ordered for the p key to successful wou the wound and that the be covering the woun A phone interview waa on 12/19/18 at 11:55 worked on 12/08/18 at done on Resident #1. 12/10/18, she only ch dressing, not Residen A telephone interview DON on 12/19/18 1:5	nt #1. ducted with the Wound t 11:14 AM. He indicated treatment nurse was not ere was an issue with pleted as ordered. He e if Resident #1 scratching ifection of her right hip. He sident #1 needed wound dressings once a day and treriorated (per the Wound '12/18, due to venous cated that the Silvadene eriwound abrasion and the und healing was to protect te dressing was supposed to d. s conducted with Nurse #2 AM. She stated that she and no treatments were She further stated that on anged another resident's it #1.					
	An interview was con Administrator on 12/2	ducted with the 0/18 from 11:14 AM to					

Facility ID: 923314

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI	E CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
					С
		345307	B. WING		12/20/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
				4414 WILKINSON BLVD	
WEADOW	WOOD NURSING CENT	EK		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 684	Continued From page	e 66	F 684	4	
	-	histrator indicated that she			
		to be done consistent with			
		She further indicated she			
	was not aware treatm	nents were not being done			
		ected all orders to be			
		eatment and schedule set			
F 000	for treatments.		E 00		4/40/40
F 686 SS=D	CFR(s): 483.25(b)(1)	event/Heal Pressure Ulcer (i)(ii)	F 680	0	1/18/19
	§483.25(b) Skin Integ	arity			
	§483.25(b)(1) Pressu				
	-	ehensive assessment of a			
	resident, the facility n	nust ensure that-			
		s care, consistent with			
	-	ds of practice, to prevent			
	-	does not develop pressure vidual's clinical condition			
		ey were unavoidable; and			
		essure ulcers receives			
		and services, consistent			
	with professional star	ndards of practice, to			
		vent infection and prevent			
	new ulcers from deve				
		is not met as evidenced			
	by: Based on observatio	ns, record review and		1.Resident # 11 and #7 have received	
		ospice Nurse and staff		wound care as ordered by the licensed	
	-	r failed to initiate pressure		nurse.	
	ulcer treatment for 3	days to a resident admitted			
		(Resident #11) and failed to		2.In order to ensure other residents are	
		cer treatment as ordered		not affected by the alleged deficient	ula.
	residents reviewed for	days (Resident #7) for 2 of 3 or pressure ulcers.		practice the wound care nurse□ schedu has been changed effective 1/15/19 to Monday-Friday to complete daily cover	
	The findings included	I:		and all nurses have been informed that when the treatment nurse is off they are	
	1 Desident #11 wee	readmitted to the facility on		perform wound care in the wound care	

Event ID: IMMS11

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/31/2019 APPROVED . 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		345307	B. WING		C 12/2	, 20/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	-R	4	414 WILKINSON BLVD		
MEADOW	NOOD NORONO OLATI		(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	Continued From page	<u>- 67</u>	F 686			
1 000	12/07/18 with diagnost tract infection, demen	ses which included urinary ntia, and pressure ulcer to	1 000	nurse absence.		
	Minimum Data Set (M 09/09/18 indicated Re impaired and was coo unstageable pressure not present on prior a A review of Care Area pressure ulcer dated #11 had a deep tissue with treatment in plac A review of the care p 11/21/18 revealed an Resident #11 had pot development related incontinence and had his coccyx and left hip pressure ulcer on his Resident #11 would b pressure ulcer develo address problem wer administer treatments effectiveness. Staff w monitor/document/rep in skin status (appear signs and symptoms stage).	recent comprehensive (IDS) assessment dated esident #11 was cognitively ded as having an a ulcer on his heel that was assessment. a Assessment (CAA) for 09/09/18 indicated Resident e injury (DTI) to right heel te injury (DTI) to right heel re. blan with an initiation date of identified problem that rential for pressure ulcer to immobility and I a stage II pressure ulcer on p and had a stage III right heel. The goal was be free from any further opment. Interventions to e as follows: Staff were to s as ordered and monitor for rere to bort as needed any changes rance, color, wound healing, of infection, wound size, and physician's note dated		 3.Education was provided to the r staff by the Registered Nurse/Inter Director of Nursing 1/16-1/18/19 r their role to provide treatments in event the wound nurse is not wor They were also educated 1/16-1/ regarding wound care procedures order to correct nurses not clarify implementing treatment orders, tw nurses must sign off that the treat orders have been clarified and implemented with each new or re resident whom requires wound care will be an on-going process. Newly hired nursing staff will be eduring subsequent orientation even 4. The Registered Nurse Superviss or Interim Director of Nursing will responsible for this aspect of the Correction. The Registered Nurse Supervisor Interim/Director of Nursing will ratcheck the compliance of Nurses process or description of Nurses process or sistent wound care according orders- 5 residents per week x 4 we The Plan of Correction will be rew the next scheduled Quality Assurate Performance Improvement Comm 	erim regarding the rking. 18/19 s. In ing and wo tment eadmit are, this educated ents. sor and be Plan of r and or ndomly providing to MD 4 weeks, eks. riewed at ance	
	right heel, and right m A review of MDS date			1/22/19. All Plan of Correction mo audit data will be reported by eac to subsequent monthly Quality As Performance Committee for revie	h auditor ssurance	

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			0.00			0.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COMF	SURVEY
				·		С
		345307	B. WING			20/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
MEADOW	WOOD NURSING CENT	ER		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 PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 686			F 68	6		
	Resident #11 had un hospital with return a	blanned discharge to the nticipated.		two months if concerns are QA Committee will continu another three months in ou	e to review	
	12/07/18 indicated Re ulcer to left and right sacrum, right hip, and receive foam dressing Santyl (debridement to right medial ankle, apply ¼ strength Dak to kill germs and prev and Santyl to right he	eview of hospital wound discharge sheet dated /07/18 indicated Resident #11 had pressure er to left and right heel, right medial ankle, crum, right hip, and left knee and was to rever foam dressing to left heel and apply ntyl (debridement ointment and foam dressing right medial ankle, sacrum, and right hip, and oly ¼ strength Dakin's solution (a solution used kill germs and prevent germ growth in wounds) d Santyl to right heel. The treatment orders did t indicate when the wound treatment was to pin or how often wound treatment was to		addition recommendations maintaining compliance.	•	
	begin or how often we administered.	sion Nursing Assessment				
	 (ANA) dated 12/07/18 revealed Resident #11 had a pressure ulcer to buttock, right and left heel, sacrum, right head and left knee which were not measured. Review of Resident #11's Medication Administration Record (MAR) dated 12/07/18 to 12/31/18 indicated there were no medication orders prescribed to treat areas on his left and right heel, right medial ankle, sacrum, right hip, buttock, and left knee. Review of Resident #11's Treatment Administration Record (TAR) from 12/07/18 through 12/10/18 indicated treatment to the right and left heel, sacrum, right hip, and right medial ankle were not completed per nurse documentation on the TAR. No treatment had 					
	been set up for areas right medial ankle, sa	crum, right hip, buttock, and to 12/10/18. A further				

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			0.00			O. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED	
			A. BUILDING			С	
		345307	B. WING		12	2/20/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
			4414 WILKINSON BLVD				
MEADOW	WOOD NURSING CENT	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 686	Continued From page 69		F 68	6			
	review of the TAR fro	5					
	12/31/18 indicated treatment orders were written by the wound physician on 12/12/18 were transcribed to the TAR and were documented as						
	completed.						
	On 12/18/18 at 8:34						
		round nurse (WN) who days a week and was					
		s not working if Resident					
		were treated. The WN					
	-	stated it was the responsibility of the floor duty					
		nd treatment when she was					
	-	stated Resident #11 was ility from the hospital on					
		ated she returned back to					
		d Resident #11 had hospital					
	dressings on his pres	ssure ulcer wounds and she					
		t wound treatment had been					
		8, 12/09/18, and 12/10/18 by					
		The WN stated when she 18 Resident #11 had no					
	-	ers from the 12/07/18					
		stated the TAR did not					
	indicate via nursing d	locumentation that wound					
		provided to Resident #11 on					
		and 12/10/18. The wound					
	Resident #11 on 12/1	formed wound treatment for					
		PM a telephone interview					
		Nurse #1 who stated she					
		:00 AM when Resident #11					
		acility on 12/07/18. She e that Resident #11 had					
		ated it had been a very busy					
		ne did not call the physician					
	-	1 's wound treatment orders					
		charge. She stated she had					

Facility ID: 923314

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/31/2019 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			(12/2	; 20/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
MEADOW	WOOD NURSING CENTE	:P	4	414 WILKINSON BLVD			
MEADOW			G	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 686	clarify the wound order On 12/8/18 at 2:33 Pt conducted with Nurses shift on 12/07/18 and head to toe admission noted he had several not have time to comp paperwork and had no clarify wound treatme Nurse #2 stated she i Nurse #1 that she had admission paper work #1 that she had not cl orders with the facility the process on admiss clarify wound treatme if the orders were not On 12/18/18 at 2:44 F was conducted with N was scheduled to be 12/08/18 and 12/09/1 administer medication not clarified with the fa- treatment orders for F	w the hospital wound etermine if she needed to ers with the facility physician. M a telephone interview was #2 who worked the day completed Resident #11's in nursing assessment and wounds. She stated she did blete his admission ot called the physician to nt orders for Resident #11. nformed the oncoming d not finished Resident #11's is but did not informed Nurse arified wound treatment or physician. Nurse #2 stated sion was that staff were to nt orders with the physician	F 686	DE	FICIENCY)		
	Nurse #3 stated she w treatment orders for F clarified with the facili On 12/18/18 at 2:55 F conducted with Nurse working day shift whe	PM an interview was #4 who stated she was n Resident #11 was					
		on 12/07/18 and helped ng pain medication orders					

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STATEMENT OF DERIGENCIES AND PLAN OF CORRECTION (M) PROVIDER OR PLANDER IDENTIFICATION NUMBER (M) PROVIDER OR PLANDER A BULINIO 		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
148307 E. WING 11220/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE STREET ADDRESS, CITY, STATE, 2P CODE (X4) ID SUMMAY STREEMENT OF GEOCORDES STREET ADDRESS, NAME CONSCIPTION Conscience Conscien	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE COMP	SURVEY PLETED
MEADOWWOOD NURSING CENTER 4114 WILKINSON BLVD OASTONA, NC 2805 WH D PRETIX TG SUMMARY STATIMENT OF DEFICIENCES (EACH DEFICIENCY MUST & PRECEEDE DY FULL RECULATORY OR LSC DENTIFYING INFORMATION) IP IP PRECINA (EACH CORRESPEND AN OF CORRECTION (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTION (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTION (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTION (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 636 F F F F F F F A Stated She had not informed the oncoming nurse that the wound treatment orders for Resident #11 had not been clarify wound orders with the facility physician. F F F On 12/18/18 at 2:17 PM an interview was conduced with the Director of Nursing (DON) who stated the admitting nurse was responsible to clarify wound treatment orders with the facility physician and transoribe wound freatment orders on the TAR. The DON stated the was the expectation that the admitting nurse would pave clarified wound treatment orders with the facility physician for Resident #11. The DON stated the was the expectation that the conording nurse if she was unable to clarify wound treatme			345307	B. WING				-
MEADOWNOOD NURSING CENTER GASTONIA, NC 28056 (M) JD PRETEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH EORESY MUST BENECOCON USE THE RECECED BY FULL RECALL TORY OR LSC DENTIFYING INFORMATION) ID PRETEX TAG PROVINCE CONRECTION ECONSECTION (EACH EORESY MUST BENECOCON USE DENTIFYING INFORMATION) D PROVINCE CONRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION SHOULD BE CROSS METERINCED TO THE APPROPRIATE DEFICIENCY 0(9) (CROSS METERINCED TO THE APPROPRIATE DEFICIENCY F 686 Continued From page 71 with the physician for Resident #11. Nurse #4 stated she had not laffied wound treatment orders for Resident #11. Nurse #4 stated she was unaware that Resident #11 had wounds. Nurse #4 stated she had not informed the oncoming nurse that the wound treatment orders for Resident #11 had not been clarified with the facility physician. Nurse #4 stated she thought the wound nurse was responsible to clarify wound orders with the facility physician. On 12/18/18 at 2:17 PM an interview was conducted with the Director of Nursing (CON) who stated the admitting nurse was responsibile to clarify wound treatment orders onto the TAR. The DON stated it was her admitting nurse's responsibility to provide a head to toe resident assessment on admission and document any wounds and skin issues and obtain wound treatment orders not Resident #11's TAR or would have communicated to the oncoming nurse if she was unable to clarify wound treatment orders with the facility physician for Resident #11's TAR or would have communicated to the expectation that the floor duty nurse would have provided wound treatment orders wound she expectation that the floor duty ment the floor duty nurse	NAME OF PF	ROVIDER OR SUPPLIER		•				
Prefers CEACH DEFICIENCY MIGT BE PRECEDED BY FULL RESULTATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT THE APPROPRIATE Convisition DEFICIENCY) F 686 Continued From page 71 with the physician for Resident #11. Nurse #4 stated she had not clarified wound treatment orders for Resident #11. Nurse #4 stated she was unaware that Resident #11 had wounds. Nurse #4 stated she had not informed the oncoming nurse that the wound treatment orders for Resident #11 had not been clarified with the facility physician. F 686 On 12/18/18 at 2:17 PM an interview was conducted with the Director of Nursing (DON) who stated the admitting nurse was responsible to clarify wound treatment orders onto the TAR. The DON stated it was the admitting nurse' responsibility to provide a head to to resident assessment on admission and document any wounds and skin issues and obtain wound treatment orders on Resident #11 TAR or would have clarified wound treatment orders with the physician for Resident #11. Nurse #4 stated she thought the wound nurse was responsible to clarify wound treatment orders onto the TAR. The DON stated it was the admitting nurse's responsible to clarify wound treatment orders on Resident #11 TAR or wound have clarified wound treatment orders with the physician for Resident #11. The DON stated it was her expectation that the floatify physician for Resident #11. The DON stated it was her expectation that the float duty nurse would have provided wound treatment for Grestient #11 on 12/8/18, 12/09/18, and 12/10/18. The DON stated it was her expectation if the wound nurse was not on duty then the floor duty nurse would provide	MEADOW	WOOD NURSING CENTE	ER					
 with the physician for Resident #11. Nurse #4 stated she had not clarified wound treatment orders for Resident #11 haw ounds. Nurse #4 stated she had not informed the oncoming nurse that the wound treatment orders for Resident #11 had not been clarified with the facility physician. Nurse #4 stated she though the wound nurse was responsible to clarify wound orders with the facility physician. On 12/18/18 at 2:17 PM an interview was conducted with the Director of Nursing (DON) who stated the admitting nurse was responsible to clarify wound treatment orders for onto the TAR. The DON stated it was the admitting nurse's responsibility to provide a head to to resident assessment on admission and document any wounds and skin issues and obtain wound treatment orders from the physician. The DON stated the expectation that the admitting nurse's not have clarified wound treatment orders with the facility physician for Resident #11 the facility physician for Resident #11 the DON stated to the respectation that the admitting nurse would have clarified wound treatment orders with the facility physician for Resident #11 the DON stated it was her expectation that the facility physician for Resident #11 the facility physician for Resident #11. The DON stated it was her expectation that the facility physician for Resident #11. The DON stated it was her expectation that the facility physician for Resident #11. The DON stated it was her expectation that the facility physician for Resident #11. The DON stated it was her expectation that the facility physician for Resident #11. The DON stated it was her expectation that the facility physician for Resident #11. The DON stated it was not on duty then the floor duty n	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		COMPLETION
On 12/18/18 at 4:07 PM a telephone interview was conducted with the facility physician who stated he had not received a call from the facility	F 686	with the physician for stated she had not cla orders for Resident # unaware that Resider #4 stated she had not nurse that the wound Resident #11 had not facility physician. Nur wound nurse was res orders with the facility On 12/18/18 at 2:17 F conducted with the Di who stated the admitt to clarify wound treater physician and transcr onto the TAR. The DC admitting nurse's resp to toe resident assess document any wound wound treatment order DON stated it was he admitting nurse would treatment orders with have transcribed treat #11's TAR or would have oncoming nurse if she wound treatment order for Resident #11. The expectation that the fl provided wound treatu 12/8/18, 12/09/18, an it was her expectation on duty then the floor wound care for Resid On 12/18/18 at 4:07 F was conducted with the	Resident #11. Nurse #4 arified wound treatment 11. Nurse #4 stated she was at #11 had wounds. Nurse t informed the oncoming treatment orders for been clarified with the se #4 stated she thought the ponsible to clarify wound physician. PM an interview was irector of Nursing (DON) ing nurse was responsible ment orders with the facility ibe wound treatment orders DN stated it was the ponsibility to provide a head sment on admission and s and skin issues and obtain ers from the physician. The r expectation that the d have clarified wound the physician and would tment orders onto Resident ave communicated to the e was unable to clarify ers with the facility physician e DON stated it was her oor duty nurse would have ment for Resident #11 on d 12/10/18. The DON stated n if the wound nurse was not duty nurse would provide ent #11.	F	686			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345307	B. WING				C 20/2018
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	staff on 12/07/18 to cl orders for Resident # staff would have called orders and not the nu physician stated it wa would have called hin with admission wound Resident #11. The ph expectation that Resid received wound treatr and 12/10/18 because tough wounds. The pl expectation that wour performed daily and c wound care to the wo On 12/18/18 at 4:34 a conducted with the wo after reviewing the ho sheet for 12/07/18 that dressing applied to hi medial ankle, coccyx, felt the dressings did daily. The wound phy dressing could stay in without being change stated he could not de occurred because Re treatments had not be 12/09/18, and 12/10/1 On 12/19/18 at 10:58 conducted with the Ad expectation was that have verified wound t facility physician and the TAR. The Adminis expectation was that	larify wound treatment 11. The physician stated d him to clarify wound rse practitioner. The s his expectation that staff in to clarify any questions d treatment orders for ysician stated it was his dent #11 would have ment on 12/08/18, 12/09/18, e Resident #11 had some hysician stated it was his nd care would have been deferred Resident #11's und physician. a telephone interview was ound physician who stated spital discharge wound at Resident #11 had a foam s pressure ulcer on the right right hip, and left heel and not need to be changed sician stated a foam n place for 3 to 5 days d. The wound physician etermine if any harm sident #11's wound een provided on 12/08/18, 18. AM an interview was dministrator who stated her the admitting nurse would reatment orders with the transcribed the orders onto	F	686	6		

Facility ID: 923314

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		345307	B. WING				C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MEADOW	WOOD NURSING CENT	ER			1414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	and 12/10/18. On 12/19/18 at 11:08 conducted with the w stated he felt that the wound treatment orded discharge physician of admission 12/07/18 fe how often wound treat provided. 2. Resident #7 admit 01/31/17 with multiple dementia, kyphosis (e of the spine), age-relat chronic pain. Review of a physician Resident #7 read in p protecting skin) to bilat with foam dressing tw Review of the signific Set (MDS) dated 10/2 was moderately impa making and displayed the 7-day assessment the MDS indicated Re extensive assistance and had 2 unhealed p Review of a care plan 10/25/18, revealed Re	an additional interview was ith the wound physician who nurse should have clarified ers with the hospital or facility physician on or Resident #11 to clarify itment should have been ted to the facility on e diagnoses that included excessive outward curvature ated osteoporosis, and h's order dated 08/30/18 for eart, "skin prep (forms a film ateral top of foot and protect vice weekly and as needed." ant change Minimum Data 24/18 revealed Resident #7 ired for daily decision d no rejection of care during it period. Further review of esident #7 required with activities of daily living	F	686			
	assistance with mobil						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/31/2019 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345307	B. WING				C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	.	
MEADOW	WOOD NURSING CENTE	ER			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	free from any signs or related to altered skin included for staff to ac ordered and monitor f Review of a physician Resident #7 read in p	r symptoms of infections i integrity. The interventions dminister treatments as for effectiveness. n's order dated 11/28/18 for art, "cleanse right outer	F	686	3		
	a mild cleaning agent	anser, pat dry, apply pe of dressing that contains activated by moisture and o the wound area) 3 times a					
	for Resident #7's righ to be completed on M Friday during the hou There were no initials treatment to Resident completed on the sch	d (TAR) revealed treatment t outer ankle was scheduled londay, Wednesday and rs of 7:00 AM to 3:00 PM. on the TAR indicating the t #7's right outer ankle was eduled days of 12/03/18, 12/17/18. Further review of initials indicating the tt #7's top of foot was					
	Wound Nurse (WN) eresponsible for completing vound the hall nu completing wound the the WN recalled characteristic of the	n 12/18/18 at 8:35 AM, the explained she was eting wound treatments for she worked, which were ays and Thursdays each rses were responsible for atments the remaining days. nging the dressing on uter ankle on 12/05/18 with nges scheduled on 12/07/18					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2019 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345307	B. WING			_		C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	B			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 PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	work on 12/11/18, the dated 12/05/18 with h hanging off the wound did not work on 12/03 and stated it was an of treatments were not b nurses on the days sh work. She added she the day she returned done by the hall nurse An observation was n wound care on 12/18/ washed her hands an old dressing from the she stated the dressir Polymen which was th dressing was dated 1. Nurse #5. The skin o foot was intact with no noticed. The WN indi was preventative and replaced to protect the her hands and as she (foot/heal protector) fr there was no dressing ankle and the wound wound was red with a slough (dead tissue) a wound bed was a dar cleaned the ankle with the area dry and appl ordered.	ated when she returned to e dressing in place was er initials, smelled and was d. The WN confirmed she /18, 12/07/18 or 12/10/18 ongoing issue that wound being completed by the hall ne was not scheduled to e completed treatments on if she noticed they were not es on the day scheduled.	F	68	6			
		terview on 12/18/18 at 1:23 led she worked as a hall						

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2019 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,					SURVEY PLETED
		345307	B. WING					20/2018
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STAT	FE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ĒR			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 686	treatment to Resident explained she was ner wound treatments and dressing when it fell of never informed she ner treatments on the day scheduled. During an interview of Nurse #4 confirmed s to provide care to Res Nurse #4 stated she of treatment to Resident any other resident as never trained to provi- explained the facility f the treatments for all informed she needed when the WN was no During a telephone in PM, Nurse #5 confirm treatment to Resident she must have forgott completed. Nurse #5 (HN) was present dur Nurse #5 explained si bandage on the top o applied Tegaderm (tra cover and protect wor to her right outer ankl reviewed the TAR prio was unable to explain on Resident #7's right	d did not complete wound t #7's right outer ankle. She ever shown how to complete d only reapplied a resident's off. Nurse #1 added she was eeded to complete ys the WN was not n 12/18/18 at 3:00 PM, she was the nurse assigned sident #7 on 12/03/18. did not complete the wound t #7's right outer ankle or signed because she was de wound care. Nurse #4 had a WN who completed residents and was never to complete the treatments	F	686				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345307	B. WING			C 12/20/2018		
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW	WOOD NURSING CENTE	ER			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
F 686	Continued From page	2 77	F	686				
	PM, the HN confirmed Nurse #5 provided wo #7 on 12/17/18. The observed the treatme ulcer on Resident #7' not familiar with the tr of her foot. She state wound treatment orde and a non-adhesive F Resident #7's right ou out of the adhesive P	iter ankle since Hospice was olymen dressing they added it was possible the						
	Wound Physician (Wi been providing wound past 3 weeks and was was an issue with wo completed as ordered a resident was on Ho dressing changes to a discomfort. The WP Resident #7's wound showed improvement and no changes were treatment as ordered unaware a dressing w Resident #7's wound dressing should have wound not left expose	stated when he treated earlier that morning, it with no signs of infection made to the current by Hospice. He was vas not observed on on 12/18/18 and stated a been applied and the ed.						
	During a telephone in	terview on 12/19/18 at 2:03						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONST G			(X3) DATE COMF	
		345307	B. WING					20/2018
	ROVIDER OR SUPPLIER	ĒR		4414 WIL	ADDRESS, CITY, STATE, ZIP .KINSON BLVD NIA, NC 28056	CODE	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 686	nursing staff were info providing wound treat description. The DOM	rrsing (DON) explained ormed upon hire that tment was a part of their job N stated she would expect nplete wound treatments as	F 6	86				
	AM, Nurse #2 confirm assigned to provide c 12/10/18. Nurse #2 s the wound treatment	terview on 12/20/18 at 9:41 ned she was the nurse are to Resident #7 on tated she did not complete to Resident #7's right outer ceived Hospice services wound care.						
F 725 SS=G	Administrator was una were not being compl when the WN was no stated she was aware the building and felt th training in wound care expectation wound tra		F 7	25				1/18/19
	the appropriate comp provide nursing and r resident safety and at practicable physical, r	Staff. e sufficient nursing staff with etencies and skills sets to elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by						

Facility ID: 923314

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPF OMB NO. 0938	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		C 12/20/2018	
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	GASTONIA, NC 28056 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP	X5) PLETION ATE
F 725	and considering the r diagnoses of the facil accordance with the r at §483.70(e). §483.35(a)(1) The fac by sufficient numbers types of personnel or nursing care to all res resident care plans: (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on observatio resident, staff and ph failed to provide suffic residents received pr treatments and assist nail care. This affect residents (Residents neglected to provide incontinence care for	s and individual plans of care number, acuity and lity's resident population in facility assessment required cility must provide services a of each of the following in a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not s. t when waived under section, the facility must nurse to serve as a charge f duty. T is not met as evidenced ons, record reviews and hysician interviews, the facility cient nursing staff to ensure essure ulcer and wound tance with incontinence and ed 4 of 12 sampled #1, #7, #11, and #13). Staff Resident #13 with in early an 8-hour time span resident lying in a large faces.	F 72	 1.Efforts continue in hiring proshifts due to call-offs, and staff A Human Resource Director st employment 1/7/19. 2. In order to ensure that none residents are affected by allege practice The Human resource I was hired on 1/07/19 to assist Administrator with the screening hiring process. The effort to hir began 12/01/2018 for C.N.A's, and Primary Department heads employees having to be held a and responsible to perform the tasks that they were hired for a had begin to quit without notice 	of e deficient Director the g and e had Nurses s due to ccountable duties and ind they	

Event ID: IMMS11

Facility ID: 923314

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		ID HUMAN SERVICES				PRINTED: 01/31/2019 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C
		345307	B. WING			12/20/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
	WOOD NURSING CENT	=P		4414 WILKINSON BLV	/D	
MEADOW				GASTONIA, NC 280	056	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE RERNCED TO THE APPROPRIA DEFICIENCY)	
F 725	Continued From page	e 80	F 72	25		
	failed to treat one rest the resident lying in a stool from 12:41 AM to of 5 residents depend care (Resident #13). b. F-600: Based on c staff and resident inter interview, and hospic staff neglected to ack bell and failed to prov an hour time frame from 1 of 5 residents depend incontinence care (Respondents as	dent interviews, the facility ident with dignity by leaving a large amount of urine and to 8:30 AM on 12/16/18 for 1 dent on staff for incontinence observations, record review, erviews, wound physician e nurse interview, the facility mowledge a resident's call vide incontinence care for 8 om 12:41 AM to 8:30 AM for		Administrator h interviews twice once a week in of hiring. The H has begin to ne obtain graduate assistants, adv updated week a D.O.N with a Because of this C.N.A's two of Med-Techs, 1 H Current staff th are given a trai staff to the dail	esource Director and have continued to conduct e a week and orientation order to continue the flo duman Resource Director etwork with colleges to e nurses and nursing rertisement is posted and y on in-deed for Nurses a sign on incentive is post s process we have hired which are C.N.A/ RN MDS nurse, and 1 LP at has been with the faci ining incentive to train ne y routines. When a extra up the employees receive time incentive.	w r and ed. 7 PN. lity w
	orders for 1 of 1 sam a wound infection (Re complete pressure ul and scheduled for 3 o residents reviewed for c. F-677: Based on o resident, and staff int	pled residents reviewed with esident #1); and failed to cer treatment as ordered days (Resident #7) for 1 of 3 or pressure ulcers.		in-service on 1 offs affects the peers and how ensure the dec call-offs. All em	taff have been provided -10-19 regarding how cal facility residents and the the facility can help to crease of turn-over and ployees and new hires a d educated to facility ing call-offs.	ir
	residents reviewed fo (ADL) care (Resident nail care for 2 of 5 de for ADL care (Reside			compliance by sheets in daily weeks and Mo Administrator a staffing needs C.N.A, License	order to ensure reviewing daily staffing stand up meeting x 4 nthly there after by the and Department heads. If are Identified the Lead ed Nurse and or	
		bbservations, record review, hysician interviews, the			vill be responsible for and the Administrator an	d

Facility ID: 923314

		MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · /	IPLETED
						С
		345307	B. WING		12	2/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	ER		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 PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 725	Continued From page	e 81	F 72	5		
	and ensure wound ca physician orders for	de treatments as scheduled are was done consistent with I of 1 sampled resident nd infection (Resident #1).		or Licensed nurse will be response scheduling staff. This will be a c process.		
e. F-686: Based on observations, and Wound Physician, Hospice Nu interviews, the facility failed to initia ulcer treatment for 3 days to a resid with pressure ulcers (Resident #11 complete pressure ulcer treatment and scheduled for 3 days (Resident residents reviewed for pressure ulcer		n, Hospice Nurse and staff failed to initiate pressure days to a resident admitted (Resident #11) and failed to cer treatment as ordered days (Resident #7) for 2 of 3		The Plan of Correction will be re the next scheduled Quality Assu Performance Improvement Com 1/22/19. All Plan of Correction m audit data will be reported by ea to subsequent monthly Quality A Performance Committee for rev recommendations given to help the staffing compliance.	arance amittee nonthly ach auditor Assurance iew and	
	Nurse #6 revealed sh working as a hall nurse morning. Nurse #6 e to work the 7:00 AM f PM she was told to s PM to 7:00 AM shift of one of the 2 nurses s PM to 7:00 AM shift of nurse wouldn't take th cart because she did	on 12/18/18 at 11:30 PM he had been at the facility se since 7:00 AM that xplained she was scheduled to 7:00 PM shift but at 8:00 tay over and work the 7:00 due to a call-out. She added cheduled to work the 7:00 called out and the other he keys to her medication not want to work by herself. felt that she could not leave				
	Nurse Aide (NA) #6 c only one NA worked shift to provide reside She recalled being th evening of 12/18/18. short-staffed, it was c	on 12/18/18 at 12:30 AM confirmed there were times the 11:00 PM to 7:00 AM ent care due to staff call-outs. le only NA working the She added when difficult to get resident care ly morning showers and				

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	S FOR MEDICARE &					10. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		FE SURVEY MPLETED
			A. BUILDING			С
		345307	B. WING		1	2/20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP COD		
			4	414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENT	ER	G	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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
E 725	Continued From non	- 99	E 305			
F 725			F 725			
	getting residents up o breakfast.	out of bed and ready for				
	Nurse #9 stated they lot lately", sometimes one NA for the entire explained it was diffic care provided when y getting residents up of day or showered and	on 12/18/18 at 6:40 AM had worked short-staffed "a s with only one nurse and building. Nurse #9 cult for staff to get resident working short, such as but of bed and ready for the d when working short, their eep the residents safe and				
	Administrator stated Nursing, who was no responsible for the so explained the number was based on the cu of the residents in the current census, her g scheduled to work or PM and 3:00 PM to 1 scheduled to work th The Administrator state employment on 11/26 dealt with was staff in when they called out difficult to find replaced the facility being short confirmed Nurse #6 v a hall nurse on 12/18 explained it happene	on 12/20/18 at 11:14 AM, the she and the Director of o longer employed, were both cheduling of staff. She er of staff scheduled per day rrent census and acuity level e building. She added at the goal was to have 4 NAs n both the 7:00 AM to 3:00 11:00 PM shifts and 3 NAs e 11:00 PM to 7:00 AM shift. ated since starting her 6/18 one of the issues she isot giving sufficient notice of work which made it ements and contributed to rt-staffed. The Administrator worked 24 hours straight as 8/18 to 12/19/18. She d due to staff call outs and nfortunate situation, Nurse #6				

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	C
		345307	B. WING		12/20/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
MEADOW	WOOD NURSING CENT	ER		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 PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 725	Continued From page	e 83	F 72	25	
	remained ongoing.				
F 732 SS=B	Posted Nurse Staffing CFR(s): 483.35(g)(1)		F 73	32	1/18/19
	§483.35(g) Nurse Sta	affing Information.			
	§483.35(g)(1) Data re	equirements. The facility			
	basis:	.g			
	(i) Facility name.(ii) The current date.				
	• •	and the actual hours worked			
		gories of licensed and			
	resident care per shift	aff directly responsible for			
	(A) Registered nurses				
	(B) Licensed practica				
	(C) Certified nurse ai	s defined under State law). des.			
	(iv) Resident census.				
	§483.35(g)(2) Posting	g requirements.			
		ost the nurse staffing data			
	daily basis at the beg	h (g)(1) of this section on a inning of each shift.			
	(ii) Data must be pos	ted as follows:			
	(A) Clear and readab	le format. ace readily accessible to			
	residents and visitors	-			
	§483.35(g)(3) Public	access to posted nurse			
		cility must, upon oral or			
	written request, make available to the public	e nurse statting data c for review at a cost not to			
	exceed the communi				
	§483.35(g)(4) Facility				
		acility must maintain the affing data for a minimum of			

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DA	NO. 0938-039 ATE SURVEY DMPLETED
		345307	B. WING _			C 12/20/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
	WOOD NURSING CENT	50		4414 WILKINSON BLVD		
WEADOW	WOOD NORSING CENT	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	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 732	Continued From page	e 84	F7	732		
	18 months, or as requising the second	uired by State law, whichever T is not met as evidenced ans and staff interview, the daily nurse staffing cility on 4 out of 4 days complaint investigation hrough 12/20/18. 2/17/18 at 11:28 AM revealed on the wall across from the n undated and blank sheet Report." eted on 12/18/18 at 11:15 AM d an undated and blank daily eted on 12/19/18 at 12:45 0 PM revealed an undated ng sheet. Further review the blank staffing sheet, sheet dated 12/13/18 with mation completed for third		 No residents were id been affected. Mandatory postings ha as of 12/21/19. Mandatory posting w responsibility of the Inte Nursing, the Registered Administrator. Nursing Staff have re regarding Posting of the of 01/08/2019. The Administrator wi for this aspect of the PI The Administrator and/ Resource Director will a compliance 3x week x d The Plan of Correction the next scheduled Qua Performance Improven 1.22.19. All Plan of Cor audit data will be report to subsequent monthly Performance Committee recommendations so co continuously achieved. 	ve been compliant vill be the erim Director of d Nurse, and or the eceived in-service e Nursing staff as Il be responsible an of Correction. or the Human audit for 4 weeks. will be reviewed at ality Assurance nent Committee rrection monthly ted by each auditor Quality Assurance e for review and ompliance is	
	revealed a staffing sh	eted on 12/20/18 at 6:30 AM neet dated 12/19/18 with only on completed for first and				

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	S FOR MEDICARE &		0.00		OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			-		С
		345307	B. WING		12/20/2018
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
MEADOW	WOOD NURSING CENT	ER		414 WILKINSON BLVD 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 732	Continued From page	e 85	F 732		
F 835 SS=G	Administrator stated was no longer emplo posting the daily staff Administrator was un staffing information w was her expectation completed and poste Administration CFR(s): 483.70	able to explain why the ras not posted and stated it the staffing sheets were d daily.	F 835		1/18/19
	enables it to use its me efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Based on observation physician interviews facility's administration of processes and pol to ensure that resident treated in a dignified nursing care, receive as ordered, and were nursing staff to meet sampled residents re and provision of nurs #1 and #11). Facility develop a facility wide the necessary resour population. Staff neg #13 with incontinence	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial		Incontinence care was provided to Resident #13 by a certified nursing assistant 12/16/18. 2.In order to ensure that others are not affected by the same alleged deficient practice all residents requiring incontinence care were assessed by the Registered Nurse/Interim Director of Nursing 1/16-1/18/19 for any adverse effects with none observed. 3. All scheduled nursing staff were allowed to work before in-service and non-scheduled staff were paid for one hour in-service. All were educated on proper incontinent	

Facility ID: 923314

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	IO. 0938-039 TE SURVEY MPLETED
		345307	B. WING			1:	C 2/20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				4	414 WILKINSON BLVD		
MEADOW		ER		G	SASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 835	Continued From page	e 86	F	835			
					Nurse/Interim Director of Nursing.		
	Findings included:				In addition, staff were educated by the	`	
	This tag was cross re	eferenced to:			Registered Nurse/Interim Director of Nursing 1/16-1/18/19 that all staff are	;	
	review, staff and resid	n observations, record dent interviews, the facility			responsible for acknowledging call lig and to tell the appropriate staff if the n		
		sident with dignity by leaving			is outside of their scope and on the		
		a large amount of urine and to 8:30 AM on 12/16/18 for 1			components of the Concern/Grievanc policy.	e	
		dent on staff for incontinence			The education will be included in		
	care (Resident #13).				subsequent new-hire orientations.		
	b. F-600: Based on	observations, record review,			No residents were identified as having]	
		erviews, wound physician			been affected by the facility assessme		
		e nurse interview, the facility			The facility Assessment was complete	ed by	
	-	nowledge a resident's call			the Administrator as of 12/26/18.		
		vide incontinence care for 8			The requirement and components of t	ha	
	1 of 5 residents depe	rom 12:41 AM to 8:30 AM for			The requirement and components of t Facility Assessment were reviewed by		
	· ·	esident #13); failed to			Regional Nurse and the administrator	lite	
		s scheduled and ensure			1/16/19.		
	•	e consistent with physician					
		pled residents reviewed with			Department Heads were trained to th	е	
	a wound infection (Re	esident #1); and failed to			facility assessment as of 1/10/2019 by	/ the	
		cer treatment as ordered			Administrator regarding their responsi	•	
		days (Resident #7) for 1 of 3			to provide updated information with th		
	residents reviewed for	or pressure ulcers.			department staffing. The Regional Nu		
	a E 656: Basad an	observations, record review,			has trained all Administrative Staff to t		
		staff interviews, and physician			cross reference tags including the auc as of 1/18/19 and will continue to prov		
		/ failed to develop a care			oversight.		
		y described the wounds for 2					
		ed for wounds (Residents #1			Monitoring the facility assessment this	s will	
		plement the care plan for			be the Regional Nurse responsibility of		
	-	of 4 residents reviewed for			x's 12 months. The Facility Administra	tor	
		1 and #7); and failed to			will		
		lan for activities of daily			update the Facility Assessment as new		
	IVING (ADLS) for 2 of	5 residents reviewed for			and or annually and present it to the C	JA A	

Facility ID: 923314

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345307	B. WING				C /20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				4	414 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 835	ADLs (Residents #1 a d. F-677: Based on a resident, and staff inter provide toileting assiss residents reviewed for (ADL) care (Resident nail care for 2 of 5 de for ADL care (Resident e. F-684: Based on a staff interviews and p facility failed to provide and ensure wound car physician orders for 1 reviewed with a wound f. F-686: Based on a and Wound Physician interviews, the facility ulcer treatment for 3 a with pressure ulcers (complete pressure ulcers (complete pressure ulcers (complete pressure ulcers (and scheduled for 3 a residents reviewed for g. F-725: Based on a and resident and staff to provide sufficient n residents received pro- treatments and assist nail care. This affected residents (Residents i h. F-838: Based on interview the facility fa document a facility-wid determine what resour-	and #13). observations, record review, erviews, the facility failed to stance for 2 of 5 dependent r Activities of Daily Living #13) and failed to provide pendent residents reviewed nt #1). observations, record review, hysician interviews, the le treatments as scheduled ire was done consistent with of 1 sampled resident rd infection (Resident #1). observations, record review h, Hospice Nurse and staff failed to initiate pressure days to a resident admitted Resident #11) and failed to cer treatment as ordered lays (Resident #7) for 2 of 3 r pressure ulcers. observations, record reviews f interviews, the facility failed ursing staff to ensure essure ulcer and wound ance with incontinence and ed 4 of 12 sampled #1, #7, #11, and #13). record review and staff ailed to conduct and	F	835	Committee for review and recommendations. The Regional Nurs will provide oversight and review the audits for two (2) months and the QA Committee will review for two (2)month concerns are identified The QA Committee will provide addition three of months of review in order to maintain compliance. The Plan of Correction will be reviewe the next scheduled Quality Assurance Performance Improvement Committee 1/22/19.	hs if (3) d at	

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2019 MAPPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345307	B. WING					C 20/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 835 F 838 SS=F	Administrator agreed identified areas of cor- starting her employme had been on staffing. work on the rest" once Facility Assessment CFR(s): 483.70(e)(1)- §483.70(e) Facility as The facility must cond facility-wide assessme resources are necess competently during be and emergencies. The update that assessme facility plans for, any of substantial modification assessment. The facil address or include: §483.70(e)(1) The faci including, but not limit (i) Both the number of resident capacity; (ii) The care required considering the types physical and cognitive	rations and in an 12/20/18 at 11:14 AM, the there were still issues in the acern and explained since ent on 11/26/18 her focus She added she "planned to a staffing was stable. (3) sessment. Nuct and document a ent to determine what ary to care for its residents oth day-to-day operations a facility must review and ent, as necessary, and at cility must also review and ent whenever there is, or the change that would require a on to any part of this lity assessment must sility's resident population,		835				1/18/19
		ncies that are necessary to types of care needed for the						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345307	B. WING				C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	P		4	4414 WILKINSON BLVD		
MEADOW	WOOD NORSING CENTE	- 1		0	GASTONIA, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 838	that are necessary to (v) Any ethnic, cultural may potentially affect facility, including, but food and nutrition ser §483.70(e)(2) The fac but not limited to, (i) All buildings and/or and vehicles; (ii) Equipment (medic (iii) Services provided pharmacy, and specif (iv) All personnel, incl employees and those contract), and volunte education and/or train related to resident can (v) Contracts, memory or other agreements of services or equipmen normal operations and (vi) Health information such as systems for e patient records and et information with other §483.70(e)(3) A faciliti community-based risk all-hazards approach. This REQUIREMENT by: Based on record revi facility failed to condu	ronment, equipment, hysical plant considerations care for this population; and al, or religious factors that the care provided by the not limited to, activities and vices. cility's resources, including r other physical structures al and non- medical); , such as physical therapy, fic rehabilitation therapies; uding managers, staff (both who provide services under ters, as well as their ning and any competencies re; andums of understanding, with third parties to provide t to the facility during both d emergencies; and n technology resources, electronically managing lectronically sharing r organizations. y-based and a assessment, utilizing an tis not met as evidenced ew and staff interview the ct and document a ent to determine what asary to care for the resident	F	838	1.No residents were identified as havi been affected by the allege deficient practice. The requirement and components of th Facility Assessment were reviewed by	ne	

Facility ID: 923314

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	-	ID HUMAN SERVICES MEDICAID SERVICES				01/31/2019 APPROVED 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SL COMPLE C	
		345307	B. WING		-	/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
MEADOW	WOOD NURSING CENT	ER		4414 WILKINSON BLVD		
		ATEMENT OF DEFICIENCIES	ID	GASTONIA, NC 28056		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	D PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
F 838	Continued From page	e 90	F 8	38		
	operations and in an	emergency situation.		Regional Nurse and the 1/16/19.	e administrator	
	12/20/18 at 11:14 AW when she began word 11/26/18 she asked th about the facility asset there was not a facilit administrator stated s assessment should b working to create a fac determine what resource	to review the facility 1/18. During an interview on I the administrator stated king at the facility on the former administrator essment and was informed y assessment. The she was aware a facility e in place and was actively acility assessment to urces were necessary to population competently		 2. The Facility Assessment by the Administrator as Casper report was give Administrator by the Readd as a key componer Assessment. 3. Department Heads Heducated to the facility 1/10/2019. 4. The facility administration assessment as needed basis and will present in Assessment Performant Committee for review a recommendations once months. The Plan of Correction the next scheduled Qui Performance Improvement as a set of the scheduled Qui Performance Improvement as a set of the scheduled Qui Performance Improvement as a set of the se	a of 12/26/2018 the en to the egional Nurse to nt to the facility have been assessment as of ator will update the d and on a annual t to the Quality nee Improvement and e per month x 12 will be reviewed at ality Assurance	
F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(g)(2)		F 8	1/22/19. 67	1,	/18/19
	§483.75(g) Quality as	ssessment and assurance.				
	assurance committee (ii) Develop and imple action to correct iden This REQUIREMENT by:	ality assessment and e must: ement appropriate plans of tified quality deficiencies; is not met as evidenced ns, staff and resident		The Statement of Defi	ciencies F867	

Facility ID: 923314

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345307 B. WING 12/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD MEADOWWOOD NURSING CENTER GASTONIA, NC 28056 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 867 Continued From page 91 F 867 interviews, physician interviews and record citation and Federal Regulation 483.75(g) reviews the facility's Quality Assessment and (2) was reviewed in stand up with the Assurance Committee failed to implement department heads on 1/8/19. Which states procedures and monitor interventions that were to that the quality assessment and implement in November 2018. This was for three assurance committee must develop and recited deficiencies that were originally cited in implement appropriate plans of action to October 2018 on a complaint survey. The correct identify quality deficiencies. deficiencies was in the areas of implementation of resident care plans (656), treatment of In order to ensure other residents are not pressure sores (686) and providing sufficient affected by the alleged deficient practice nursing staffing (725). The continued failure monitoring tools were created on during two federal surveys of record reflects a 12/26/2018. pattern of the facility's inability to sustain an effective Quality Assurance Program. The Department heads were educated on 01/8/2019 to the monitoring tools, The findings included: usefulness of those tools and their responsibility regarding the audits. This tag is cross-referenced to: The Plan of Correction was reviewed by 1a. F-656: Based on observations, record review, the committee on 1/08/19 to discuss and resident interviews, staff interviews, and physician approve stated interventions, monitoring interviews, the facility failed to develop a care tools, and follow up by the committee. plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 4. Ongoing, the committee will review and #11); failed to implement the care plan for monitoring tools and audit data as treating wounds for 2 of 4 residents reviewed for specified in the Plan of Correction to wounds (Residents #1 and #7); and failed to ensure all monitoring tools are utilized and implement the care plan for activities of daily completed once per month x 2 months to living (ADLs) for 2 of 5 residents reviewed for help to ensure continue compliance if ADLs (Residents #1 and #13). concerns are identified the QA committee will provide addition three (3) months The facility was recited for failure to implement review to assist with maintaining care plans. Tag F- 656 was originally cited during compliance. a complaint investigation survey on 10/25/18 for failure to implement care plan interventions for feeding a resident and failure to implement care plan interventions for wound dressing changes. b. F-686: Based on observations, record review

FORM CMS-2567(02-99) Previous Versions Obsolete

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/31/2019 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING			_		C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER			\$	STREET ADDRESS, CITY, ST	ATE, 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 PREF TAG	IX	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	interviews, the facility ulcer treatment for 3 d with pressure ulcers (complete pressure uld and scheduled for 3 d residents reviewed fo The facility was recite complete pressure uld Tag F- 686 was origin investigation survey d correctly treat pressure complete pressure uld c. F-725: Based on of and resident, staff and facility failed to provid ensure residents rece wound treatments and incontinence and nail sampled residents (R #13). Staff neglected with incontinence card span which resulted in amount of urine and f The facility was recite sufficient nursing staff originally cited during survey on 10/25/18 for nursing staff to ensure assistance with meals care/treatments. A review of the facility	h, Hospice Nurse and staff failed to initiate pressure days to a resident admitted Resident #11) and failed to cer treatment as ordered lays (Resident #7) for 2 of 3 r pressure ulcers. d for failure imitate and cer treatments as ordered. ally cited during a complaint on 10/25/18 for failure to re ulcers and failed to cer treatments as ordered. observations, record reviews d physician interviews, the e sufficient nursing staff to ever the sufficient time in the resident lying in a large ecces. d for failure to provide fing. Tag F-725 was a complaint investigation or failure to provide sufficient e residents received s, bathing and wound the sufficient of the sufficient e residents received s, bathing and wound the sufficient of the sufficient of the sufficient e resident streceived s, bathing and wound the sufficient of the sufficient of the sufficient of the sufficient e resident streceived s, bathing and wound	F	867				

Facility ID: 923314

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/31/2019 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		345307	B. WING		_	(12/2) 20/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		4414 WILKINSON BLVD			
04015		ATEMENT OF DEFICIENCIES			PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page indicated in the facility related to care plans, sufficient nursing staff During an interview of Administrator confirm notebook from the co- completed on 10/25/1 monitoring and auditin was in the process of for the four areas, but and not yet completed her employment on 1 hiring staff and then " once staffing was staff acknowledged the mo- components for care and staffing, were not	e 93 y's POC for the areas pressure ulcer care and fing. n 12/20/18 at 11:14 AM, the ed the facility's POC mplaint investigation 8 was inclusive of all ng tools. She explained she creating monitoring forms it was a work in progress d. She added since starting 1/25/18 she had focused on planned to work on the rest" ole. The Administrator pnitoring and auditing plans, pressure ulcer care being completed and she planned to implement	F 86	2 			

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		ID HUMAN SERVICES				FORI	MAPPROVED
	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> </u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	COM	E SURVEY PLETED
		345307	B. WING _				₹-C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ĒR			14 WILKINSON BLVD ASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
{F 550} SS=G	During this survey no following tags were re F656, F677, F686 and out of compliance.		{F 5	50}			1/18/19
	self-determination, ar access to persons an	ght to a dignified existence, nd communication with and					
	with respect and dign resident in a manner promotes maintenance	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and					
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.					
		right to exercise his or her f the facility and as a citizen					
	§483.10(b)(1) The fac	sility must ensure that the					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
Electroni	cally Signed						01/18/2019

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345307	B. WING			-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	.	
MEADOW	WOOD NURSING CENT	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 550}	resident can exercise interference, coercior from the facility. §483.10(b)(2) The res free of interference, cor reprisal from the facilit rights and to be supp exercise of his or her subpart. This REQUIREMENT by: Based on observatio resident interviews, the resident with dignity be in a large amount of the AM to 8:30 AM on 12 dependent on staff for (Resident #13). Findings included: Resident #13 was rea 04/04/17 with an origit with the following diag dysfunction of bladde infections, major deput contractures of right a cellulitis of lower extra unsteadiness of feet a A review of Resident Set (MDS), dated 02/ cognitively intact and staff for toileting. The Resident #13 was alve	his or her rights without a, discrimination, or reprisal sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this " is not met as evidenced ms, record review, staff and be facility failed to treat one by leaving the resident lying urine and stool from 12:41 /16/18 for 1 of 5 residents r incontinence care admitted to the facility on nal admission on 10/08/09 gnoses: neuromuscular r, history of urinary tract ressive episode, anxiety, and left hands, history of emities with sepsis, and type 2 diabetes mellitus. #13's Annual Minimum Data 28/18, indicated he was was totally dependent on MDS further indicated vays incontinent of bowel S revealed that he displayed	{F 55	 Incontinence care was provided Resident #13 by a certified nursing assistant 12/16/18. All residents requiring incontinenc were assessed by the Registered N Interim Director of Nursing from 1/10 through 1/18/2019 for any adverse of with none observed. All nursing staff were educated on proper incontinence care on 1/16/19 through 1/18/19 by the Registered Nurse/Interim Director of Nursing. A were educated by the Registered N Interim Director of Nursing 1/16/19-1/18/19, that all staff are responsible for acknowledging call I and to inform the appropriate staff if need is outside of their scope and o components of the Concern/Grievar policy. In addition, the above educar will be included in subsequent new- orientations. In order to ensure compliance the Director of Nursing/ Interim Director 	e care urse/ 6/2019 effects urse/ urse/ ights the n the nce tion hire	

Facility ID: 923314

			0.00			NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	ATE SURVEY
			A. BUILDING	3		R-C
		345307	B. WING			
	ROVIDER OR SUPPLIER	0-10001		STREET ADDRESS, CITY, STATE, ZIP		12/20/2018
	KOWDER OR SOLT EIER			4414 WILKINSON BLVD	CODE	
MEADOW	WOOD NURSING CENT	ER		GASTONIA, NC 28056		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION
{F 550}	Continued From page	e 2	{F 550	0}		
				Nursing will be responsibl		
		ties of Daily Living (ADL)		of the Plan of Correction.		
		Area Assessment (CAA) and CAA associated with the		nurse will randomly check of Certified Nursing Assist		
		Resident #13 needed		incontinence care-5 reside		
		ing as the resident was		4weeks, then 2 residents	•	
		and bladder and staff		4weeks. The Social Servio		
		care routinely and as		Interview random cognitiv		
		or Symptom CAA revealed		about timely call light resp		
	-	gression directed toward		week x 4 weeks then 2 read	sidents per	
	staff.			week x 4 weeks.		
	A review of Resident	#13's care plan, dated		The resident council minu	tes will be	
	03/14/18, indicated th	ne resident had an ADL		submitted at the next sche	eduled Quality	
	-	e deficit and required		Assurance Performance I		
		from staff for toileting		Committee meeting. The		
	-	n further indicated that		Correction will be reviewe		
		as provided routinely and as #13 and that Resident #13		scheduled Quality Assura Performance Committee r		
		se bell to call for assistance.		1/22/19. The Committee in	•	
	-	plan for Resident #13		Medical Director, Adminis		
		the potential to be verbally		of nursing, Registered Nu		
	aggressive toward ca	aregivers. The care plan,		Social Service Director, D		
		t being verbally aggressive		Medical Records/Human		
	-	irther revealed staff were to		Director, Maintenance Dire	ector, and line	
		e resident's toileting needs I and the resident needed		staff member.		
		g, assistance to turn or		All Plan of Correction aud	it data will be	
		ery 2 hours and more often		reported by each auditor t		
	as needed or request	•		monthly Quality Assurance		
				Committee for review and		
		nducted with Resident #13 on		recommendations until co	mpliance is	
		1. The resident provided the		achieved.		
	-	I unresponsiveness and lack				
	of response on 12/16	s. He stated that on 12/16/18				
		laying in urine and feces and				
		light and pressed record on				
		er voice recorder and				

If continuation sheet Page 3 of 94

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/31/2019 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING					-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD	νE	-	
MEADOW	WOOD NURSING CENTE	R			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI		(X5) COMPLETION DATE
{F 550}	light off without check stated that at 4:41 AM again and pressed re- computer voice record turned off by staff and needs. He indicated th his call light and press recorder and it took 3 came to his room. Wit the play button, the su statements made by th by the resident on 12/ entering his room, he asked Resident #13, bell? What do you new stated he responded, haven't been cleaned stated NA #2 did not of Resident #13's room 7:30 AM, Resident #1 his call light because and feces and had be without being cleaned his personal compute indicated that Nurse # he told her that he ha she stated that she w someone to the hospi come in to help. Then room and did not retu Resident #13 reveale again and NA # 3 can cleaned him, and she and the under pad wa soaked up the urine a	his room and turned the call ing on him. He further 4, he turned his call light on cord on his personal der and his call light was 1 no one responded to his hat at 5:51 AM, he turned on sed record on his voice 0 minutes before NA #2 th his recording pushed to urveyor heard the the NA #2 and the response (16/18 at 5:51 am. Upon further indicated that NA #2 "You keep ringing the call ed, huh?" Resident #13 "That should be obvious. I up all night." Resident #13 change his brief, then left and turned off his light. At 3 indicated that he pressed he was soaked with urine ten laying there all night 4 up and pressed record on r voice recorder. He further #1 came into his room and d not been cleaned up and as "in the middle of sending tal and can't make the NA's a, Nurse #1 left the resident's rn to his room. At 8:30 AM, d that he rang his call light he into his room and washed his bed 3 times as turned upside down and ind the pad looked like 3 tearfully reported he felt	{F !	550}				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 MAPPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		345307	B. WING		_	R-C 12/20/2018		
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
MEADOW	WOOD NURSING CENTE	R		1414 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 550}	An interview was con- Worker on 12/18/18 at there were no grievar December 2018. An interview was con- 12/18/18 at 3:01 PM. into Resident #13's ro and had to change his was wet with urine for to his knee cap. NA # #13 soaked with urine was the worst she sar #3 stated that Reside incontinence care. NA was wet all the way th the chux (disposable) was brown. In cleanin she took a chux (disp cotton side of the chu chux pad was soaked that at the end of first of the condition she fo he reported regarding being addressed from #3 further stated that that the social worker addressed the grieval mentioned something regarding 3rd shift be right how he was bein A phone interview wa 12/19/18 at 8:00 pm. third shift and frequer #13. NA #4 stated Re received incontinence am, at a minimum and	ducted with the Social t 1:13 PM. She revealed loces filed for the month of ducted with NA #3 on She indicated that she went oom on 12/16/18 at 8:30 AM is whole bed because he im just below his shoulders 3 stated she found Resident and feces before but this w his bed that soaked. NA int #13 never refused A #3 recalled the bed spread forough and everything from pad to the washable pad g up the bed, NA #3 stated osable) pad and placed the x pad on mattress and the with urine. NA #3 stated shift, she notified Nurse #2 bund Resident #13 and what his need for assistance not a 12:41 AM to 8:30 AM. NA Nurse #2 told Resident #13 was the one who nees and that Resident #13 about writing a grievance cause he said it was not ag treated. s conducted with NA #4 on NA #4 stated she worked tty worked with Resident	{F 550}					

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_		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTI	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í			(X3) DATE COMP	SURVEY LETED
		345307	B. WING				-C 20/2018
NAME OF PROVIDER OF	R SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEADOWWOOD NU		P			4414 WILKINSON BLVD		
	KSING CENT	-R			GASTONIA, NC 28056		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
never sa but that compute room ho A phone 12/19/18 assistan to Resid him. Sha given a resident #13 did 12/15/18 percepti 1:30 am his room stated th that he I him and reported did not r first shiff A phone on 12/20 expecte respect requeste A phone on 12/20 expecte morning	he got a little er equipment it. a interview wa 3 at 8:21 PM. its who came lent #13's roo e further state suppository, t more often. S not get a sup 3. She further on that Resid and 5:30 am h, woke him u hat Resident # hadn't been cl changed him any concern mention that s t regarding Re e interview wa D/18 at 6:50 A d all residents and dignity an ed. e interview wa D/18 at 9:13 A 7:00 am to 7: he end of her ed to file a grid d him for an e of 12/16/18.	e 5 ed due to his incontinence sweaty because he had in his room that made the s conducted with NA #2 on She stated that the nursing in at 11:00 PM typically went m at 1:30 AM and change ed that if Resident #13 was he NA's went to change the She indicated that Resident pository during 2nd shift on indicated that it was her ent #13 rang his call bell at and both times went into p and changed him. She #13 had been telling 1st shift hanged, so the NAs woke be further stated that she s to the oncoming shift. She she reported any concerns to esident #13 on 12/16/18. s conducted with the DON M. She indicated that she s would be treated with he care to be provided when s conducted with Nurse #2 M. She indicated that she s sonducted that she s would be treated with he care to be provided when	{F 5	550			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	CONSTRUCTION		E SURVEY
		345307	B. WING		R-C	
	ROVIDER OR SUPPLIER	040007		IREET ADDRESS, CITY, STATE, ZIP COD	•	2/20/2018
				14 WILKINSON BLVD	_	
MEADOW	WOOD NURSING CENT	ER		ASTONIA, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
{F 550}	Continued From pag	e 6	{F 550}			
[]		e night shift Nurse #7. She	{i 550}			
	indicated that she did	d not notify the social worker ecause the social worker				
	Worker on 12/20/18	nducted with the Social at 9:39 AM. She indicated				
	week of December 1	to Resident #13 during the 7th, 2018 and wasn't aware lving Resident #13. She				
	complained about be	in the past, Resident #13 ing soaked in urine when the Nursing (DON) was working				
		vas before December 2018.				
	· ·	e didn't remember Resident				
		20/18 from 11:14 AM to				
		ed she expected all residents inity and respect and told this				
	-	er when she started working				
	at the facility on 11/2	6/18. She further stated she				
	expected concerns to could be done. She i	b be reported so follow-up				
		residents and it was a				
	problem of dignity if a	care was not given. She				
	indicated again she s the incident, so she o	should have been told about				
{F 584}		able/Homelike Environment	{F 584}			1/18/19
SS=E	CFR(s): 483.10(i)(1)-					
	§483.10(i) Safe Envi	ronment.				
	The resident has a ri					
	comfortable and hom but not limited to reco	nelike environment, including				
	supports for daily livi	orving a cauncin and				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 / APPROVED) <u>. 0938-0391</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345307	B. WING				-C 20/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW	WOOD NURSING CENTE	R		4	414 WILKINSON BLVD			
MEADOW		.N		GASTONIA, NC 28056				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE				
{F 584}	homelike environmen- use his or her persona possible. (i) This includes ensur- receive care and serv physical layout of the independence and do (ii) The facility shall ex- the protection of the mo- or theft. §483.10(i)(2) Houseka services necessary to and comfortable interior §483.10(i)(3) Clean ba- in good condition; §483.10(i)(4) Private of resident room, as spect §483.10(i)(5) Adequat levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observation facility failed to store of	ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can ices safely and that the facility maximizes resident es not pose a safety risk. kercise reasonable care for esident's property from loss eeping and maintenance maintain a sanitary, orderly, or; ed and bath linens that are	{F 5	84}	1. The Laundry Supervisor moved the clean linen from the closet to an appropriate location 12/20/18. The Director of Maintenance replaced the			

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			A/A) • • • • • •			NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	· · ·	ATE SURVEY OMPLETED
			A. BUILDIN			R-C
		345307	B. WING			12/20/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		12/20/2010
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENT	ER		GASTONIA, NC 28056		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION DATE
{F 584}	Continued From page	e 8	{F 58	34}		
	The findings include:			stained tiles on 12/20/18.		
	32			2.The Maintenance Direct	or will continue	
		AM an observation was		to check the facility for any		
	-	clean linen closet which was		stained , bulging ceiling tile	es, replacing	
		loset within the facility.		any stained.		
		oustic ceiling tiles inside the re badly stained with a brown		3. The Administrator has in	a conviced the	
		nd/or bulging. Brown, dried		Maintenance Director and		
		I on the wall and extended		Supervisor regarding the r		
		e floor. Inside the linen		components of the facility	-	
	closet were six open	shelving units housing		environment of the regulat		
	-	sable incontinence briefs and		12/20/18. The education o	•	
	resident equipment.	-		physical environment of th	-	
		ieet from the ceiling and on the top shelf had dried		will be included in subseque orientations.	uent new-nire	
		ppeared to be the same		onentations.		
		ceiling tiles. In addition,		4.The Maintenance Direct	or will be	
		ing tile were observed on the		responsible for monitoring		
		hree sheets. A nursing		the Plan of Correction. The	e Maintenance	
	· · · · · · · · · · · · · · · · · · ·	he time of the observation		Director will observe facilit		
		oset staff went to obtain		monthly x 4 months to ass	-	
	linen for resident use			water damage as evidence		
	On 12/19/18 at 10·05	AM a nursing assistant was		bulging tiles. Any noted wi documented on the Mainte		
		of the clean linen closet with		replaced and reported for		
	clean linens in her ha			Administrator to sign off to		
				compliance.		
		AM the maintenance				
		he recent heavy snow there		The Plan of Correction will		
		m the roof and it affected		the Quality Assurance Cor		
		nich included the clean linen ance director stated when		next scheduled Quality As Performance Improvemen		
		iling tiles got wet they turned		meeting on 1-22-19. The r		
		The maintenance director		findings and corrections w		
		n stains on the walls of the		the QA Committee for revi		
		re from water leaking from		recommendation to assist	with ensuring	
		les when they got wet. The		continue compliance.		
	maintenance director	stated there had been				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345307	B. WING				R-C / 20/2018
NAME OF P	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 584}	facility was in the prod done. On 12/19/18 at 11:20 stated the three stains the linen closet had b water when there wer The laundry director s been an ongoing prot she tried to move the the closet that were n leak. On 12/20/18 at 9:30 A observed moving line because of the start of the observation.) Th every time it rained st because of leaks in th time of the observatio acoustic ceiling tiles n a brown color, were b brown stains were ob extended from the ce broken tile remained clean linen room. An was stored inside the laundry director noted closet when it rained stored on the cart. On 12/20/18 at 11:14 she had just recently and, after the last sno leaks in the clean line stated she contacted inform him of the leak	AM the laundry director ed sheets on the top shelf of een put in place to absorb re leaks from the ceiling. stated the ceiling leak had olem and, when it leaked clean linens to areas within ot affected by the ceiling AM the laundry director was ns within the linen closet of heavy rain (at the time of e laundry director stated ne had to move the linen ne clean linen closet. At the	{F 5	584	1}		

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TATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		345307	B. WING		R-C 12/20/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIF 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 PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETIC D THE APPROPRIATE DATE
{F 584} {F 600} SS=G	clean linen carts until clean linen room. Th	them between the three I repairs were done to the e administrator stated she ems in the clean linen closet ed as requested. I Neglect	{F 58 {F 60		1/18/19
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's m	involuntary seclusion and ical restraint not required to edical symptoms.			
	physical abuse, corpo involuntary seclusion This REQUIREMENT by: Based on observation resident interviews, we and hospice nurse in neglected to acknowle and failed to provide hour time frame from of 5 residents depend care (Resident #13); as scheduled and en consistent with physic	e verbal, mental, sexual, or oral punishment, or ; T is not met as evidenced ons, record review, staff and vound physician interview, terview, the facility staff ledge a resident's call bell incontinence care for 8 an 12:41 AM to 8:30 AM for 1 dent on staff for incontinence failed to provide treatments sure wound care was done cian orders for 1 of 1		Resident #13- Incontiner by a certified nursing ass Resident #1- Consistent of provided by a licensed nu 12/18/18. Resident # 7- Consistent wound care was provided nurse on 12/19/18.	istant 12/16/18. wound care was urse beginning and correct
	sampled residents re infection (Resident # pressure ulcer treatm	1); and failed to complete		2.All residents requiring in have the potential to be a	

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY MPLETED
	CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING	·	R-C	
		345307	B. WING			2/20/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
MEADOW	WOOD NURSING CENT	ER		4414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD DR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) DEFICIENCY		SHOULD BE	(X5) COMPLETIO DATE	
{F 600}	Continued From page	e 11	{F 600)}		
. ,	-	(Resident #7) for 1 of 3	(wounds. In order to ensure the	at other	
	residents reviewed fo	,		residents are not affected by t		
				alleged deficient practice, all r		
	Findings include:			requiring incontinence care we assessed for wounds 1/16/19		
	1. Resident #13 was	readmitted to the facility on		1/18/19 by the Registered Nu	-	
		inal admission on 10/08/09		Director of Nursing		
		gnoses: neuromuscular				
		r, history of urinary tract		3.Certified Nursing Assistant s		
		ressive episode, anxiety, and left hands, history of		educated 1/16/19-1/18/19 on of incontinence care by the Re		
	cellulitis of lower extre			Nurse/Interim Director of Nurs	-	
		and type 2 diabetes mellitus.		Nurses were educated by Re	•	
		51		nurse/ Interim Director of Nurs	-	
		#13's Annual Minimum Data		1/16/19-1/18/19 that they are	-	
		28/18, indicated he was		for completing wound care if t		
		was totally dependent on		care nurse is on duty. They w		
		MDS further indicated vays incontinent of bowel		educated 1/16/19-1/18/19 reg wound care procedures by the	•	
		S revealed that he displayed		Nurse and or Interim Director		
	verbal behaviors towa			Newly hired nursing staff will a	-	
	rejection of care.			educated during subsequent of		
		ties of Daily Living (ADL)		4.Monitoring performance In c		
		rea Assessment (CAA) and		ensure compliance the Regist		
		CAA associated with the Resident #13 needed		Supervisor and or Interim Dire		
		ing as the resident was		Nursing will be responsible for of the Plan of Correction. The	•	
	incontinent of bowel a	-		Nurse Supervisor and or Inter	•	
	provided incontinent			of Nursing will randomly check		
		or Symptom CAA revealed		compliance of Certified Nursin	-	
	-	gression directed toward		providing incontinence care- 5		
	staff.			per week x 4 weeks, then 2 re	-	
	A review of Resident	#13's care plan, dated		week x 4 weeks. The Register Supervisor and or the Interim		
		ne resident had an ADL		Nursing will interview three (3		
	self-care performance			oriented residents per week x		
	extensive assistance	from staff for toileting		then 1 resident per week x 4 v		
	needs. The care plan	further indicated that		ensure compliance.		

Facility ID: 923314

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CO	MPLETED
						R-C
		345307	B. WING		1	2/20/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
		ED		4414 WILKINSON BLVD		
WEADOW	WOOD NORSING CENT	ER		GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 600}	Continued From page	e 12	{F 600	1		
[is provided routinely and as	1 000	51		
		#13 and that Resident #13		The Registered nurse Super	visor and or	
		se bell to call for assistance.		Interim DON will randomly c		
		plan for Resident #13		compliance of Nurses provid		
		the potential to be verbally		documenting wound care ac		
	aggressive toward ca	aregivers. The care plan,		orders- 5 residents per weel	x 4 weeks,	
		t being verbally aggressive		then 2 residents per week x	4 weeks.	
		rther revealed staff were to				
		e resident's toileting needs		The plan of correction will be		
		I and the resident needed		the next scheduled Quality A		
		g, assistance to turn or		Performance Improvement (1/22/19.	committee on	
	as needed or request	ery 2 hours and more often		1/22/19.		
	as needed of reques	led.		All Plan of Correction month	lv audit data	
	An interview was con	ducted with Resident #13 on		will be reported to the QA Co		
		1. The resident provided the		reviewed by the Committee		
		I unresponsiveness and lack		months and recommendatio		
	of response on 12/16			order to help to ensure that	•	
		3. He stated that on 12/16/18		stay in compliance and if co		
	at 12:41 AM, he was	laying in urine and feces and		identified the QA committee	will add on an	
		light and pressed record on		addition three months to ass	ist with	
	his personal compute			maintaining compliance.		
		his room and turned the call				
		king on him. He further				
		M, he turned his call light on				
	again and pressed re	der and his call light was				
	-	d no one responded to his				
	-	that at 5:51 AM, he turned on				
		sed record on his voice				
		30 minutes before NA #2				
	came to his room. W	ith his recording pushed to				
	the play button, the s	-				
	-	the NA #2 and the response				
	-	/16/18 at 5:51 am. Upon				
	-	e further indicated that NA #2				
		"You keep ringing the call				
	stated he responded	ed, huh?" Resident #13				

Facility ID: 923314

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345307	B. WING				-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	ĒR			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	haven't been cleaned stated NA #2 did not of Resident #13's room 7:30 AM, Resident #1 his call light because and feces and had be without being cleaned his personal compute indicated that Nurse # he told her that he has she stated that she w someone to the hosp come in to help. Ther room and did not retu Resident #13 reveale again and NA # 3 car cleaned him, and she and the under pad wa soaked up the urine a tobacco. Resident #1 hurt because staff did An interview was con Worker on 12/18/18 a there were no grievar December 2018. An interview was con 12/18/18 at 3:01 PM. into Resident #13's ro and had to change hi was wet with urine fro to his knee cap. NA # #13 soaked with urine was the worst she sa #3 stated that Reside incontinence care. No was wet all the way th	up all night." Resident #13 change his brief, then left and turned off his light. At 3 indicated that he pressed he was soaked with urine een laying there all night d up and pressed record on r voice recorder. He further #1 came into his room and d not been cleaned up and as "in the middle of sending ital and can't make the NA's n, Nurse #1 left the resident's rn to his room. At 8:30 AM, d that he rang his call light ne into his room and washed his bed 3 times as turned upside down and and the pad looked like 3 tearfully reported he felt in't clean him up. ducted with the Social at 1:13 PM. She revealed nees filed for the month of She indicated that she went bom on 12/16/18 at 8:30 AM s whole bed because he om just below his shoulders 3 stated she found Resident e and feces before but this w his bed that soaked. NA	{F 6	500			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/31/2019 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE (COMPL	SURVEY .ETED
		345307	B. WING			R-C 12/20/2018	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE,	ZIP CODE	12/2	0,2010
				414 WILKINSON BLVD			
MEADOW	WOOD NURSING CENTE	R		GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE
{F 600}	she took a chux (disp cotton side of the chu chux pad was soaked that at the end of first of the condition she fo he reported regarding being addressed from #3 further stated that that the social worker addressed the grievan mentioned something regarding 3rd shift be right how he was bein A phone interview wa 12/19/18 at 8:00 pm. third shift and frequer #13. NA #4 stated Re received incontinence am, at a minimum and change. She indicated never saturated his be but that he got a little computer equipment room hot. A phone interview wa 12/19/18 at 8:21 PM. assistants who came to Resident #13's roo him. She further stated given a suppository, t resident more often. \$ #13 did not get a sup 12/15/18. She further perception that Resid 1:30 am and 5:30 am	g up the bed, NA #3 stated osable) pad and placed the x pad on mattress and the l with urine. NA #3 stated shift, she notified Nurse #2 ound Resident #13 and what his need for assistance not a 12:41 AM to 8:30 AM. NA Nurse #2 told Resident #13 was the one who nces and that Resident #13 about writing a grievance cause he said it was not ng treated. s conducted with NA #4 on NA #4 stated she worked ttly worked with Resident	{F 600}				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING				-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG						(X5) COMPLETION DATE	
{F 600}	stated that Resident # that he hadn't been of him and changed him reported any concern did not mention that s first shift regarding Re A phone interview wa on 12/20/18 at 6:50 A expected all residents respect and dignity ar requested. A phone interview wa on 12/20/18 at 9:13 A worked 7:00 am to 7:0 toward the end of her he wanted to file a gri changed him for an et morning of 12/16/18. end of first shift NA # very wet. She further information to the nigl indicated that she did or file a grievance bee checked on Resident An interview was com Worker on 12/20/18 at that she did not talk to week of December 17 of any concerns invol- further indicated that complained about bei previous Director of N at the facility which was	 #13 had been telling 1st shift hanged, so the NAs woke She further stated that she is to the oncoming shift. She he reported any concerns to esident #13 on 12/16/18. is conducted with the DON M. She indicated that she is would be treated with hid care to be provided when is conducted with Nurse #2 M. She indicated that she boo pm on 12/16/18 and that shift, Resident #13 told her evance because no one extended time the early She stated that towards the B confirm Resident #13 was stated that she reported the hit shift Nurse #7. She not notify the social worker cause the social worker #13 daily. ducted with the Social to 9:39 AM. She indicated to Resident #13 during the 7th, 2018 and wasn't aware ving Resident #13. She in the past, Resident #13 ng soaked in urine when the lursing (DON) was working as before December 2018. a didn't remember Resident 	{F 600}				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345307	B. WING				-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	4414 WILKINSON BLVD		
	WOOD NURSING CENTE	IR		G	GASTONIA, 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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	12:25 PM. She stated to be changed 2 times administrator thought but when he fell aslee didn't know he was be given. The administra- the room and changir were for residents to l ensure they were dry needed. The administ coming in the building and expected care to on all shifts and that s Saturday night during midnight and left at 1: be difficult to please, follow his care plan an him and all residents administrator revealer incident or that a griev expectation was that treated with dignity ar to every staff member at the facility on 11/26 expected concerns to could be done, and st for residents and it was care was not given. T again she should hav incident, so she could 2. Resident #1 was re 04/5/17 with an origin with the following diag infection, dementia wid disturbance, generalize	ducted with the 0/18 from 11:14 AM to I Resident #13 only wanted is at night and the care was being provided ep she thought maybe he eing changed after care was not felt staff were going in ng him and her expectations be checked every 2 hours to and to provide care if trator stated she was g all shifts to check on care be provided to all residents she was in the building 3rd shift and arrived around 30 AM. Resident #13 could but she expected staff to nd do rounds to check on throughout their shift. The d she was not aware of the vance had been filed. Her all residents were to be nd respect and this was told r when she started working 5/18. The administrator also be reported so follow-up taff were supposed to care as a problem of dignity if he administrator indicated e been told about the I fix the problem. eadmitted to the facility on al admission on 01/10/17 gnoses: right hip wound	{F 6	500}			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMP	SURVEY LETED
		345307	B. WING				-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 WILKINSON BLVD ASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
{F 600}	2 diabetes mellitus, lo subcutaneous tissue depressive disorder. A review of Resident 5 Set (MDS), dated 01// severe cognitive impa symptoms of scratchi incontinent of bowel a extensive assistance assistance for transfe and extensive assista assistance for person indicated that she was development but that A review of the Press Assessment (CAA) as MDS revealed Reside breakdown due to her assistance with positi admitted with multiple primarily to her legs a history of chronic prur A review of the Facilit Non-Pressure Ulcer 5 Wound Infection, date following wound meas (cm): 8.5 cm in length in depth and 8.1 cm u A review of the Facilit Non-Pressure Ulcer 5 Wound Infection, date following wound meas (cm): 4.2 cm in length	and infection of the skin and (onset 01/11/17), and major #1's Annual Minimum Data 08/18, indicated she had airment, she had behavioral ng herself, she was always and bladder and needed with 2 plus person physical rs, bed mobility, toileting, nce with 1-person physical al hygiene. The MDS also is at risk for pressure ulcer she had no pressure ulcer. ure Ulcer Care Area ssociated with the 01/08/18 ent #1 was at risk for r incontinence and needed oning. Resident #1 was also a areas of breakdown nd buttocks and had a	{F 600}				

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	MENT OF HEALTH AN				FO	ED: 01/31/2019 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DA CO	TE SURVEY MPLETED
		345307	B. WING			R-C 2/20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO		2,20,2010
MEADOW	WOOD NURSING CENTE	R		414 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 600}	A review of Resident is dated 12/05/18, revea 1. Cleanse Right hip dry, pack with Dakins cover with dry dressin needed. 2. Cleanse Right hip cleanser, pat dry, app dry dressing every da A review of the care p area to right hip or po development, dated 1 #1's pressure ulcer w and would remain free plan further indicated were in place for staff ordered and were mo dressing was monitor and adhering and stat to the treatment nurse moisturizer applied to A review of the Facilit Non-Pressure Ulcer S Wound Infection, date following wound meas (cm): 5.1 cm in length in depth and 4.8 cm u (progress: improved). A review of the Decer Administration Record resident's right hip dre periwound dressing c done on the following 12/10/18; & 12/17/18.	 #1's Physician Orders, aled the following: with wound cleanser, pat 'soaked Kling gauze, and ag every day and as periwound with wound dy Silvadene and cover with y and as needed. Ilan for the nonstageable tential for pressure ulcer 2/6/18, indicated Resident ould show signs of healing e from infection. The care the following interventions to administer treatments as nitored for effectiveness, ed to ensure it was intact ff to report loose dressings e, and the resident needed her skin. y Skin Condition Record for Skin Conditions for Right Hip ed 12/12/18, indicated the surements in centimeters a x 1.1 cm in width x 2.0 cm indermining at 3 o'clock mber 2018 Treatment d (TAR) revealed the essing change and hange was not initialed as dates: 12/07/18; 12/08/18; 	{F 600}			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	DRM APPROVED NO. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED		
		345307	B. WING				R-C 12/20/2018		
NAME OF P	ROVIDER OR SUPPLIER		•	5	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
{F 600}	initialed as done the f 1. Apply zinc oxide to day. (not initialed on 1 12/10/18; & 12/17/18) 2. Doxepin Cream 59 with abrasion every n areas are healed initialed on 12/07/18; 12/15/18; 12/16/18; a 3. Eucerin Cream- at Extremities twice daily 7am (not initialed on 1 4. Eucerin Unscenter areas topically every (not initialed on 12/07 12/17/18) 5. Ketoconazole Shar once a week for itch of on12/07/18 and 12/14 6. Vitamin A+D ointm A&D - apply topically day. (not initialed on 1 12/10/18; & 12/17/18) An observation of Resibed via Hoyer Lift was 2:30 pm with Nurse # time of the transfer, N skin assessment on the continuing observation repositioning the resided change the dressing, undated. An interview with Nur 12/17/18 from 2:45 P	for Resident #1 were not following dates: o groin redness/area every 12/07/18; 12/08/18; %- apply to all body parts ight on 3pm-11 pm until all and then as needed. (not 12/8/18; 12/11/18; 12/14/18; nd 12/17/18) oply to Bilateral Lower y for 7am-7 pm and 7pm to 12/10/18 for 7am to 7 pm) d Cream- apply to affected day on upper extremities 7/18; 12/08/18; 12/10/18; & mpoo 2%- apply to scalp on 11 p-7p (not initialed 4/18) ent for Desitin Clear with Vit to buttocks and thighs every 12/07/18; 12/08/18;) sident #1 being assisted to s conducted on 12/17/18 at 6 and NA #5 present. At the lurse #6 was performing a he resident. During n of Nurse #6 and NA #5 dent, the nurse did not	{F 6	500}					

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						10.0938-039
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BOILDING			R-C
		345307	B. WING			2/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/20/2010
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENT	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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
{F 600}	Continued From page	20	(E.00)			
{F 000}	10		{F 600	1}		
		nent nurse on Saturdays				
		ther weekend but there was n Mondays and Fridays.				
		at the wound on Resident				
		out as a bump about 2				
		icility had a wound doctor.				
	0	cated the resident had				
		tion of tissue extending				
		so that the pressure ulcer				
		than at the skin surface) of				
	-	a decubitus pressure ulcer.				
		e right hip wound treatment				
		be packed and covered with				
	a blue dry dressing.					
	An interview was con	ducted with the Treatment				
		8:52 AM. She stated that				
		out Resident #1's right hip				
		; 11/24/18, which was the				
		and for the first time. She				
		right hip wound had already				
		s draining and developed				
		licated that she documented				
		ility doctor's book about				
	Resident #1's right hi	-				
		iated treatment to the right				
		stated that when she was				
	_ ·	ments on residents were not				
		one because she would find				
		hat she placed on residents				
		orked. She indicated that on				
	12/05/18, she comple	eted the treatments on all the				
		she went back to work on				
		e checked Resident #1's				
	-	e foam was saturated with				
		e on it, and the wound was				
	-	d. She said the wound				
		because Resident #1 had				
	undermining of the w					

Facility ID: 923314

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & MI				FOR	D: 01/31/2019 M APPROVED D. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	345307	B. WING			R-C / 20/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
			4414 WILKINSON BLVD		
MEADOWWOOD NURSING CENTER			GASTONIA, NC 28056		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 600} Continued From page 2	21	{F 600]	}		
PM to 1:35 PM. She was change on Resident #1' when the wound doctor resident's right hip wour stated that the wound lo and he removed the dea the wound which reveal further stated that the u decreased from 8 centin During continued obser sponge was still noted o and the periwound (skir was not covered with a areas of thick yellow ad the dressing. Further ob was no odor noted from wound itself. The Treatr dry dressing she remov not have been there be not follow the physician been changed daily. Sh Resident #1 never refus scratch her right hip and caused the dressing to wound. The Treatment the dressing may come notify the hall nurses ar dressing because the tr needed also. She also s responsible for doing a An interview was condu 12/18/18 at 2:04 PM. Si change the dressing on	se on 12/18/18 from 1:15 as performing a dressing 's right hip. She stated that first came to assess the nd after it opened up, he boked like a bad infection ad tissue off of the top of led the undermining. She indermining had meters (cm) to 4 cm. vation, the undated blue on Resident #1's right hip n surrounding the wound) dressing and had 4 small therent tissue surrounding bservation indicated there in the old dressing or the ment Nurse stated that the ved from the wound should cause the dressing did i's order and it should have he further stated that sed care, but she did d around the wound which hang loosely off the Nurse stated that because e off, she told the Na's to nd they could change the reatment order was as stated that all nurses were weekly skin assessment. ucted with Nurse #6 on he stated that she did not in 12/17/18 for Resident #1. when the treatment nurse				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I					FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
	345307	B. WING		-		-C 20/2018
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
MEADOWWOOD NURSING CENTE	R		414 WILKINSON BLVD GASTONIA, NC 28056			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
Nurse #8, on 12/17/18 been done for ResideA phone interview was on 12/19/18 at 9:53 A did not do the treatment 12/17/18 because shewith only one NA.A phone interview was on 12/19/18 at 10:07 J 12/08/18, she only pe on another resident, mA phone interview was on 12/19/18 at 10:27 J worked with Resident PM to 7:00 AM, and d treatments on ResiderAn interview was cond Doctor on 12/19/18 at 10:27 J worked with Resident PM to 7:00 AM, and d treatments on ResiderAn interview was cond Doctor on 12/19/18 at that when the regular working every day, that treatments being com stated he was not sum her skin caused the in further stated that Resident that the periwound de Care notes, dated 12/ insufficiency). He indi was ordered for the perive key to successful would de	ing the dressing. She ified oncoming 3rd shift, 3 that a treatment had not nt #1. s conducted with Nurse #8 M. She indicated that she ents on Resident #1 on a was working by herself s conducted with Nurse #4 AM. She indicated that on rformed a dressing change iot Resident #1. s conducted with Nurse #7 AM. She stated that she #1 on 12/17/18, from 11:00 id not perform any nt #1. ducted with the Wound 11:14 AM. He indicated treatment nurse was not ere was an issue with pleted as ordered. He e if Resident #1 scratching ifection of her right hip. He sident #1 needed wound dressings once a day and teriorated (per the Wound 12/18, due to venous icated that the Silvadene eriwound abrasion and the ind healing was to protect e dressing was supposed to	{F 600}				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
			A. BUILDI	NG _		R	-C
		345307	B. WING			12/	20/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ER			4414 WILKINSON BLVD		
	I			(GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG				(X5) COMPLETION DATE
{F 600}	Continued From page	23	{F 6	00}	}		
	DON on 12/19/18 1:5	was conducted with the 3 PM. She indicated her treatment orders should be ents completed as					
	12:25 PM. The admin expected treatments the physician orders. was not aware treatm as scheduled but exp	20/18 from 11:14 AM to histrator indicated that she to be done consistent with She further indicated she hents were not being done					
	dementia, kyphosis (e	ted to the facility on e diagnoses that included excessive outward curvature ated osteoporosis, and					
	Resident #7 read in p protecting skin) to bila	n's order dated 08/30/18 for eart, "skin prep (forms a film ateral top of foot and protect vice weekly and as needed."					
	Set (MDS) dated 10/2 was moderately impa making and displayed	ant change Minimum Data 24/18 revealed Resident #7 ired for daily decision d no rejection of care during t period. Further review of					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/31/2019 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345307	B. WING				-C 20/2018	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE	1 12/	20/2010	
	WOOD NURSING CENTE	E D	4	414 WILKINSON BLVD				
WEADOW	WOOD NORSING CENTE	-n	G	SASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE	
{F 600}	the MDS indicated Re extensive assistance and had 2 unhealed p Review of a care plan 10/25/18, revealed Re for pressure ulcer dev assistance with mobil decreased oral intake free from any signs ou related to altered skin included for staff to ac ordered and monitor f Review of a physician Resident #7 read in p ankle with wound clea Polymen Dressing (ty a mild cleaning agent gradually released int week." Review of the Decem Administration Record for Resident #7's righ to be completed on M Friday during the hou There were no initials treatment to Resident completed on the sch	esident #7 required with activities of daily living pressure ulcers. n, with a revised date of esident #7 had the potential velopment related to needing lity, incontinence and e with the goal she would be r symptoms of infections n integrity. The interventions dminister treatments as for effectiveness. n's order dated 11/28/18 for part, "cleanse right outer anser, pat dry, apply ype of dressing that contains t activated by moisture and to the wound area) 3 times a her 2018 Treatment d (TAR) revealed treatment t outer ankle was scheduled fonday, Wednesday and irs of 7:00 AM to 3:00 PM. c on the TAR indicating the t #7's right outer ankle was heduled days of 12/03/18, r 12/17/18. Further review of initials indicating the nt #7's top of foot was	{F 600}	DE	EFICIENCY)			
	week." Review of the Decem Administration Record for Resident #7's righ to be completed on M Friday during the hou There were no initials treatment to Resident completed on the sch 12/07/18, 12/10/18 or the TAR revealed no treatment for Resident	aber 2018 Treatment d (TAR) revealed treatment t outer ankle was scheduled Monday, Wednesday and thrs of 7:00 AM to 3:00 PM. s on the TAR indicating the t #7's right outer ankle was neduled days of 12/03/18, r 12/17/18. Further review of initials indicating the nt #7's top of foot was						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345307	B. WING		_		-C 20/2018
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			4	414 WILKINSON BLVD			
MEADOW	WOOD NURSING CENTE	R	0	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	Wound Nurse (WN) e responsible for compl residents on the days Tuesdays, Wednesda week, and the hall nur completing wound tre The WN recalled char Resident #7's right out the next dressing cha and 12/10/18. She st work on 12/11/18, the dated 12/05/18 with h hanging off the wound did not work on 12/03 and stated it was an of treatments were not b nurses on the days st work. She added she the day she returned i done by the hall nurse An observation was m wound care on 12/18/ washed her hands an old dressing from the she stated the dressin Polymen which was th dressing was dated 12 Nurse #5. The skin o foot was intact with no noticed. The WN indi was preventative and replaced to protect the her hands and as she (foot/heal protector) fr	n 12/18/18 at 8:35 AM, the xplained she was eting wound treatments for she worked, which were ys and Thursdays each rses were responsible for atments the remaining days. nging the dressing on ter ankle on 12/05/18 with nges scheduled on 12/07/18 ated when she returned to dressing in place was er initials, smelled and was d. The WN confirmed she /18, 12/07/18 or 12/10/18 ongoing issue that wound being completed by the hall ne was not scheduled to e completed treatments on if she noticed they were not es on the day scheduled.	{F 600})EFICIENCY)		
	(foot/heal protector) fr there was no dressing	-					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345307	B. WING				R-C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER	I	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ER			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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	wound was red with a slough (dead tissue) a wound bed was a dar cleaned the ankle wit the area dry and appl ordered. During a telephone in	a small amount of yellow and the skin surrounding the k reddish color. The WN h wound cleanser, patted lied Polymen dressing as	{F 6	500 <u>)</u>	}		
	nurse on 12/07/18 an treatment to Resident explained she was ne wound treatments an	-					
	Nurse #4 confirmed s to provide care to Res Nurse #4 stated she of treatment to Resident any other resident as never trained to provi explained the facility the treatments for all	n 12/18/18 at 3:00 PM, she was the nurse assigned sident #7 on 12/03/18. did not complete the wound t #7's right outer ankle or signed because she was de wound care. Nurse #4 had a WN who completed residents and was never to complete the treatments t scheduled.					
	PM, Nurse #5 confirm treatment to Resident she must have forgot completed. Nurse #5	terview on 12/18/18 at 3:31 ned she provided wound t #7 on 12/17/18 and stated ten to initial the TAR when added the Hospice Nurse ring the wound treatment.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		345307	B. WING	OMB NO. 0938-03 2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY BUILDING COMPLETED WING R-C 12/20/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056 ID PROVIDER'S PLAN OF CORRECTION (X5)	-		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
MEADOW	WOOD NURSING CENT	ĒR					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
{F 600}	bandage on the top of applied Tegaderm (tra- cover and protect wo to her right outer ankli reviewed the TAR pri- was unable to explain on Resident #7's righ wrong dressing was a foot. During a telephone in PM, the HN confirme Nurse #5 provided wo #7 on 12/17/18. The observed the treatmen ulcer on Resident #7' not familiar with the tr of her foot. She state wound treatment orde and a non-adhesive F Resident #7's right ou out of the adhesive P	he put a 4 inch (in) by 4 in f Resident #7's left foot and ansparent dressing used to und) and Polymen dressing le. Nurse #5 added she or to providing treatment and n why there was no dressing t outer ankle or why the applied to the top of her left terview on 12/18/18 at 4:08 d she was present when bund treatment to Resident HN explained she only ent provided for the pressure s right outer ankle and was reatment ordered for the top ed Nurse #5 followed the ers and applied Tegaderm Polymen dressing to uter ankle since Hospice was olymen dressing they added it was possible the	{F 6	500	}		
	Wound Physician (W been providing wound past 3 weeks and wa was an issue with wo completed as ordered a resident was on Ho dressing changes to a discomfort. The WP	n 12/19/18 at 11:14 AM, the P) indicated he had only d care at the facility for the s not able to confirm if there und treatments not being d or scheduled. He added if spice he tried to limit the avoid causing them stated when he treated earlier that morning, it					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/31/2019 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING					-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE,	ZIP CODE		
MEADOW	WOOD NURSING CENTE	R			414 WILKINSON BLVD GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
{F 600}	showed improvement and no changes were treatment as ordered unaware a dressing w Resident #7's wound dressing should have wound not left expose During a telephone in PM the Director of Nu nursing staff were info providing wound treat description. The DON the hall nurses to com ordered and schedule absent. During a telephone in AM, Nurse #2 confirm assigned to provide c 12/10/18. Nurse #2 s the wound treatment f ankle because she re and the HN provided f During an interview of Administrator was una were not being compl when the WN was no stated she was aware the building and felt th training in wound care expectation wound treat	a with no signs of infection e made to the current by Hospice. He was vas not observed on on 12/18/18 and stated a been applied and the ed. terview on 12/19/18 at 2:03 ursing (DON) explained ormed upon hire that tment was a part of their job N stated she would expect hplete wound treatments as ed when the WN was terview on 12/20/18 at 9:41 hed she was the nurse are to Resident #7 on stated she did not complete to Resident #7's right outer received Hospice services	{F	600}				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) D4	NO. 0938-039 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	MPLETED	
						R-C	
		345307	B. WING			12/20/2018	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW	WOOD NURSING CENTE	R		414 WILKINSON BLVD ASTONIA, 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
{F 656}	Continued From page	29	{F 656}				
{F 656} SS=G		comprehensive Care Plan	{F 656}			1/18/19	
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that into objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re- under §483.10, include treatment under §483. (iii) Any specialized so rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the resider (iv)In consultation with resident's representation (A) The resident's pre- future discharge. Fac- whether the resident's	cility must develop and densive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ded in the comprehensive mprehensive care plan must g- are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 6.10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)- als for admission and efference and potential for					

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		1	R-C 2/20/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENT	ER		GASTONIA, 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{F 656}	Continued From page	e 30	{F 65	6)		
(,	entities, for this purpo		1.00			
		in the comprehensive care				
		in accordance with the				
		h in paragraph (c) of this				
	section.					
	This REQUIREMEN	Γ is not met as evidenced				
	by:					
		ons, record review, resident		1. Resident #1 and #11 care	•	
	interviews, staff inter			updated 1/17/19 with accurate		
	-	y failed to develop a care		descriptions by the Interim D		
		y described the wounds for 2		Nursing/Regional RN. Reside		
		ed for wounds (Residents #1 plement the care plan for		#7 care plans regarding wou implemented 12/19/18 by the		
		2 of 4 residents reviewed for		nurse.	licenseu	
		t1 and #7); and failed to				
		plan for activities of daily		2.In order to ensure that othe	er residents	
		5 residents reviewed for		are not affected by the allege		
	ADLs (Residents #1			practice the care plans have		
	, , , , , , , , , , , , , , , , , , ,	,		revamped by the Registered		
	The findings included	d:		Interim Director of nursing as	s of 12/20/18	
				in which to help to identify sp	ecific needs	
		readmitted to the facility on		of the residents.		
	-	inal admission on 10/08/09				
		gnoses: neuromuscular		The care plans regarding AD		
	-	er, history of urinary tract		residents #1 nail care was in		
		ressive episode, anxiety, and left hands, history of		by the Certified Nursing Assist 12/20/2018	SIGHT ON	
	cellulitis of lower extr	-				
		and type 2 diabetes mellitus.		In regards to resident #13 inc	continence	
				care was performed by the C		
	A review of Resident	#13's Annual Minimum Data		Nursing Assistant on 12/19/1		
		/28/18, indicated he was		#13 has been informed as of		
		was totally dependent on		that random audits will be co	mpleted with	
		MDS further indicated		him to ensure call-lights are I		
		ways incontinent of bowel		addressed in a timely manne		
	and bladder.			being changed when needed	l.	
	A review of the Activi	ties of Daily Living (ADL)		The Nurse and or Interim Do	n will audit at	
		Area Assessment (CAA) and		least three (3) cognitively res		

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		(X3) DATE SURVEY COMPLETED
		345307	B. WING		R-C 12/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				4414 WILKINSON BLVD	
MEADOW	WOOD NURSING CENT	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
{F 656}	Continued From page	e 31	{F 656	n	
(* * * * *)	Urinary Incontinence 02/28/18 MDS noted	CAA associated with the Resident #13 needed ing as the resident was	(i 000	regarding ADL care weekly x 4 we then weekly x 2 weeks.	eks and
	incontinent of bowel a provided incontinent needed.			The care plans of residents with w were audited 1/16/19 and 1/17/19 Regional RN for accurate descript and corrected.	by the
	03/14/18, indicated the self-care performance extensive assistance	#13's care plan, dated ne resident had an ADL e deficit and required from staff for toileting		The wound care nurse's schedule been changed effective 1/15/19 to Monday-Friday to complete daily coverage.	
	needs. The care plan further indicated that incontinence care was provided routinely and as needed for Resident #13 and that Resident #13 was encouraged to use bell to call for assistance.			3.Education was provided to the n staff 1/16/18-1/18/19 regarding the to provide treatments in the event wound nurse is not working.	eir role
	12/18/18 at 10:30 AM recordings of call bell of response on 12/16 resident's statements at 12:41 AM, he was he turned on his call	b. He stated that on 12/16/18 laying in urine and feces and light and pressed record on		In-Service was also provided to th nursing staff 1/16/19-1/18/19 in th provision of ADL care including na incontinence care for residents red assistance. Education will be inclu subsequent new-hire orientations.	e il and quiring ided in
	light off without check stated that at 4:41 AM again and pressed re computer voice recor turned off by staff and needs. He indicated this his call light and press recorder and it took 3 came to his room.Wit	his room and turned the call king on him. He further M, he turned his call light on ecord on his personal rder and his call light was d no one responded to his that at 5:51 AM, he turned on esed record on his voice 00 minutes before NA #2 th his recording pushed to		4. Monitoring To ensure compliance Registered Nurse and or Interim I of Nursing will be responsible for t aspect of the Plan of Correction. T Registered Nurse and or Interim E of Nursing will randomly check compliance of Certified Nursing As providing ADL care including incor care and nail care-5 residents per weeks then 2 residents per weeks	Director his The Director ssistants ntinence x 4 x 4
	by the resident on 12 entering his room, he	urveyor heard the the NA #2 and the response //16/18 at 5:51 am. Upon e further indicated that NA #2 "You keep ringing the call		weeks. The treatment nurse and c Registered Nurse will monitor the plans for accurate description of w once (1) weekly x 4 weeks.	care

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TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING		R-C	
		345307	B. WING		12/20/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ER		4414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET	
{F 656}	bell? What do you ne stated he responded, haven't been cleaned stated NA #2 did not of Resident #13's room 7:30 AM, Resident #1 his call light because and feces and had be without being cleaned his personal compute indicated that Nurse # he told her that he ha she stated that she w someone to the hosp come in to help. Then room and did not retu Resident #13 reveale again and NA # 3 can cleaned him, and she and the under pad wa soaked up the urine a tobacco. Resident #1 hurt because staff did An interview was con 12/18/18 at 3:01 PM. into Resident #13's ro and had to change his was wet with urine fro to his knee cap. NA # #13 soaked with urine was the worst she sa #3 stated that Reside incontinence care. NA was wet all the way th the chux (disposable)	ed, huh?" Resident #13 "That should be obvious. I "up all night." Resident #13 change his brief, then left and turned off his light. At 13 indicated that he pressed he was soaked with urine een laying there all night d up and pressed record on er voice recorder. He further #1 came into his room and d not been cleaned up and ras "in the middle of sending ital and can't make the NA's h, Nurse #1 left the resident's irn to his room. At 8:30 AM, d that he rang his call light ne into his room and e washed his bed 3 times as turned upside down and and the pad looked like 3 tearfully reported he felt in't clean him up. ducted with NA #3 on She indicated that she went toom on 12/16/18 at 8:30 AM s whole bed because he om just below his shoulders t3 stated she found Resident e and feces before but this w his bed that soaked. NA and #3 recalled the bed spread hough and everything from o pad to the washable pad ng up the bed, NA #3 stated	{F 656		nd g to MD eeks, ks. ewed at ce 1/22/19 eported nthly	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345307	B. WING				R-C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ER			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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 656}	chux pad was soaked that at the end of first of the condition she for he reported regarding being addressed from #3 further stated that that the social worker addressed the grievar mentioned something regarding 3rd shift be right how he was bein A phone interview wa Director of Nursing (D PM. She stated that s for ADL's be followed An interview was con Administrator on 12/2 12:25 PM. She stated be accurate and experient followed in terms of c treatments or ADLs. 2. Resident #1 was re 04/5/17 with an origin with the following diag behavioral disturbance disorder, pruritus (itch peripheral vascular di diabetes mellitus, loca subcutaneous tissue depressive disorder. 2a. A review of Resid dated 12/05/18, revea 1. Cleanse Right hip v	I with urine. NA #3 stated shift, she notified Nurse #2 pund Resident #13 and what h is need for assistance not in 12:41 AM to 8:30 AM. NA Nurse #2 told Resident #13 was the one who inces and that Resident #13 about writing a grievance cause he said it was not ing treated. s conducted with the DON) on 12/19/18 at 1:53 whe expected all care plans ducted with the 0/18 from 11:14 AM to I she expected care plans to acted interventions to be are whether it was care for eadmitted to the facility on al admission on 01/10/17 gnoses: dementia without e, generalized anxiety ning), right hip infection, sease, (PVD), type 2 al infection of the skin and (onset 01/11/17), and major	{F 6	656	5}		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345307	B. WING				R-C / 20/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
MEADOW	WOOD NURSING CENTE	ĒR			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	2. Cleanse Right hip i cleanser, pat dry, app dry dressing every da A review of the care p area to right hip or po development, dated 1 #1's pressure ulcer w and would remain free plan further indicated were in place for staff ordered and were mo dressing was monitor and adhering and sta to the treatment nurse moisturizer applied to A review of Resident Set (MDS), dated 01/ severe cognitive impa symptoms of scratchi incontinent of bowel a extensive assistance and extensive assistance and extensive assistance assistance for person indicated that she wa development but that	ng every day and as needed. Deriwound with wound by Silvadene and cover with and as needed. Dan for the nonstageable tential for pressure ulcer 2/6/18, indicated Resident ould show signs of healing e from infection. The care the following interventions to administer treatments as nitored for effectiveness, ed to ensure it was intact ff to report loose dressings e, and the resident needed her skin. #1's Annual Minimum Data 08/18, indicated she had airment, she had behavioral ng herself, she was always and bladder and needed with 2 plus person physical rs, bed mobility, toileting, ince with 1-person physical al hygiene. The MDS also s at risk for pressure ulcer she had no pressure ulcer.	{F 6	\$56}			
	MDS revealed Reside breakdown due to her assistance with positi admitted with multiple primarily to her legs a	essociated with the 01/08/18 ent #1 was at risk for r incontinence and needed oning. Resident #1 was also e areas of breakdown and buttocks with a history of g). The CAA also revealed					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/31/2019 MAPPROVED D. 0938-0391		
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE			
AND I LAN OF	CONTRECTION	BENNI IOANON NOWBEN.	A. BUILDI	ING .					
		345307	B. WING				-C 20/2018		
NAME OF P	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	CH CORRECTIVE ACTION SHOULD BE COMPLETIN S-REFERENCED TO THE APPROPRIATE DATE			
{F 656}	Continued From page	35	{F 6	656]	}				
	done on the following 12/10/18; & 12/17/18. A review of December following treatments f initialed as done the f 1. Apply zinc oxide day. (not initialed on 12/10/18; & 12/17/18) 2. Doxepin Cream & with abrasion every n areas are healed initialed on 12/07/18; 12/15/18; 12/16/18; a 3. Eucerin Cream & Extremities twice daily 7am (not initialed on 4. Eucerin Unscente areas topically every (not initialed on 12/07 12/17/18) 5. Ketoconazole Sh once a week for itch of 12/07/18 and 12/14/1 6. Vitamin A+D oint Vit A&D - apply topica every day. (not initialed 12/10/18; & 12/17/18) An observation of Res bed via Hoyer Lift was 2:30 pm with Nurse #	d (TAR) revealed the ressing change and hange was not initialed as dates:12/07/18; 12/08/18; r 2018 TAR revealed the or Resident #1 were not ollowing dates: to groin redness/area every 12/07/18; 12/08/18;							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		-C 20/2018
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
		_	4	414 WILKINSON BLVD			
MEADOW	WOOD NURSING CENTE	R	C	GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	repositioning the resid change the dressing, undated. An interview with Nurs 12/17/18 from 2:45 PI stated that the facility Tuesdays, Wednesda the week and a treatm and Sundays every of no treatment nurse or Nurse #6 indicated the #1's right hip started of weeks ago and the fa Nurse #6 further indic undermining (destruct under the skin edges was larger at its base the wound and it was She indicated that the was for the wound to a blue dry dressing. An interview was com Nurse on 12/18/18 at she knew nothing abo wound until Saturday; date she saw the wou further stated that the popped open and was undermining. She ind information in the faci Resident #1's right hip indicated that she initi hip on 11/24/18. She not at work, the treatm	n of Nurse #6 and NA #5 dent, the nurse did not as the dressing was se #6 was conducted on M to 3:00 PM. Nurse #6 had a treatment nurse on ys, and Thursdays during nent nurse on Saturdays ther weekend but there was n Mondays and Fridays. at the wound on Resident but as a bump about 2 cility had a wound doctor. ated the resident had tion of tissue extending so that the pressure ulcer than at the skin surface) of a decubitus pressure ulcer. eright hip wound treatment be packed and covered with ducted with the Treatment 8:52 AM. She stated that but Resident #1's right hip 11/24/18, which was the ind for the first time. She right hip wound had already a draining and developed icated that she documented lity doctor's book about	{F 656}				
		one because she would find nat she placed on residents					

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
						R-C
		345307	B. WING			2/20/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 656}	Continued From pag	e 37	{F 656	}		
	from when she last w	vorked. She indicated that on				
	-	eted the treatments on all the				
		she went back to work on				
		ne checked Resident #1's				
		e foam was saturated with e on it, and the wound was				
	0	ed. She said the wound was				
	-	because Resident #1 had				
	undermining of the w					
	An observation and i	nterview were conducted				
		urse on 12/18/18 from 1:15				
		was performing a dressing				
		#1's right hip. She stated that				
		tor first came to assess the				
	• .	ound after it opened up, he				
		d looked like a bad infection				
		dead tissue off of the top of				
	further stated that the	ealed the undermining. She				
		ntimeters (cm) to 4 cm.				
		servation, the undated blue				
		d on Resident #1's right hip				
		skin surrounding the wound)				
	was not covered with	a dressing and had 4 small				
		adherent tissue surrounding				
	-	observation indicated there				
		om the old dressing or the				
		eatment Nurse stated that the noved from the wound should				
		because it the dressing did				
		an's order and it should have				
		She further stated that				
	Resident #1 never re	fused care, but she did				
		and around the wound which				
	-	to hang loosely off the				
		nt Nurse stated that because				
1		ne off, she told the Na's to				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	i		PLETED
		345307	B. WING				-C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	20/2010
MEADOW	WOOD NURSING CENTE	-R			4414 WILKINSON BLVD		
		-N			GASTONIA, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	Continued From page	38	{F 6	356	n		
[1 000]		e treatment order was as	ι (F C	500	55 		
	needed also. She also	a weekly skin assessment.					
	An interview was con	ducted with Nurse #6 on					
		She stated that she did not					
		on 12/17/18 for Resident #1.					
	She further stated that was not at the facility,	at when the treatment nurse					
	-	jing the dressing. She					
		tified oncoming 3rd shift,					
	been done for Reside	8 that a treatment had not ent #1.					
	•	s conducted with Nurse #8 M. She indicated that she					
		ents on Resident #1 on					
	12/17/18 because she with only one NA.	e was working by herself					
		s conducted with Nurse #4					
		AM. She indicated that on erformed a dressing change					
	on another resident, r						
		s conducted with Nurse #7 AM. She stated that she					
		#1 on 12/17/18, from 11:00					
	PM to 7:00 AM, and c treatments on Reside						
		ducted with the Wound					
		t 11:14 AM. He indicated					
	-	treatment nurse was not ere was an issue with					
	treatments being com	pleted as ordered. He					
		e if Resident #1 scratching					
		nfection of her right hip. He sident #1 needed wound					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (AND PLAN OF	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C					
		345307	B. WING				-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ĒR			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	packing wet to moist of that the periwound de Care notes, dated 12, insufficiency). He indi was ordered for the p key to successful wou the wound and that th be covering the woun A phone interview wa on 12/19/18 at 11:55 treatments were done 12/08/18. She further only changed another Resident #1. A telephone interview DON on 12/19/18 1:5 Resident #1. A telephone interview DON on 12/19/18 1:5 Resident #1's treatment followed, and treatment scheduled. An interview was con Administrator on 12/2 12:25 PM. The administreatment orders show completed as schedu 2b. A review of Care I at the facility for nursi resident specific need she was supposed to needed. Review of th and nail care sheet for nail care was document A review of Resident Set (MDS), dated 01/	dressings once a day and eteriorated (per the Wound /12/18, due to venous cated that the Silvadene eriwound abrasion and the und healing was to protect he dressing was supposed to id. s conducted with Nurse #2 AM. She stated that no e on Resident #1 on stated that on 12/10/18, she r resident's dressing, not r was conducted with the 3 PM. She stated that ent orders should be ents completed as ducted with the 10/18 from 11:14 AM to histrator stated that uld be followed and led. Kardex (the system in place ng assistants to know ds) for Resident #1 revealed get nail care daily and as e December 2018 bed baths or Resident #1 indicated no	{F 6	\$56}			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM APPROVED B NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING) DATE SURVEY COMPLETED
		345307	B. WING				R-C 12/20/2018
NAME OF P	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 PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
{F 656}	incontinent of bowel a extensive assistance assistance for transfe and extensive assista assistance for person indicated that she wa development but that A review of the Press Assessment (CAA) as MDS revealed Reside with multiple areas of legs and buttocks with (itching). The CAA als to self-inflict scratches A review of ADL Func associated with the 0 Resident #1 had a dia CAA further revealed assistance with perso assist with basic hygi physical assistance with remain free from infeor revealed the following for potential for pressure indicated Resident #1 and wound would sho remain free from infeor revealed the following for potential for press to make sure fingerna and had no jagged eo treatments as ordered monitored for effective An observation of Res	ng herself, she was always and bladder and needed with 2 plus person physical rs, bed mobility, toileting, ince with 1-person physical al hygiene. The MDS also is at risk for pressure ulcer she had no pressure ulcer associated with the 01/08/18 ent #1 was also admitted breakdown primarily to her in a history of chronic pruritis so revealed she was prone is. Ational/Potential CAA 1/08/18 MDS revealed agnosis of dementia. The she required extensive and hygiene but was able to ene with setup and needed with bathing or showering. Alan, dated 01/08/18, for the e Ulcer Development 's self-inflicted scratches bow signs of healing and ction. The care plan also g interventions were in place ure ulcer development: staff als were clean, trimmed, dges and staff to administer d and treatments were	{F 6	356)			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345307	B. WING				-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	to be dirty with a brow under her fingernalis length and the fingerr the right hand had a ji An interview with Nur 12/17/18 from 2:45 Pl stated that the resider nail care and NA's we when they gave her a Resident #1 did not re An interview with NA 12/17/18 at 3:00 PM. Resident #1 was supp during her shower and refuse care. An observation conduc conducted on 12/18/1 The observation of the dressing changed rev both hands were still colored substance un nails were ½ inch in le the second digit of the edge. An interview was com 12/19/18 at 8:55 AM. 3rd shift and did not of because that was dor An observation of Res 12/19/18 at 12:40 PM Resident #1's nails or	6 and NA #5 present. n both hands were observed which red colored substance and the nails were ¼ inch in hail on the second digit of agged edge. se #6 was conducted on M to 3:00 PM. Nurse #6 int definitely needed good ere supposed to cut her nails is shower and also stated that efuse care. #5 was conducted on NA #5 indicated that bosed to have her nails cut d that Resident #1 was 8 from 1:15 PM to 1:35 PM. e resident during the realed Resident #1's nails on dirty with a brownish red der her fingernails and the ength and the fingernail on e right hand had a jagged ducted with NA #4 on She stated that she worked lo nail care on Resident #1	{F 6	\$56]	<pre>}</pre>		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING							E SURVEY PLETED
		345307	B. WING				R-C / 20/2018
NAME OF PF	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 656}	and the fingernail on the hand had a jagged eding in the mount of the hand in her mound. An interview was considered and the resident and the resident's nail care. An observation of Resident #1's nails or with a brownish red care fingernails and the name of the hand had a jagged eding and the fingernail on the hand had a jagged eding and the fingernails and the fingernail on the hand had a jagged eding and the fingernails and the fingernails and the fingernail on the hand had a jagged eding and the fingernails and the fingernails and the fingernails and the fingernail on the hand had a jagged eding and the fingernails and the fingernails and the fingernail on the hand had a jagged eding to detect and or trimmed and have been followed. An interview was conserved and the followed. An interview was conserved and the seven the followed. An interview was conserved and have been followed. An interview was conserved and the seven do for the followed and the followed and the followed and the followed. An interview was conserved and the followed and the	 were ¼ inch in length the second digit of the right dige and the resident put her th. ducted with NA #5 on She stated that nail care Resident#1's shower. After 1's fingernail, NA #5 stated Is needed to be cut. NA #5 s room without performing sident #1 in the Activity I on 12/20/18 at 10:35 AM. In both hands were still dirty olored substance under her ils were ¼ inch in length the second digit of the right dige. was conducted with the 3 PM. She stated that her every time residents got a buld be checked and rmine if they needed to be nd the care plan should 	{F 6	356}			
	had severe cognitive						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C AND PLAN OF	(X3) DATE						
		345307	B. WING				-C 20/2018
NAME OF PF	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	WOOD NURSING CENTE	B		4	1414 WILKINSON BLVD		
INEADOW	WOOD NORSING CENTE			Ģ	GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	needed extensive ass physical assistance for toileting, and extensive physical assistance for MDS also indicated the pressure ulcer develop pressure ulcer. A review of the Press Assessment (CAA) ass MDS revealed Reside with multiple areas of legs and buttocks with (itching). The CAA also to self-inflict scratches A review of the care p area to right hip or po development, dated 1 #1's pressure ulcer w and would remain free An interview was com on 12/19/18 at 12:26 had to clarify with the 12/19/18 because she documented the right ulcer on the 12/06/18 11/28/18, it was mark Wound Tracking Report the wound stages por A telephone interview DON on 12/19/18 1:5 Resident #1's wound was incorrectly staged	nt of bowel and bladder and sistance with 2 plus person or transfers, bed mobility, ve assistance with 1-person or personal hygiene. The nat she was at risk for opment but that she had no ure Ulcer Care Area ssociated with the 01/08/18 ent #1 was also admitted breakdown primarily to her n a history of chronic pruritis so revealed she was prone s. blan for the nonstageable tential for pressure ulcer 2/6/18, indicated Resident ould show signs of healing e from infection. ducted with the MDS nurse PM. She indicated that she treatment nurse on e didn't know why she hip unstageable pressure care plan other than on ed Unstaged on the facility ort and had an X through	{F 6	\$56}			

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	-	ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING							SURVEY PLETED
		345307	B. WING				-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	20/2010
					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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	Continued From page	9 44	{F 6	656	;}		
	MDS nurse on 12/19/ that the Unstageable have been listed on F plan because the wou pressure ulcer. An interview was con Administrator on 12/2 12:25 PM. The admin should be an accurate wound. 3. Resident #7 admit 01/31/17 with multiple dementia, kyphosis (et	0/18 from 11:14 AM to istrator stated the care plan e reflection of Resident #1's					
	Set (MDS) dated 10/2 was moderately impa making and displayed the 7-day assessmen the MDS indicated Re extensive assistance and had 2 unhealed p Review of a care plan 10/25/18, revealed Re for pressure ulcer dev assistance with mobil decreased oral intake free from any signs or related to altered skin	a no rejection of care during t period. Further review of esident #7 required with activities of daily living pressure ulcers. a, with a revised date of esident #7 had the potential velopment related to needing					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		345307	B. WING				R-C 12/20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTE	=R		C	GASTONIA, 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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 656}	Continued From page ordered and monitor		(F 6	56}			
	Resident #7 read in p ankle with wound clea Polymen Dressing (ty a mild cleaning agent	n's order dated 11/28/18 for aart, "cleanse right outer anser, pat dry, apply upe of dressing that contains activated by moisture and to the wound area) 3 times a					
	for Resident #7's righ to be completed on M Friday during the hou There were no initials treatment to Resident	d (TAR) revealed treatment t outer ankle was scheduled londay, Wednesday and rs of 7:00 AM to 3:00 PM. s on the TAR indicating the t #7's right outer ankle was reduled days of 12/03/18,					
	Wound Nurse (WN) eresponsible for completing residents on the days Tuesdays, Wednesdaweek, and the hall nurcompleting wound tree The WN recalled cha Resident #7's right outhe next dressing char and 12/10/18. She st work on 12/11/18, the dated 12/05/18 with the hanging off the wound did not work on 12/03	n 12/18/18 at 8:35 AM, the explained she was leting wound treatments for a she worked, which were ays and Thursdays each rses were responsible for eatments the remaining days. nging the dressing on uter ankle on 12/05/18 with anges scheduled on 12/07/18 tated when she returned to be dressing in place was her initials, smelled and was d. The WN confirmed she b/18, 12/07/18 or 12/10/18 tongoing issue that wound					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT AND PLAN OF	(X3) DATE SURVEY COMPLETED						
		345307	B. WING				R-C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	ER			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 656}	treatments were not to she was not schedule completed treatments	being completed on the days ed to work. She added she s on the day she returned to ey were not done by the hall	{F 6	\$56}	}		
	PM, Nurse #1 confirm nurse on 12/07/18 an treatment to Residen explained she was ne wound treatments an						
	Nurse #4 confirmed s to provide care to Re- Nurse #4 stated she treatment to Residen any other resident as never trained to provi explained the facility the treatments for all	n 12/18/18 at 3:00 PM, the was the nurse assigned sident #7 on 12/03/18. did not complete the wound t #7's right outer ankle or signed because she was de wound care. Nurse #4 had a WN who completed residents and was never to complete the treatments t scheduled.					
	PM the Director of Nu nursing staff were info providing wound treat description. The DOI expectation nursing s	tment was a part of their job					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345307	B. WING				-C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 656}	Continued From page scheduled and ordere		{F 6	56]	}		
	AM, Nurse #2 confirm assigned to provide c 12/10/18. Nurse #2 s the wound treatment ankle because she re	terview on 12/20/18 at 9:41 ned she was the nurse are to Resident #7 on stated she did not complete to Resident #7's right outer ceived Hospice services se provided wound care.					
	Administrator was un were not being compl when the WN was no stated she was aware the building and felt th training in wound care expectation wound tra	n 12/20/18 at 11:14 AM, the aware wound treatments eted by the hall nurses t scheduled to work. She e of all the training needs in ne nurses needed more e. She stated it was her eatments were completed as ed and staff provided care dent's care plan.					
	11/21/18 revealed an Resident #11 had pot development related in incontinence and had his coccyx and left hip pressure ulcer on his Resident #11 would b pressure ulcer develo address problem wer	a stage II pressure ulcer on					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						(X3) DATE COMF	
		345307	B. WING				20/2018
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MEADOW	WOOD NURSING CENTE	ĒR			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
{F 656}	in skin status (appear signs and symptoms stage). A review of a wound p 11/29/18 indicated Re unstageable pressure right heel, and right m A review of hospital w 12/07/18 indicated Re pressure ulcer to left right heel, pressure u that was not staged, p left knee, and right he and pressure ulcer to staged. A review of the Admis (ANA) dated 12/07/18 an unstageable press sacrum, right head, a pressure ulcer to left to right heel. A review of a wound p 12/12/2018 indicated unstageable pressure right heel, left heel, an to right medial ankle. On 12/19/18 at 10:36 conducted with the M nurse who stated she updating the care plan location and stage for	ere to bort as needed any changes rance, color, wound healing, of infection, wound size, and obysician's note dated esident #11 had an a ulcer to coccyx, right hip, hedial ankle. Yound discharge sheet dated esident #11 had stage I heel and deep tissue injury lcer to right medial ankle bressure ulcer to sacrum, ead that was unstageable, right hip that was not esion Nursing Assessment B revealed Resident #11 had sure ulcer to buttock, nd left knee and a stage I heel, and deep tissue injury obysician's note dated Resident #11 had an e ulcer to coccyx, right hip, nd a stage IV pressure ulcer AM an interview was inimum Data Set (MDS)	{F 6	556			

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/31/201 RM APPROVE IO. 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	TE SURVEY MPLETED R-C
		345307	B. WING			2/20/2018
NAME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO	•	
MEADOW	WOOD NURSING CENT	ER	4	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 PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
{F 656}	Continued From page	e 49	{F 656}			
	pressure ulcers but h	ad not reviewed the wound 1/29/18 that indicated	(
	ulcers. She stated sh	Resident #11's pressure le had not reviewed the				
	and hospital discharg	sessment dated 12/07/18 ge information dated e ulcer location and stage				
	dated 12/12/18 for pr	d the wound physician note essure ulcer location and				
	Resident #11's care p	se stated she did not update plan to indicate pressure age because she had been				
	pulled from performin	ig her duties as MDS nurse tions and admit residents to				
	conducted with the A MDS nurse was resp	AM an interview was dministrator who stated the onsible for updating blan to indicate stage of				
	pressure ulcers and l expectation was that	ocation. She stated her the MDS nurse would have n to indicate Resident #11				
	was conducted with t stated it was her exp would have updated	5 PM a telephone interview he Director of Nursing who ectation that the MDS nurse the care plan to indicate pressure ulcers for Resident				
{F 677} SS=G	#11.	or Dependent Residents	{F 677}	•		1/18/19
55=6	§483.24(a)(2) A resic out activities of daily	lent who is unable to carry living receives the necessary good nutrition, grooming, and				

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						NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
			A. DOILDING			R-C
		345307	B. WING			2/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENT	ER		GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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)	SHOULD BE	(X5) COMPLETION DATE
{F 677}	Continued From page	e 50	{F 677	n		
[1 0//]	1.0	Γ is not met as evidenced		\$		
	by:	ו וא חטו חופו מא פיועכוונכע				
		ons, record review, resident,		1.Incontinence care was prov	rided to	
		the facility failed to provide		Resident #13 by a certified nu	•	
	-	or 2 of 5 dependent residents		assistant 12/16/18. Nail care		
		s of Daily Living (ADL) care		provided to Resident # 1 12/2	0/18 by the	
		ailed to provide nail care for		Certified Nursing Assistant.		
	(Resident #1).	idents reviewed for ADL care		2.The Registered Nurse/Interi	m Director	
				of Nursing completed an audit		
	The findings included	1:		-1/18/19 to assess for adverse		
				other residents with none obs		
	1. Resident #13 was	readmitted to the facility on				
	04/04/17 with an orig	inal admission on 10/08/09		3.The nursing staff were educ		
	-	gnoses: neuromuscular		Registered Nurse/Interim Dire		
		er, history of urinary tract		Nursing 1/16-1/18/19 in prope		
		ressive episode, anxiety,		including nail and incontinenc		
	contractures of right a cellulitis of lower extr	and left hands, history of		residents requiring assistance education will be included in s		
		and type 2 diabetes mellitus.		new-hire orientation.	ubsequent	
	A review of Desident	#13's Annual Minimum Data		4 The Director of Nursing/Inte	rim Director	
		/28/18, indicated he was		4.The Director of Nursing/Inte of Nursing will be responsible		
		was totally dependent on		aspect of the Plan of Correction		
		MDS further indicated		The Registered Nurse will ran		
		ways incontinent of bowel		compliance of Certified Nursir	-	
	and bladder. The MD	S revealed had no rejection		providing ADL care including i	ncontinence	
	of care.			care and nail care- 5 resident		
				x 4 weeks, then 2 residents pe	er week x 4	
		ties of Daily Living (ADL)		weeks.		
		Area Assessment (CAA) and CAA associated with the		The Plan of Correction will be	reviewed at	
	-	Resident #13 needed		the next scheduled Quality As		
		ing as the resident was		Performance Improvement Co		
		and bladder and staff		1/22/19. The committee include		
		care routinely and as		Medical Director, Administrate		
	needed.	-		of Nursing, Registered Nurse,		
				Services, Dietary, Medical		
	A review of Resident	#13's care plan, dated		Records/Human Resource Di	rector,	

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		(X1) PROVIDER/SUPPLIER/CLIA	יסיד II וו X2) או וו	LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
			A. BOILDING			R-C
		345307	B. WING			2/20/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		2/20/2010
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENT	ER		GASTONIA, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 677}	Continued From pag	o 51	(E 677			
1 0775	1 0		{F 677	•	Lline stoff	
	self-care performance	he resident had an ADL be deficit and required		Maintenance Director, and member.	i ine stan	
		e from staff for toileting n further indicated that		All Plan of Correction mon	thly audit data	
	-	as provided routinely and as		will be reported by each at	•	
		#13 and that Resident #13		subsequent monthly Qualit		
	was encouraged to u	use bell to call for assistance.		Performance Committee for		
	A review of the care	plan for Resident #13		recommendations and upd	lated as needed	
		I the potential to be verbally		to ensure continuous comp	oliance.	
		aregivers. The care plan,				
		nt being verbally aggressive				
	-	urther revealed staff were to				
	assess and anticipat	e resident's toileting needs .				
		nducted with Resident #13 on				
		M. The resident provided the Il unresponsiveness and lack				
	of response on 12/16	•				
		s. He stated that on 12/16/18				
		laying in urine and feces and				
	he turned on his call light and pressed record on his personal computer voice recorder and					
		his room and turned the call				
	light off without chec	king on him. He further				
		M, he turned his call light on				
	- ·	ecord on his personal				
		rder and his call light was				
		d no one responded to his				
		that at 5:51 AM, he turned on				
		ssed record on his voice 30 minutes before NA #2				
		/ith his recording pushed to				
	the play button, the s	- ·				
		the NA #2 and the response				
	-	2/16/18 at 5:51 am. Upon				
	-	e further indicated that NA #2				
	-	, "You keep ringing the call				
		eed, huh?" Resident #13				
	stated he responded	l, "That should be obvious. I				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/31/2019 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,			(X3) DATE COMF	SURVEY PLETED
		345307	B. WING				R-C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		20,2010
					4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTE	iR .			GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
{F 677}	stated NA #2 did not of Resident #13's room 7:30 AM, Resident #1 his call light because and feces and had be without being cleaned his personal computer indicated that Nurse # he told her that he ha she stated that Nurse # he told her that he ha she stated that she w someone to the hosp come in to help. Then room and did not retu Resident #13 reveale again and NA # 3 can cleaned him, and she and the under pad wa soaked up the urine a tobacco. Resident #1 hurt because staff did An interview was con Worker on 12/18/18 a there were no grievar December 2018. An interview was con 12/18/18 at 3:01 PM. into Resident #13's ro and had to change his was wet with urine fro to his knee cap. NA # #13 soaked with urine was the worst she sa #3 stated that Reside incontinence care. Na was wet all the way th	up all night." Resident #13 change his brief, then left and turned off his light. At 13 indicated that he pressed he was soaked with urine een laying there all night d up and pressed record on revoice recorder. He further #1 came into his room and d not been cleaned up and as "in the middle of sending ital and can't make the NA's n, Nurse #1 left the resident's rm to his room. At 8:30 AM, d that he rang his call light ne into his room and e washed his bed 3 times as turned upside down and and the pad looked like 3 tearfully reported he felt In't clean him up. ducted with the Social at 1:13 PM. She revealed nees filed for the month of She indicated that she went bom on 12/16/18 at 8:30 AM s whole bed because he om just below his shoulders i3 stated she found Resident e and feces before but this w his bed that soaked. NA	{F 6	677	}		

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE	D. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,			PLETED
					R-C	
		345307	B. WING			/20/2018
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE		
	WOOD NURSING CENT	= P		4414 WILKINSON BLVD		
MEADOW	WOOD NORSING CENT			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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
{F 677}	Continued From page	e 53	{F 677	3		
	was brown. In cleanir	ng up the bed, NA #3 stated				
		osable) pad and placed the				
		ix pad on mattress and the				
		d with urine. NA #3 stated				
		ound Resident #13 and what				
	he reported regarding	g his need for assistance not				
		n 12:41 AM to 8:30 AM. NA				
		Nurse #2 told Resident #13				
	that the social worker	r was the one who nces and that Resident #13				
		about writing a grievance				
		cause he said it was not				
	right how he was beir	ng treated.				
	A phone interview we	a conducted with NA #4 on				
		is conducted with NA #4 on NA #4 stated she worked				
		ntly worked with Resident				
	#13. NA #4 stated R	esident #13 typically				
		e care at 1:30 am and 5:30				
		d that was close to shift				
		d that Resident #13 had ed due to his incontinence				
		sweaty because he had				
	-	in his room that made the				
	room hot.					
		is conducted with NA #2 on She stated that the nursing				
		in at 11:00 PM typically went				
		m at 1:30 AM and change				
	him. She further state	ed that if Resident #13 was				
		the NA's went to change the				
		She indicated that Resident				
		pository during 2nd shift on indicated that it was her				
		lent #13 rang his call bell at				
	1 · · ·	and both times went into				
	his room woke him u	p and changed him. She				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY LETED
		345307	B. WING				-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 WILKINSON BLVD BASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
{F 677}	that he hadn't been cl him and changed him reported any concern did not mention that s first shift regarding Re A phone interview wa on 12/20/18 at 6:50 A expected all residents respect and dignity ar requested. A phone interview wa on 12/20/18 at 9:13 A worked 7:00 am to 7:0 toward the end of her he wanted to file a gri changed him for an el morning of 12/16/18. end of first shift NA #2 very wet. She further information to the nigli indicated that she did or file a grievance bee checked on Resident An interview was com Worker on 12/20/18 a that she did not talk to week of December 17 of any concerns invol- further indicated that complained about bei previous Director of N at the facility which was	 #13 had been telling 1st shift hanged, so the NAs woke She further stated that she is to the oncoming shift. She he reported any concerns to esident #13 on 12/16/18. is conducted with the DON M. She indicated that she is would be treated with hid care to be provided when is conducted with Nurse #2 M. She indicated that she boo pm on 12/16/18 and that shift, Resident #13 told her evance because no one extended time the early She stated that towards the B confirm Resident #13 was stated that she reported the hit shift Nurse #7. She not notify the social worker cause the social worker #13 daily. ducted with the Social to 9:39 AM. She indicated o Resident #13. She in the past, Resident #13 ing soaked in urine when the lursing (DON) was working as before December 2018. a didn't remember Resident 	{F 677}				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345307	B. WING				R-C
NAME OF PE	ROVIDER OR SUPPLIER	040007			STREET ADDRESS, CITY, STATE, ZIP CODE	12/	/20/2018
10 112 01 11					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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 677}	 12:25 PM. She stated to be treated with digit to every staff member at the facility on 11/26 expected concerns to could be done. She ir supposed to care for problem of dignity if c indicated again she si the incident, so she could be done. She ir supposed to care for problem of dignity if c indicated again she si the incident, so she could be done. She is the incident, so she could be done. She is the incident so she could be done. She is the incident so she could be done. She is the incident so she could be done. She is the incident so she could be done. She is the incident so she could be done. She is the incident so she could be done. She is the incident so she could be done. She is the incident so she could be done. She is the incident so she could be done. She is the incident so she could be done. She is the incident so she could be done. She is the incident she was development of bowel are shares assistance for person indicated that she was development but that A review of the Press Assessment (CAA) review of the Pre	ducted with the 20/18 from 11:14 AM to d she expected all residents nity and respect and told this r when she started working 5/18. She further stated she be reported so follow-up ndicated staff were residents and it was a are was not given. She hould have been told about ould fix the problem. eadmitted to the facility on all admission on 01/10/17 gnoses: dementia without ee, generalized anxiety ning), Right hip infection, isease, (PVD), type 2 al infection of the skin and (onset 01/11/17), and major #1's Annual Minimum Data 8/18, indicated she had airment, she had behavioral ng herself, she was always and bladder and needed with 2 plus person physical ers, bed mobility, toileting, ince with 1-person physical al hygiene. The MDS also s at risk for pressure ulcer. ure Ulcer Care Area evealed Resident #1 was at	{F 6	577}			
	Assessment (CAA) re						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345307	B. WING				-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ĒR			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 PREFI TAG				(X5) COMPLETION DATE
{F 677}	was also admitted with breakdown primarily th had a history of chron also revealed she was scratches. A review of ADL Func- revealed Resident #1 dementia. The CAA fu- extensive assistance was able to assist with Resident #1 also nee bathing or showering. A review of the care p Pressure Ulcer Devel #1's self-inflicted scra revealed the following for potential for press to make sure fingerna and had no jagged ed treatments as ordered monitored for effective A review of Care Kard she was supposed to needed and the Dece nail care sheet indica documented. An observation of Resi bed via Hoyer Lift was 2:30 pm with a nurse present. Nurse #6 was assessment on the re- on both hands were of colored substance un	th positioning. Resident #1 h multiple areas of to her legs and buttocks and hic pruritis (itching). The CAA s prone to self-inflict tional/Potential CAA had a diagnosis of urther revealed she required with personal hygiene but h basic hygiene with setup). ded physical assistance with blan for the Potential for opment indicated Resident tches. The care plan also g interventions were in place ure ulcer development: staff alls were clean, trimmed, dges and staff to administer d and treatments were eness. dex for Resident #1 revealed get nail care daily and as ember 2018 bed baths and ted no nail care was sident #1 being assisted to s conducted on 12/17/18 at and nursing assistant	{F 6	577}			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/3 FORM APPR OMB NO. 0938	ROVED
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
		345307	B. WING		R-C 12/20/201	18
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	
MEADOW	WOOD NURSING CENTE	ER		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 PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPL E APPROPRIATE DA	K5) LETION ATE
{F 677}	Continued From page	e 57	{F 67]	7}		
	the second digit of the edge.	e right hand had a jagged				
	12/17/18 from 2:45 P stated that the reside nail care and NA's we when they give her a Resident #1 was gett Resident #1 did not re with Nurse #6 regard An observation and ir with the Treatment No PM to 1:35 PM. She change on Resident #	•				
	changed revealed Re hands were still dirty substance under her were ¼ inch in length second digit of the rig The Treatment Nurse dressing may come of the hall nurses and the dressing because the	sident during the dressing esident #1's nails on both with a brownish red colored fingernails and the nails and the fingernail on the ght hand had a jagged edge. e stated that because the off, she told the Na's to notify hey could change the e treatment order is as o stated that all nurses were				
	An interview was con 12/19/18 at 8:55 AM. do nail care on Resid done on day shift. An observation of Re 12/19/18 at 12:40 PM Resident #1's nails or with a brownish red c	a weekly skin assessment. ducted with NA #4 on She stated that she did not ent #1 because that was sident #1 was conducted on 1. During the observation, n both hands were still dirty colored substance under her ails were 1⁄4 inch in length				

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	-	D HUMAN SERVICES MEDICAID SERVICES			F	ITED: 01/31/2019 ORM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345307	B. WING			R-C 12/20/2018
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, Z		12/20/2010
			4	414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTE	:K	G	GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
{F 677}	Continued From page and the fingernail on thand had a jagged ed right hand in her mou An interview was com 12/19/18 at 12:45 PM should be done after looking at Resident # that the resident's nai then left the resident's nail care. A telephone interview DON on 12/19/18 1:5 expectation was that shower their nails sho checked daily to deter cleaned or trimmed a have been followed. An observation of Res Room was conducted Resident #1's nails or with a brownish red co fingernails and the na and the fingernail on th hand had a jagged ed An interview was com Administrator on 12/2 12:25 PM. The admin nails to be cleaned ev stated NAs should be have time to do this d	e 58 the second digit of the right lge and the resident put her th. ducted with NA #5 on . She stated that nail care Resident#1's shower. After 1's fingernail, NA #5 stated ls needed to be cut. NA #5 s room without performing was conducted with the 3 PM. She stated that her every time residents get a build be checked and rmine if they needed to be nd the care plan should sident #1 in the Activity on 12/20/18 at 10:35 AM. h both hands were still dirty olored substance under her ils were ¼ inch in length the second digit of the right lge. ducted with the 0/18 from 11:14 AM to istrator stated she expected rery day by NAs. She further able to do this and should	{F 677}			
	should have been dor	ther indicated that nail care ne consistent with the plan rator stated she expected				

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE	CONSTRUCTION			
ND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG		COMPLETED		
		345307	B. WING		R-C 12/20/2018			
NAME OF P	ROVIDER OR SUPPLIER	1		ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW	WOOD NURSING CENT	FR	4414 WILKINSON BLVD		14 WILKINSON BLVD			
			GASTONIA, NC 28056		ASTONIA, NC 28056			
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE		
{F 677}	Continued From page	e 59	{F 6	77}				
	care plans to be accu	urate and expected		1				
		llowed in terms of care						
F 604		or treatments or ADLs.	Г	204			1/18/19	
F 684 SS=D				684			1/10/19	
00-D								
	§ 483.25 Quality of c							
	-	Indamental principle that						
		nt and care provided to ed on the comprehensive						
	-	dent, the facility must ensure						
	that residents receive	e treatment and care in						
	-	essional standards of						
	care plan, and the res	nensive person-centered						
		F is not met as evidenced						
	by:							
		ons, record review, staff			1.Resident #1 wound care has been			
		cian interviews, the facility			provided consistently by the licensed			
	· ·	ments as scheduled and vas done consistent with			nurse.			
		1 of 1 sampled residents			2.In order to ensure other residents are			
		nd infection (Resident #1).			not affected by the alleged deficient			
					practice the wound care nurse s			
	The findings included	i:			schedule has been changed effective			
	Resident #1 was read	dmitted to the facility on			1/15/19 to Monday-Friday to complete daily coverage and all nurses have bee	n		
		nal admission on 01/10/17			informed that when the treatment nurse			
	with the following dia	gnoses: right hip wound			off they are to perform wound care in th	ie		
	infection, dementia w				wound care nurse absence.			
		zed anxiety disorder, pruritus			2 Education was provided to the average	a		
		ascular disease, (PVD), type ocal infection of the skin and			3.Education was provided to the nursing staff 1/16-1/18/19 by the Registered	y		
		(onset 01/11/17), and major			Nurse/Interim Director of Nursing			
	depressive disorder.	· · · · · · · · · · · · · · · · · · ·			regarding their role to provide treatmen	ts		
					in the event the wound nurse is not			
		#1's Annual Minimum Data /08/18, indicated she had			working. They were also educated 1/16-1/18/19 regarding wound care			

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		MEDICAID SERVICES			CONSTRUCTION		<u>D. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				· · ·	PLETED
				<u> </u>		R-C	
		345307	B. WING				/20/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				44	414 WILKINSON BLVD		
WEADOW	WOOD NURSING CENTE	EK		G	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 60	F 68	84			
		airment, she had behavioral		•.	procedures by the Registered		
		ng herself, she was always			Nurse/Interim Director of Nursing.		
	incontinent of bowel a			Newly hired nursing staff will be educated	ted		
		with 2 plus person physical			during subsequent orientation events.		
	assistance for transfe						
		ance with 1-person physical al hygiene. The MDS also			4.Monitoring to ensure compliance the Registered Nurse/Interim Director of		
		s at risk for pressure ulcer			Nursing will be responsible for this asp	ect	
		she had no pressure ulcer.			of the Plan of Correction.		
					The Registered Nurse will randomly ch	leck	
	A review of the Press				the compliance of Nurses providing	_	
		ssociated with the 01/08/18			consistent wound care according to MI		
	MDS revealed Reside	r incontinence and needed			orders- 5 residents per week x 4 week then 2 residents per week x 4 weeks.	KS,	
		oning. Resident #1 was also					
	admitted with multiple	-			The Plan of Correction will be reviewed	d at	
		and buttocks with a history of			the next scheduled Quality Assurance		
	chronic pruritis (itchin	ıg).			Performance Improvement Committee		
	A review of the Facilit	he Chin Condition Depend for			1/22/19. All Plan of Correction monthly		
		ty Skin Condition Record for Skin Conditions for Right Hip			audit data will be reported by each aud to subsequent monthly Quality Assurar		
		ed 11/24/18, indicated the			Performance Committee for review and		
		surements in centimeters			recommendations to continue the		
		n x 1.4 cm in width x 1.2 cm			achievement of compliance.		
	in depth and 8.1 cm ι	undermining at 12 o'clock.					
	A review of the Facilit	ty Skin Condition Record for					
		Skin Conditions for Right Hip					
		ed 12/05/18, indicated the					
	•	surements in centimeters					
		n x 1.2 cm in width x 0.8 cm undermining at 12 o'clock.					
	A review of Resident dated 12/05/18, revea	#1's Physician Orders, aled the following:					
	1. Cleanse Right hi	p with wound cleanser, pat ' soaked Kling gauze, and					
		essing every day and as					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		345307	B. WING				/20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	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 PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 684	 Cleanse Right hij cleanser, pat dry, app dry dressing every A review of the care p area to right hip or po development, dated 1 #1's pressure ulcer w and would remain free plan further indicated were in place for staff ordered and were mo dressing was monitor and adhering and star to the treatment nurse moisturizer applied to A review of the Facilit Non-Pressure Ulcer S Wound Infection, date following wound meas (cm): 5.1 cm in length in depth and 4.8 cm u (progress: improved). A review of the Decer Administration Record resident's Right hip di periwound dressing c done on the following 12/10/18; & 12/17/18. A review of Decembe following treatments f initialed as done the f 1. Apply zinc oxide day. (not initialed on 12/10/18; & 12/17/18) 	 p periwound with wound by Silvadene and cover with day and as needed. blan for the nonstageable tential for pressure ulcer 2/6/18, indicated Resident ould show signs of healing e from infection. The care the following interventions to administer treatments as nitored for effectiveness, ed to ensure it was intact ff to report loose dressings e, and the resident needed her skin. y Skin Condition Record for Skin Conditions for Right Hip ed 12/12/18, indicated the surements in centimeters a x 1.1 cm in width x 2.0 cm undermining at 3 o'clock mber 2018 Treatment d (TAR) revealed the ressing change and hange was not initialed as dates: 12/07/18; 12/08/18; r 2018 TAR revealed the or Resident #1 were not ollowing dates: to groin redness/area every 12/07/18; 12/08/18; 	F	684			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE	
		345307	B. WING				-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	414 WILKINSON BLVD		
	WOOD NURSING CENTE			G	GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	areas are healed initialed on 12/07/18; 12/15/18; 12/16/18; a 3. Eucerin Cream- Extremities twice daily 7am (not initialed on 4. Eucerin Unscent areas topically every (not initialed on 12/07 12/17/18) 5. Ketoconazole Sh once a week for itch of 12/07/18 and 12/14/1 6. Vitamin A+D oint Vit A&D - apply topica every day. (not initiale 12/10/18; & 12/17/18) An observation of Res bed via Hoyer Lift was 2:30 pm with Nurse # time of the transfer, N skin assessment on ti continuing observatio repositioning the resid change the dressing, undated. An interview with Nur 12/17/18 from 2:45 P stated that the facility Tuesdays, Wednesda the week and a treatr and Sundays every o no treatment nurse or Nurse #6 indicated th #1's right hip started of	ight on 3pm-11 pm until all and then as needed. (not 12/8/18; 12/11/18; 12/14/18; nd 12/17/18) apply to Bilateral Lower y for 7am-7 pm and 7pm to 12/10/18 for 7am to 7 pm) ed Cream- apply to affected day on upper extremities 7/18; 12/08/18; 12/10/18; & nampoo 2%- apply to scalp on 11 p-7p (not initialed on 8) ment for Desitin Clear with ally to buttocks and thighs ed on 12/07/18; 12/08/18;) sident #1 being assisted to s conducted on 12/17/18 at 6 and NA #5 present. At the lurse #6 was performing a he resident. During n of Nurse #6 and NA #5 dent, the nurse did not	F	684			

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		MEDICAID SERVICES				NO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED	
			A. BUILDING	;	R-C		
		345307	B. WING			2/20/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
				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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 684	Continued From page	- 63	Гсо				
1 004	Continued From page	e os cated the resident had	F 68	4			
		tion of tissue extending					
		so that the pressure ulcer					
		e than at the skin surface) of					
		a decubitus pressure ulcer.					
		e right hip wound treatment					
		be packed and covered with					
	a blue dry dressing.						
	An interview was con	ducted with the Treatment					
		8:52 AM. She stated that					
	she knew nothing abo	out Resident #1's right hip					
	-	; 11/24/18, which was the					
		und for the first time. She					
		e right hip wound had already					
		s draining and developed licated that she documented					
		ility doctor's book about					
	Resident #1's right hi						
		iated treatment to the right					
	-	stated that when she was					
		ments on residents were not					
		one because she would find hat she placed on residents					
		orked. She indicated that on					
		eted the treatments on all the					
		she went back to work on					
		ne checked Resident #1's					
		e foam was saturated with					
		e on it, and the wound was					
		d. She said the wound because Resident #1 had					
	undermining of the w						
	An observation and in	nterview were conducted					
		urse on 12/18/18 from 1:15					
		was performing a dressing					
		#1's right hip. She stated that					
	الممام المعربية بالمطافع مرمانين	tor first came to assess the					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	· · ·	IO. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			MPLETED
		345307	B. WING			R-C 2/20/2018
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			2/20/2010
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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	9 64	F 684			
	and he removed the of the wound which rever further stated that the decreased from 8 cer During continued obs sponge was still noted and the periwound (sl was not covered with areas of thick yellow a the dressing. Further was no odor noted fro wound itself. The Tread dry dressing she remen not have been there be not follow the physicial been changed daily. S Resident #1 never ref scratch her right hip a caused the dressing to wound. The Treatment the dressing may com- notify the hall nurses	I looked like a bad infection dead tissue off of the top of ealed the undermining. She undermining had ntimeters (cm) to 4 cm. ervation, the undated blue d on Resident #1's right hip kin surrounding the wound) a dressing and had 4 small adherent tissue surrounding observation indicated there on the old dressing or the atment Nurse stated that the oved from the wound should because it the dressing did an's order and it should have She further stated that fused care, but she did and around the wound which to hang loosely off the nt Nurse stated that because he off, she told the Na's to and they could change the treatment order was as				
c r r 4 1 c c s v v r ii	needed also. She also responsible for doing An interview was con 12/18/18 at 2:04 PM. change the dressing of She further stated that was not at the facility,	o stated that all nurses were a weekly skin assessment. ducted with Nurse #6 on She stated that she did not on 12/17/18 for Resident #1. it when the treatment nurse				
	indicated that she not	ified oncoming 3rd shift, 8 that a treatment had not				

Facility ID: 923314

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345307	B. WING				R-C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	ĒR			1414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 684	did not do the treatment 12/17/18 because she with only one NA. A phone interview wa on 12/19/18 at 10:07 12/08/18, she only pe on another resident, r A phone interview wa on 12/19/18 at 10:27 worked with Resident PM to 7:00 AM, and of treatments on Reside An interview was com Doctor on 12/19/18 at that when the regular working every day, th treatments being com stated he was not sur her skin caused the ir further stated that Res packing wet to moist of that the periwound de Care notes, dated 12/ insufficiency). He indi was ordered for the p key to successful wou the wound and that th be covering the woun A phone interview wa on 12/19/18 at 11:55 worked on 12/08/18 at done on Resident #1.	M. She indicated that she ents on Resident #1 on e was working by herself s conducted with Nurse #4 AM. She indicated that on enformed a dressing change not Resident #1. s conducted with Nurse #7 AM. She stated that she : #1 on 12/17/18, from 11:00 did not perform any nt #1. ducted with the Wound t 11:14 AM. He indicated treatment nurse was not ere was an issue with upleted as ordered. He e if Resident #1 scratching nfection of her right hip. He sident #1 needed wound dressings once a day and eteriorated (per the Wound '12/18, due to venous cated that the Silvadene eriwound abrasion and the and healing was to protect he dressing was supposed to d. s conducted with Nurse #2 AM. She stated that she and no treatments were She further stated that on anged another resident's	F	684			

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	-	ND HUMAN SERVICES			PRINTED: 01/31/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345307	B. WING		R-C 12/20/2018
NAME OF PR	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 12/20/2010
MEADOW	WOOD NURSING CENT	ER		14 WILKINSON BLVD ASTONIA, NC 28056	
	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETIO
F 684	Continued From pag	e 66	F 684		
	DON on 12/19/18 1:5 expectation was that followed, and treatme scheduled.				
{F 686}	An interview was conducted with the Administrator on 12/20/18 from 11:14 AM to 12:25 PM. The administrator indicated that she expected treatments to be done consistent with the physician orders. She further indicated she was not aware treatments were not being done as scheduled but expected all orders to be followed for type of treatment and schedule set for treatments. Treatment/Svcs to Prevent/Heal Pressure Ulcer		{F 686}		1/18/19
SS=D	resident, the facility r (i) A resident receive professional standard pressure ulcers and o ulcers unless the ind demonstrates that the (ii) A resident with pro- necessary treatment with professional stat promote healing, pre- new ulcers from deve This REQUIREMENT by:	grity ure ulcers. ehensive assessment of a nust ensure that- s care, consistent with ds of practice, to prevent does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to vent infection and prevent eloping. T is not met as evidenced		1 Desident # 11 and #7 have received	
	Wound Physician, He	ons, record review and ospice Nurse and staff y failed to initiate pressure		1.Resident # 11 and #7 have received wound care as ordered by the licensed nurse.	

Event ID: BK8H12

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		MEDICAID SERVICES			OMB NO. 09	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURV COMPLETE	
			A. BUILDING	i		-
		345307	B. WING		R-C	
		545507	B. WING		12/20/2	018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	ER		4414 WILKINSON BLVD		
	I			GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y 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 COM	(X5) MPLETIO DATE
{F 686}	Continued From page	e 67	{F 686	5}		
		days to a resident admitted				
		(Resident #11) and failed to		2.In order to ensure other resident	s are	
		lcer treatment as ordered		not affected by the alleged deficient		
		days (Resident #7) for 2 of 3		practice the wound care nurse s		
	residents reviewed for	or pressure ulcers.		has been changed effective 1/15/	19 to	
				Monday-Friday to complete daily of	-	
	The findings included	d:		and all nurses have been informed		
				when the treatment nurse is off the		
		readmitted to the facility on		perform wound care in the wound	care	
	-	ses which included urinary		nurse absence.		
	sacral region, right he	ntia, and pressure ulcer to				
	Sacial region, right ne	eer, and fight hip.		3.Education was provided to the n	ureing	
	A review of the most	recent comprehensive		staff by the Registered Nurse/Inte		
		MDS) assessment dated		Director of Nursing 1/16-1/18/19 re		
		esident #11 was cognitively		their role to provide treatments in		
	impaired and was co			event the wound nurse is not work		
	-	e ulcer on his heel that was		They were also educated 1/16-1/1	0	
	not present on prior a			regarding wound care procedures		
				order to correct nurses not clarifyin	ng and	
	A review of Care Area	a Assessment (CAA) for		implementing treatment orders, tw	o	
		09/09/18 indicated Resident		nurses must sign off that the treat	ment	
	-	e injury (DTI) to right heel		orders have been clarified and		
	with treatment in place	ce.		implemented with each new or rea		
				resident whom requires wound ca	re, this	
		plan with an initiation date of		will be an on-going process.		
		identified problem that		Nowly bired purging stoff will be a	ducated	
	development related	tential for pressure ulcer		Newly hired nursing staff will be ed during subsequent orientation eve		
		d a stage II pressure ulcer on		during subsequent orientation eve	11.5.	
	his coccyx and left hi			4.The Registered Nurse Supervise	or and	
		right heel. The goal was		or Interim Director of Nursing will b		
		be free from any further		responsible for this aspect of the F		
		opment. Interventions to		Correction.		
		re as follows: Staff were to		The Registered Nurse Supervisor	and or	
		s as ordered and monitor for		Interim/Director of Nursing will ran		
	effectiveness. Staff w			check the compliance of Nurses p	-	
		port as needed any changes		consistent wound care according t		
	in skin status (appea	rance, color, wound healing,		orders- 5 residents per week x 4	weeks.	

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		0. 0938-039 E SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED	
		345307	B. WING	ING		R-C	
	ROVIDER OR SUPPLIER	345307		STREET ADDRESS, CITY, STATE, ZIP CODE	12/20/2018		
	NOWDER ON SOLVER			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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
{F 686}	Continued From page	e 68	{F 686	}			
	10		(then 2 residents per week x 4 wee	eks.		
	 signs and symptoms of infection, wound size, and stage). A review of a wound physician's note dated 11/29/18 indicated Resident #11 had an unstageable pressure ulcer to coccyx, right hip, right heel, and right medial ankle. A review of MDS dated 11/30/18 indicated Resident #11 had unplanned discharge to the hospital with return anticipated. A review of hospital wound discharge sheet dated 12/07/18 indicated Resident #11 had pressure ulcer to left and right heel, right medial ankle, sacrum, right hip, and left knee and was to receive foam dressing to left heel and apply Santyl (debridement ointment and foam dressing to right medial ankle, sacrum, and right hip, and apply ¼ strength Dakin's solution (a solution used to kill germs and prevent germ growth in wounds) and Santyl to right heel. The treatment was to begin or how often wound treatment was to be administered. 			The Plan of Correction will be revi the next scheduled Quality Assura Performance Improvement Comm 1/22/19. All Plan of Correction mo audit data will be reported by each to subsequent monthly Quality Ass Performance Committee for review two months if concerns are identif QA Committee will continue to rev another three months in order to p addition recommendations to assi maintaining compliance.	ince ittee nthly a auditor surance v for ied the iew rovide		
	(ANA) dated 12/07/18 a pressure ulcer to be	ssion Nursing Assessment 8 revealed Resident #11 had uttock, right and left heel, nd left knee which were not					
	12/31/18 indicated th orders prescribed to the orders of the orders are serviced to the order of	d (MAR) dated 12/07/18 to ere were no medication treat areas on his left and al ankle, sacrum, right hip,					

Facility ID: 923314

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	through 12/10/18 india and left heel, sacrum, ankle were not compl documentation on the been set up for areas right medial ankle, sa left knee for 12/08/18 review of the TAR fron 12/31/18 indicated tree by the wound physicia transcribed to the TAF completed. On 12/18/18 at 8:34 A conducted with the was stated she worked 3 of unsure when she was #11's pressure ulcers stated it was the resp nurse to provide woun not on duty. The WN readmitted to the facil 12/07/18. The WN sta work on 12/11/18 and dressings on his pres saw no indication that provided on 12/08/18 the floor duty nurse. T came on duty 12/11/1 wound treatment orde admission. The WN s indicate via nursing du treatment had been p 12/08/18, 12/09/18, a	11's Treatment d (TAR) from 12/07/18 cated treatment to the right right hip, and right medial eted per nurse TAR. No treatment had on his left and right heel, crum, right hip, buttock, and to 12/10/18. A further m 12/12/18 through eatment orders were written an on 12/12/18 were R and were documented as M an interview was ound nurse (WN) who days a week and was a not working if Resident were treated. The WN onsibility of the floor duty nd treatment when she was stated Resident #11 was ity from the hospital on ated she returned back to I Resident #11 had hospital sure ulcer wounds and she t wound treatment had been , 12/09/18, and 12/10/18 by The WN stated when she 8 Resident #11 had no ers from the 12/07/18 tated the TAR did not ocumentation that wound rovided to Resident #11 on nd 12/10/18. The wound ormed wound treatment for	{F 686}				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTI		(X3) DATE COMF	SURVEY PLETED	
		345307	B. WING				-C 20/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE			
MEADOW	WOOD NURSING CENTE	R			KINSON BLVD IIA, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ACTION SHOULD BE COMPI D TO THE APPROPRIATE DA		
{F 686}	On 12/18/18 at 1:10 F was conducted with N worked 7:00 PM to 7: was admitted to the fa stated she was aware wounds. Nurse #1 sta shift that night and sh to clarify Resident #1 from the hospital disc not had time to review discharge orders to d clarify the wound orde On 12/8/18 at 2:33 PI conducted with Nurse shift on 12/07/18 and head to toe admission noted he had several not have time to comp paperwork and had n clarify wound treatmen Nurse #2 stated she i Nurse #1 that she had admission paper work #1 that she had not cl orders with the facility the process on admiss clarify wound treatmen if the orders were not On 12/18/18 at 2:44 F was conducted with N was scheduled to be 12/08/18 and 12/09/1 administer medication not clarified with the f	PM a telephone interview Jurse #1 who stated she 00 AM when Resident #11 acility on 12/07/18. She e that Resident #11 had ated it had been a very busy e did not call the physician 1 's wound treatment orders harge. She stated she had w the hospital wound etermine if she needed to ers with the facility physician. M a telephone interview was e #2 who worked the day completed Resident #11's in nursing assessment and wounds. She stated she did blete his admission ot called the physician to nt orders for Resident #11. nformed the oncoming d not finished Resident #11's is but did not informed Nurse arified wound treatment of physician. Nurse #2 stated sion was that staff were to nt orders with the physician	{F 6	86}				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345307	B. WING				R-C 2/ 20/2018	
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 DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	CTIVE ACTION SHOULD BE COMP NCED TO THE APPROPRIATE D		
{F 686}	treatment orders for F clarified with the facili On 12/18/18 at 2:55 F conducted with Nurse working day shift whe admitted to the facility Nurse #2 with clarifyin with the physician for stated she had not cla orders for Resident # unaware that Resider #4 stated she had not nurse that the wound Resident #11 had not facility physician. Nur wound nurse was res orders with the facility On 12/18/18 at 2:17 F conducted with the Di who stated the admitt to clarify wound treating physician and transcr onto the TAR. The DC admitting nurse's resp to toe resident assess document any wound wound treatment orders document orders with have transcribed trea #11's TAR or would ho oncoming nurse if she wound treatment orders for Resident #11. The	was unaware that wound Resident #11 had not been ty physician. PM an interview was #4 who stated she was in Resident #11 was of on 12/07/18 and helped ing pain medication orders Resident #11. Nurse #4 arified wound treatment 11. Nurse #4 stated she was in #11 had wounds. Nurse tinformed the oncoming treatment orders for been clarified with the se #4 stated she thought the ponsible to clarify wound of physician. PM an interview was frector of Nursing (DON) ing nurse was responsible ment orders with the facility ibe wound treatment orders DN stated it was the ponsibility to provide a head sment on admission and s and skin issues and obtain per from the physician. The	{F 6	586				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345307	B. WING		_		-C 20/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		20/2010
_				414 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	(EACH CORREC CROSS-REFEREN	ROVIDER'S PLAN OF CORRECTION (X: CH CORRECTIVE ACTION SHOULD BE COMPL S-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG {F 686}	Continued From page provided wound treat 12/8/18, 12/09/18, an it was her expectation on duty then the floor wound care for Resid On 12/18/18 at 4:07 F was conducted with th stated he had not rec staff on 12/07/18 to cl orders for Resident # staff would have called orders and not the nu physician stated it wa would have called hin with admission wound Resident #11. The ph expectation that Resid received wound treats and 12/10/18 because tough wounds. The ph expectation that wour performed daily and co wound care to the wo On 12/18/18 at 4:34 at conducted with the wo	e 72 ment for Resident #11 on d 12/10/18. The DON stated of the wound nurse was not duty nurse would provide ent #11. PM a telephone interview he facility physician who eived a call from the facility darify wound treatment 11. The physician stated of him to clarify wound rse practitioner. The s his expectation that staff in to clarify any questions d treatment orders for ysician stated it was his dent #11 would have ment on 12/08/18, 12/09/18, e Resident #11 had some hysician stated it was his nd care would have been deferred Resident #11's	TAG {F 686}			ATE	DATE
	sheet for 12/07/18 that dressing applied to hi medial ankle, coccyx, felt the dressings did daily. The wound phy dressing could stay in without being change stated he could not de occurred because Re	at Resident #11 had a foam s pressure ulcer on the right right hip, and left heel and not need to be changed sician stated a foam a place for 3 to 5 days d. The wound physician etermine if any harm sident #11's wound een provided on 12/08/18,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			LETED
		345307	B. WING				-C 20/2018
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	20/2010
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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	Continued From page	973	{F 6	686	}		
	expectation was that have verified wound t facility physician and the TAR. The Adminis expectation was that received wound treatr and 12/10/18. On 12/19/18 at 11:08 conducted with the wi stated he felt that the wound treatment orded discharge physician of admission 12/07/18 for	dministrator who stated her the admitting nurse would reatment orders with the transcribed the orders onto strator stated her Resident #11 would have ment on 12/08/18, 12/09/18, an additional interview was ith the wound physician who nurse should have clarified ers with the hospital					
	dementia, kyphosis (e	ted to the facility on e diagnoses that included excessive outward curvature ated osteoporosis, and					
	Resident #7 read in p protecting skin) to bila	n's order dated 08/30/18 for art, "skin prep (forms a film ateral top of foot and protect vice weekly and as needed."					
	Set (MDS) dated 10/2 was moderately impa making and displayed	no rejection of care during t period. Further review of					

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DEFICIENCIES ORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUC	TION		D. 0938-0391
		A. BUILDI	NG			E SURVEY PLETED
	345307	B. WING_				R-C / 20/2018
VIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STATE, ZIP CODE		
OOD NURSING CENTE	R		4414 WILKINS GASTONIA.			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		EACH CORRECTIVE ACTION SHOUL) BE	(X5) COMPLETION DATE
extensive assistance	with activities of daily living	(F 6	86}			
10/25/18, revealed Re or pressure ulcer dev assistance with mobili decreased oral intake ree from any signs or related to altered skin ncluded for staff to ac	esident #7 had the potential velopment related to needing ity, incontinence and with the goal she would be r symptoms of infections integrity. The interventions dminister treatments as					
Resident #7 read in p ankle with wound clea Polymen Dressing (ty a mild cleaning agent	art, "cleanse right outer anser, pat dry, apply pe of dressing that contains activated by moisture and					
Administration Record for Resident #7's right to be completed on M Friday during the hour There were no initials reatment to Resident completed on the sch 12/07/18, 12/10/18 or the TAR revealed no i reatment for Residen completed on 12/17/1	d (TAR) revealed treatment t outer ankle was scheduled londay, Wednesday and rs of 7:00 AM to 3:00 PM. on the TAR indicating the #7's right outer ankle was eduled days of 12/03/18, 12/17/18. Further review of initials indicating the t #7's top of foot was 8.					
	SUMMARY STJ (EACH DEFICIENC' REGULATORY OR L Continued From page extensive assistance and had 2 unhealed p Review of a care plan 0/25/18, revealed Re or pressure ulcer dev assistance with mobil decreased oral intake ree from any signs of elated to altered skin included for staff to ad ordered and monitor f Review of a physiciar Resident #7 read in p inkle with wound clea Polymen Dressing (ty mild cleaning agent yradually released int veek." Review of the Decem doministration Record or Resident #7's right o be completed on M friday during the hou here were no initials reatment to Resident 2/07/18, 12/10/18 or ne TAR revealed no in reatment for Resident completed on 12/17/1	DOD NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 extensive assistance with activities of daily living ind had 2 unhealed pressure ulcers. Review of a care plan, with a revised date of 0/25/18, revealed Resident #7 had the potential or pressure ulcer development related to needing visistance with mobility, incontinence and lecreased oral intake with the goal she would be ree from any signs or symptoms of infections elated to altered skin integrity. The interventions neluded for staff to administer treatments as indered and monitor for effectiveness. Review of a physician's order dated 11/28/18 for Resident #7 read in part, "cleanse right outer inkle with wound cleanser, pat dry, apply Polymen Dressing (type of dressing that contains in mild cleaning agent activated by moisture and iradually released into the wound area) 3 times a week." Review of the December 2018 Treatment doministration Record (TAR) revealed treatment or Resident #7's right outer ankle was scheduled be completed on Monday, Wednesday and riday during the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the reatment to Resident #7's top of foot was completed on 12/17/18. Further review of ne TAR revealed no initials indicating the reatment for Resident #7's top of foot was completed on 12/17/18.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFD TAG Continued From page 74 {F 6i extensive assistance with activities of daily living and had 2 unhealed pressure ulcers. {F 6i Review of a care plan, with a revised date of 0/25/18, revealed Resident #7 had the potential or pressure ulcer development related to needing ussistance with mobility, incontinence and lecreased oral intake with the goal she would be ree from any signs or symptoms of infections elated to altered skin integrity. The interventions neluded for staff to administer treatments as urdered and monitor for effectiveness. Review of a physician's order dated 11/28/18 for Resident #7 read in part, "cleanse right outer inkle with wound cleanser, pat dry, apply Polymen Dressing (type of dressing that contains in mid cleaning agent activated by moisture and irradually released into the wound area) 3 times a week." Review of the December 2018 Treatment doministration Record (TAR) revealed treatment or Resident #7's right outer ankle was scheduled to be completed on Monday, Wednesday and friday during the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the reatment to Resident #7's right outer ankle was completed on the scheduled days of 12/03/18, 2/07/18, 12/10/18 or 12/17/18. Further review of ne TAR revealed no initials indicating the reatment for Resident #7's top of foot was completed on 12/17/18.	CASTONIA. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ID OT CONTINUED FROM PAGE 74 ID PREFIX TAG ID OT CONTINUED FROM PAGE 74 (F 686) Continued From page 74 (F 686) (F 686) (F 686) Continued From page 74 (F 686) (F 686) Evelow of a care plan, with a revised date of 0/25/18, revealed Resident #7 had the potential or pressure ulcer development related to needing issistance with mobility, incontinence and lecreased oral intake with the goal she would be ree from any signs or symptoms of infections lelated to altered skin integrity. The interventions neluded for staff to administer treatments as inderded and monitor for effectiveness. ID Review of a physician's order dated 11/28/18 for Resident #7 read in part, "cleanse right outer inkle with wound cleanser, pat dry, apply 'olymen Dressing (type of dressing that contains in mid cleaning agent activated by moisture and iradually released into the wound area) 3 times a week." ID Review of the December 2018 Treatment vor Resident #7's right outer ankle was scheduled to be completed on Monday, Wednesday and riday during the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the reatment to Resident #7's right outer ankle was completed on the scheduled days of 12/03/18, 2/07/18, 12/10/18 or 12/17/18. Further review of the TAR revealed no initials indicating the reatment for Resident #7's top of foot was completed on 12/17/18.	GASTONIA, NC 20050 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS IN AN OF CORRECTING (EACH CORRECTING ACTION SHOULD CROSS-REFERENCE OF CONSTRUCTION SHOULD CROSS-REFERENCE OF CONSTRUCTION CROSS-REFERENCE OF CONSTRUCTION DEFICIENCY) Continued From page 74 xtensive assistance with activities of daily living and had 2 unhealed pressure ulcers. (F 686) Review of a care plan, with a revised date of 0/25/18, revealed Resident #7 had the potential or pressure ulcer development related to needing sistance with mobility, incontinence and lecreased oral intake with the goal she would be ree from any signs or symptoms of infections related to altered skin integrity. The interventions ncluded for staff to administer treatments as rdered and monitor for effectiveness. Review of a physician's order dated 11/28/18 for tesident #7 read in part, "cleanse right outer nikle with wound cleanser, pat dry, apply 'obymen Dressing (type of dressing that contains mild cleaning agent activated by moisture and radually released into the wound area) 3 times a veek." Review of the December 2018 Treatment or Resident #7's right outer ankle was completed on Monday, Wednesday and right dy ulting the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the reatment for Resident #7's top of foot was ompleted on 12/17/18.	CASTONIA, NC 28056 ID REALH DEFICIENCY MUST BE PRECEDED BY FULL REDULATORY OR LSC IDENTIFYING INFORMATION) ID PRETIX TAG PRETIX PRETIX TAG PRETIX REDULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 74 xtensive assistance with activities of daily living ind had 2 unhealed pressure ulcers. (F 686) Continued From page 74 xtensive assistance with activities of daily living ind had 2 unhealed pressure ulcers. (F 686) Review of a care plan, with a revised date of or pressure ulcer development related to needing ssistance with mobility, incontineene and lecreased oral intake with the goal she would be ree from any signs or symptoms of infections elated to altered skin integrity. The interventions included for staff to administer treatments as rdered and monitor for effectiveness. Review of a physician's order dated 11/28/18 for Veytown Dressing (type of dressing that contains in mild cleaning agent activated by moisture and radually released into the wound area) 3 times a veek." Review of the December 2018 Treatment drinistration Record (TAR) revealed treatment or Resident #7's right outer ankle was completed on Monday, Wednesday and rinday duing the hours of 7:00 AM to 3:00 PM. There were no initials on the TAR indicating the reatment to Resident #7's tip of outer ankle was completed on 12/17/18. Further review of the TAR revealed no initials indicating the reatment for Resident #7's tip of otor was completed on 12/17/18.

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) TAU	10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		· · ·	MPLETED
						R-C
		345307	B. WING		1	2/20/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTI	EK		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
{F 686}	Continued From page	2 75	{F 686}			
(i 000)						
	Wound Nurse (WN) e	leting wound treatments for				
		s she worked, which were				
		ays and Thursdays each				
		irses were responsible for				
		eatments the remaining days.				
	The WN recalled cha	nging the dressing on				
	Resident #7's right ou	uter ankle on 12/05/18 with				
the next dressing cha	anges scheduled on 12/07/18					
		tated when she returned to				
		e dressing in place was				
		ner initials, smelled and was				
		d. The WN confirmed she				
		3/18, 12/07/18 or 12/10/18 or ngoing issue that wound				
		being completed by the hall				
		he was not scheduled to				
		e completed treatments on				
		if she noticed they were not				
		es on the day scheduled.				
	An observation was r	nade of Resident #7's				
		/18 at 10:40 AM. The WN				
		nd as she was removing the				
		top of Resident #7's left foot				
	-	ng that was in place was				
		he wrong treatment. The				
		2/17/18 and initialed by				
		on top of Resident #7's left				
		o redness or inflammation				
		icated the treatment ordered				
		I the dressing would be				
		e area. The WN washed				
		e removed the bunny boot				
		rom Resident #7's right foot,				
	the second secon					
		g covering the right outer was exposed to air. The				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345307	B. WING				R-C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	ĒR			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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
{F 686}	slough (dead tissue) wound bed was a dar cleaned the ankle wit	e 76 and the skin surrounding the k reddish color. The WN h wound cleanser, patted lied Polymen dressing as	{F 6	686	}}		
	PM, Nurse #1 confirm nurse on 12/07/18 an treatment to Residen explained she was ne wound treatments an	•					
	Nurse #4 confirmed s to provide care to Re- Nurse #4 stated she treatment to Residen any other resident as never trained to provi explained the facility the treatments for all	n 12/18/18 at 3:00 PM, she was the nurse assigned sident #7 on 12/03/18. did not complete the wound t #7's right outer ankle or signed because she was de wound care. Nurse #4 had a WN who completed residents and was never to complete the treatments t scheduled.					
	PM, Nurse #5 confirm treatment to Resident she must have forgot completed. Nurse #5 (HN) was present dur	terview on 12/18/18 at 3:31 ned she provided wound t #7 on 12/17/18 and stated ten to initial the TAR when added the Hospice Nurse ring the wound treatment. he put a 4 inch (in) by 4 in					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345307	B. WING				20/2018
NAME OF P	ROVIDER OR SUPPLIER	l		5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MEADOW	WOOD NURSING CENT	ER			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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	bandage on the top of applied Tegaderm (tra cover and protect wo to her right outer ankl reviewed the TAR prive was unable to explain on Resident #7's righ wrong dressing was a foot.	f Resident #7's left foot and ansparent dressing used to und) and Polymen dressing le. Nurse #5 added she or to providing treatment and n why there was no dressing t outer ankle or why the applied to the top of her left	{F 6	86}	}		
	PM, the HN confirme Nurse #5 provided we #7 on 12/17/18. The observed the treatme ulcer on Resident #7' not familiar with the tr of her foot. She state wound treatment orde and a non-adhesive F Resident #7's right ou out of the adhesive P	uter ankle since Hospice was olymen dressing they added it was possible the					
	Wound Physician (W been providing wound past 3 weeks and wa was an issue with wo completed as ordered a resident was on Ho dressing changes to a discomfort. The WP Resident #7's wound	n 12/19/18 at 11:14 AM, the P) indicated he had only d care at the facility for the s not able to confirm if there und treatments not being d or scheduled. He added if spice he tried to limit the avoid causing them stated when he treated earlier that morning, it t with no signs of infection					

Facility ID: 923314

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345307	B. WING _				-0 20/2018
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R			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 PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 686}	dressing should have wound not left expose During a telephone in PM the Director of Nu nursing staff were info providing wound treat description. The DON the hall nurses to com ordered and schedule absent. During a telephone in AM, Nurse #2 confirm assigned to provide c 12/10/18. Nurse #2 s the wound treatment ankle because she re and the HN provided During an interview of Administrator was una were not being compl when the WN was no stated she was aware the building and felt th	 made to the current by Hospice. He was vas not observed on on 12/18/18 and stated a been applied and the ed. terview on 12/19/18 at 2:03 ursing (DON) explained ormed upon hire that ment was a part of their job N stated she would expect aplete wound treatments as ed when the WN was terview on 12/20/18 at 9:41 hed she was the nurse are to Resident #7 on tated she did not complete to Resident #7's right outer ceived Hospice services wound care. n 12/20/18 at 11:14 AM, the aware wound treatments eted by the hall nurses t scheduled to work. She e of all the training needs in the nurses needed more 	{F 6	86}			
{F 725}	expectation wound tre	e. She added it was her eatments were completed as stent with the physician ff	{F 7	25}			1/18/19

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/31/2019 MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	СОМ	E SURVEY PLETED
		345307	B. WING			२-C 2/ 20/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MEADOW	WOOD NURSING CENTI	ER		4414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
{F 725}	Continued From page	e 79	{F 72	5}		
SS=G	CFR(s): 483.35(a)(1)					
	the appropriate comp provide nursing and r resident safety and a practicable physical, well-being of each re- resident assessments and considering the r diagnoses of the facil accordance with the at §483.70(e). §483.35(a)(1) The fac by sufficient numbers types of personnel or nursing care to all re- resident care plans: (i) Except when waive this section, licensed	e sufficient nursing staff with vetencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care number, acuity and ity's resident population in facility assessment required cility must provide services s of each of the following n a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not				
	designate a licensed nurse on each tour of This REQUIREMENT by: Based on observatio	section, the facility must nurse to serve as a charge		1.Efforts continue in hiring pro-		
	failed to provide suffice residents received pre- treatments and assist nail care. This affect	cient nursing staff to ensure essure ulcer and wound tance with incontinence and ed 4 of 12 sampled #1, #7, #11, and #13). Staff		 A Human Resource Director statemployment 1/7/19. 2. In order to ensure that none residents are affected by allege practice The Human resource I 	of e deficient	

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					OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A BOILDING		R-C
		345307	B. WING	12/20/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
MEADOW	WOOD NURSING CENT	ER		4414 WILKINSON BLVD GASTONIA, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLET
(5.725)		- 00	(5.30	_	
{F 725}			{F 72		
		nearly an 8-hour time span resident lying in a large		was hired on 1/07/19 to assist the Administrator with the screening a	
	amount of urine and	, , ,		hiring process. The effort to hire h	
				began 12/01/2018 for C.N.A's, Nu	
				and Primary Department heads d	
	Findings included:			employees having to be held acco	
				and responsible to perform the du	
	This tag is cross-refe	erenced to:		tasks that they were hired for and had begin to quit without notice.	uley
	1 a. E 550: Based of	n observations, record		The Human Resource Director a Administrator have continued to c	-
		dent interviews, the facility		interviews twice a week and orier	
		sident with dignity by leaving		once a week in order to continue	
	the resident lying in a	a large amount of urine and		of hiring. The Human Resource D	virector
		to 8:30 AM on 12/16/18 for 1		has begin to network with college	
		dent on staff for incontinence		obtain graduate nurses and nursi	•
	care (Resident #13).			assistants, advertisement is poste updated weekly on in-deed for Nu	
				a D.O.N with a sign on incentive i	
	b. F-600: Based on o	observations, record review,		Because of this process we have	
		erviews, wound physician		C.N.A's two of which are C.N.A/	
		ce nurse interview, the facility		Med-Techs, 1 RN MDS nurse, an	
		knowledge a resident's call vide incontinence care for 8		Current staff that has been with the are given a training incentive to tr	-
	-	rom 12:41 AM to 8:30 AM for		staff to the daily routines. When a	
	1 of 5 residents depe			shift is picked up the employees r	
	-	esident #13); failed to		their paid over-time incentive.	
		s scheduled and ensure			
		e consistent with physician pled residents reviewed with		3. Education-Staff have been pro	vided
		esident #1); and failed to		in-service on 1-10-19 regarding h	
	-	lcer treatment as ordered		offs affects the facility residents a	
	and scheduled for 3 of	days (Resident #7) for 1 of 3		peers and how the facility can hel	p to
	residents reviewed for	or pressure ulcers.		ensure the decrease of turn-over	
				call-offs. All employees and new l	
	C F-677 Based on (observations, record review,		re-educated and educated to facil policies regarding call-offs.	ity
		terviews, the facility failed to			

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STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		R-C 12/20/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/20/2010	
MEADOW	WOOD NURSING CENTE	ĒR		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC	
{F 725}	provide toileting assis residents reviewed fo (ADL) care (Resident nail care for 2 of 5 de for ADL care (Resident d. F-684: Based on c staff interviews and p facility failed to provid and ensure wound ca physician orders for 1 reviewed with a wour e. F-686: Based on and Wound Physiciar interviews, the facility ulcer treatment for 3 d with pressure ulcers (complete pressure ulcers (puring an interview o Nurse #6 revealed sh working as a hall nurs morning. Nurse #6 e to work the 7:00 AM the PM to 7:00 AM shift of nurse wouldn't take th cart because she did	stance for 2 of 5 dependent or Activities of Daily Living (#13) and failed to provide pendent residents reviewed int #1). bbservations, record review, hysician interviews, the le treatments as scheduled are was done consistent with of 1 sampled resident and infection (Resident #1). observations, record review n, Hospice Nurse and staff or failed to initiate pressure days to a resident admitted (Resident #11) and failed to cer treatment as ordered days (Resident #7) for 2 of 3	{F 725}	 4.Monitoring in order to ensure compliance by reviewing daily staff sheets in daily stand up meeting x weeks and Monthly there after by th Administrator and Department head staffing needs are Identified the Lec C.N.A, Licensed Nurse and or Administrator will be responsible fo covering shifts and the Administrato or Licensed nurse will be responsible scheduling staff. This will be a on g process. The Plan of Correction will be reviee the next scheduled Quality Assurar Performance Improvement Commit 1/22/19. All Plan of Correction mon audit data will be reported by each to subsequent monthly Quality Assi Performance Committee for review recommendations given to help to of the staffing compliance. 	4 he ds. If ad r or and ble for ioing wed at nce ttee thly auditor urance and	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345307	B. WING				₹-C / 20/2018
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	ĒR			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 725}	Continued From page	82	{F 7	25]	}		
	Nurse Aide (NA) #6 c only one NA worked t shift to provide reside She recalled being th evening of 12/18/18. short-staffed, it was d provided such as early	n 12/18/18 at 12:30 AM onfirmed there were times he 11:00 PM to 7:00 AM nt care due to staff call-outs. e only NA working the She added when ifficult to get resident care y morning showers and out of bed and ready for					
	Nurse #9 stated they lot lately", sometimes one NA for the entire explained it was diffic care provided when v getting residents up of day or showered and	n 12/18/18 at 6:40 AM had worked short-staffed "a with only one nurse and building. Nurse #9 ult for staff to get resident working short, such as but of bed and ready for the when working short, their ep the residents safe and					
	Administrator stated s Nursing, who was no responsible for the so explained the number was based on the cur of the residents in the current census, her g scheduled to work on PM and 3:00 PM to 1 scheduled to work the The Administrator sta employment on 11/26	n 12/20/18 at 11:14 AM, the she and the Director of longer employed, were both heduling of staff. She r of staff scheduled per day rent census and acuity level building. She added at the oal was to have 4 NAs both the 7:00 AM to 3:00 1:00 PM shifts and 3 NAs e 11:00 PM to 7:00 AM shift. ted since starting her i/18 one of the issues she ot giving sufficient notice					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345307	B. WING			/20/2018
	ROVIDER OR SUPPLIER	R		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 CORRECT	LD BE	(X5) COMPLETION DATE
{F 725} F 732 SS=B	when they called out difficult to find replace the facility being shor confirmed Nurse #6 w a hall nurse on 12/18 explained it happened although it was an un had agreed to stay. So on filling open position remained ongoing. Posted Nurse Staffing CFR(s): 483.35(g)(1) §483.35(g) Nurse Staf §483.35(g)(1) Data re- must post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number by the following catego unlicensed nursing st resident care per shift (A) Registered nurses (B) Licensed practica vocational nurses (as (C) Certified nurse aid (iv) Resident census. §483.35(g)(2) Posting (i) The facility must post specified in paragraph daily basis at the beg (ii) Data must be post (A) Clear and readab	of work which made it ements and contributed to t-staffed. The Administrator vorked 24 hours straight as (18 to 12/19/18. She d due to staff call outs and fortunate situation, Nurse #6 She added she has focused hs and the hiring process a Information (4) ffing Information. equirements. The facility information on a daily and the actual hours worked pories of licensed and aff directly responsible for t: 	{F 72			1/18/19

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/31/20 FORM APPROV OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED R-C	
		345307	B. WING		12/20/2018	
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
MEADOW	WOOD NURSING CENTI	ER		414 WILKINSON BLVD 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC	
F 732	§483.35(g)(3) Public staffing data. The fac written request, make available to the public exceed the communi §483.35(g)(4) Facility requirements. The fa posted daily nurse sta 18 months, or as requis greater. This REQUIREMENT by: Based on observation facility failed to post of information for the fac	access to posted nurse cility must, upon oral or e nurse staffing data c for review at a cost not to ty standard. data retention acility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced ons and staff interview, the daily nurse staffing cility on 4 out of 4 days complaint investigation	F 732	 No residents were identified been affected. Mandatory postings have been as of 12/21/19. Mandatory posting will be the responsibility of the Interim Dir Nursing,the Registered Nurse, Administrator. 	compliant e ector of	
	a clipboard hanging on nurses' station with a titled "Daily Staffing For Observations conductions cond	2/17/18 at 11:28 AM revealed on the wall across from the n undated and blank sheet Report." eted on 12/18/18 at 11:15 AM d an undated and blank daily		 Nursing Staff have received regarding Posting of the Nursin of 01/08/2019. The Administrator will be res for this aspect of the Plan of Co The Administrator and/or the H Resource Director will audit for 	g staff as ponsible prrection. uman	
	AM, 9:50 AM and 4:1 and blank daily staffir revealed underneath	eted on 12/19/18 at 12:45 0 PM revealed an undated ng sheet. Further review the blank staffing sheet, sheet dated 12/13/18 with		compliance 3x week x 4 weeks The Plan of Correction will be r the next scheduled Quality Ass Performance Improvement Cor 1.22.19. All Plan of Correction r audit data will be reported by er to subsequent monthly Quality	eviewed at urance nmittee monthly ach auditor	

Event ID: BK8H12

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/31/20 FORM APPROV OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		R-C 12/20/2018	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	12/20/2010	
MEADOW	WOOD NURSING CENT	ER		414 WILKINSON BLVD		
			G	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC	
F 732	Continued From page	e 85	F 732			
	only the staffing inform shift.	mation completed for third		Performance Committee for review an recommendations so compliance is continuously achieved.	ıd	
	revealed a staffing sh	ted on 12/20/18 at 6:30 AM neet dated 12/19/18 with only on completed for first and				
F 835 SS=G	Administrator stated t was no longer employ posting the daily staff Administrator was un staffing information w	able to explain why the ras not posted and stated it the staffing sheets were	F 835		1/18/19	
	enables it to use its re efficiently to attain or practicable physical, well-being of each res	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial				
	Based on observation physician interviews facility's administration of processes and polit to ensure that resident treated in a dignified nursing care, received as ordered, and were	ns, staff, resident and and record reviews the in failed to provide oversight icies and effective leadership ints were free from neglect, manner, provided with basic d pressure ulcer treatments e provided with sufficient their needs for 4 of 12		Incontinence care was provided to Resident #13 by a certified nursing assistant 12/16/18. 2.In order to ensure that others are no affected by the same alleged deficient practice all residents requiring incontinence care were assessed by t Registered Nurse/Interim Director of		

Event ID: BK8H12

Facility ID: 923314

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							10.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN				R-C
		345307	B. WING			12/20/2018	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 1	2,20,2010
					414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTE	ER			ASTONIA, NC 28056		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION
F 835	Continued From page	e 86	F 8	35			
		viewed for neglect, dignity,		-	Nursing 1/16-1/18/19 for any adverse		
	and provision of nursi	administration also failed to			effects with none observed.		
		e assessment to determine			3. All scheduled nursing staff were		
		ces to care for the resident			allowed to work before in-service and		
	population. Staff neg			non-scheduled staff were paid for one			
	#13 with incontinence			hour in-service.			
	-	Ited in the resident lying in			All were educated on proper incontine	nce	
	large amount of urine	and reces.			care 1/16/-1/18/19 by the Registered Nurse/Interim Director of Nursing.		
	Findings included:				In addition, staff were educated by the	;	
	-	e			Registered Nurse/Interim Director of		
	This tag was cross re	eterenced to:			Nursing 1/16-1/18/19 that all staff are responsible for acknowledging call light	ate	
	1a. F-550: Based or			and to tell the appropriate staff if the n			
	review, staff and resid			is outside of their scope and on the	ccu		
		ident with dignity by leaving			components of the Concern/Grievance	Э	
		large amount of urine and			policy.		
	stool from 12:41 AM t	to 8:30 AM on 12/16/18 for 1			The education will be included in		
		dent on staff for incontinence			subsequent new-hire orientations.		
	care (Resident #13).				No regidente ware identified as bevins		
	1b E-600 Based or	n observations, record			No residents were identified as having been affected by the facility assessme		
		dent interviews, wound			The facility Assessment was complete		
		and hospice nurse interview,			the Administrator as of 12/26/18.		
		cted to acknowledge a					
	resident's call bell and	-			The requirement and components of t		
		8 an hour time frame from			Facility Assessment were reviewed by	the	
	12:41 AM to 8:30 AM				Regional Nurse and the administrator		
	dependent on staff fo				1/16/19.		
		I to provide treatments as e wound care was done			Department Hoads were trained to th	0	
	consistent with physic				Department Heads were trained to th facility assessment as of 1/10/2019 by		
	sampled residents re				Administrator regarding their responsi		
		1); and failed to complete			to provide updated information with the		
	pressure ulcer treatm				department staffing. The Regional Nu		
	scheduled for 3 days	(Resident #7) for 1 of 3			has trained all Administrative Staff to t		
	residents reviewed fo	r pressure ulcers.			cross reference tags including the auc	lits	

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OF DEFICIENCIES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	B. WING		R-C 12/20/2018
ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
			4414 WILKINSON BLVD	
MEADOWWOOD NORSING CENTER			GASTONIA, NC 28056	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
Continued From page	9 87	F 83	5 as of 1/18/19 and will continue to	provide
			oversight.	
 physician interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #11); failed to implement the care plan for treating wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #7); and failed to implement the care plan for activities of daily living (ADLs) for 2 of 5 residents reviewed for ADLs (Residents #1 and #13). 1d. F-677: Based on observations, record review, resident, and staff interviews, the facility 			Monitoring the facility assessment be the Regional Nurse responsibil x's 12 months. The Facility Admin will update the Facility Assessment as and or annually and present it to th Committee for review and recommendations. The Regional I will provide oversight and review t audits for two (2) months and the Committee will review for two (2)n concerns are identified The QA Committee will provide addition th	lity once istrator s needed he QA Nurse he QA nonths if ree (3)
Daily Living (ADL) ca to provide nail care for reviewed for ADL care 1e. F-684: Based or review, staff interview the facility failed to pr scheduled and ensur- consistent with physic	re (Resident #13) and failed or 2 of 5 dependent residents e (Resident #1). n observations, record vs and physician interviews, ovide treatments as e wound care was done cian orders for 1 of 1		The Plan of Correction will be revi the next scheduled Quality Assura Performance Improvement Comm 1/22/19.	ewed at ance
and Wound Physician interviews, the facility ulcer treatment for 3 of with pressure ulcers (complete pressure ul- and scheduled for 3 of residents reviewed for	n, Hospice Nurse and staff failed to initiate pressure days to a resident admitted (Resident #11) and failed to cer treatment as ordered days (Resident #7) for 2 of 3 r pressure ulcers.			
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page 1c. F-656: Based or review, resident interp physician interviews, a care plan which acc wounds for 2 of 4 res (Residents #1 and #1 care plan for treating reviewed for wounds failed to implement th daily living (ADLs) for for ADLs (Residents # 1d. F-677: Based or review, resident, and failed to provide toilet dependent residents Daily Living (ADL) car to provide nail care for review, staff interview the facility failed to pr scheduled and ensur consistent with physic sampled resident rev (Resident #1). 1f. F-686: Based on and Wound Physiciar interviews, the facility ulcer treatment for 3 of with pressure ulcers of complete pressure ul and scheduled for 3 of residents reviewed for	ROVIDER OR SUPPLIER WOOD NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 87 1c. F-656: Based on observations, record review, resident interviews, staff interviews, and physician interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #11); failed to implement the care plan for treating wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #7); and failed to implement the care plan for activities of daily living (ADLs) for 2 of 5 residents reviewed for ADLs (Residents #1 and #13). 1d. F-677: Based on observations, record review, resident, and staff interviews, the facility failed to provide toileting assistance for 2 of 5 dependent residents reviewed for Activities of Daily Living (ADL) care (Resident #13) and failed to provide nail care for 2 of 5 dependent residents reviewed for ADL care (Resident #1). 1e. F-684: Based on observations, record review, staff interviews and physician interviews, the facility failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled resident reviewed with a wound infection	ROVIDER OR SUPPLIER WOOD NURSING CENTER Image: Summary Statement of DeFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 87 F 83 1c. F-656: Based on observations, record review, resident interviews, staff interviews, and physician interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #11); failed to implement the care plan for treating wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #13). 1d. F-677: Based on observations, record review, resident, and staff interviews, the facility failed to provide toileting assistance for 2 of 5 dependent residents reviewed for ACL vities of Daily Living (ADLs) for 2 of 5 dependent residents reviewed for ADL care (Resident #1) and failed to provide toileting assistance for 1 of 5 dependent residents reviewed for ADL care (Resident #1). 1e. F-684: Based on observations, record review, staff interviews and physician interviews, the facility failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled resident reviewed with a wound infection (Resident #1). 1f. F-686: Based on observations, record review and Wound Physician, Hospice Nurse and staff interviews, the facility failed to inditate pressure ulcer treatment of 3 days to a resident admitted with pressure ulcers (Resident #11) and failed to complete pressure ulcers.	ROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2/P CODE WOOD NURSING CENTER STREET ADDRESS, CITY, STATE, 2/P CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX Tag PROVIDER'S FLAN OF CORREC (EACH OERRECTIVE ACTION SHO CROSS-REFERENCE) TO THE APPE DEFICIENCY) Continued From page 87 F 835 1c. F-656: Based on observations, record review, resident interviews, staff interviews, and physician interviews, the facility failed to develop a care plan which accurately described the wounds for 2 of 4 residents reviewed for wounds (Residents #1 and #11), failed to implement the care plan for treating wounds for 2 of 5 residents reviewe for ADLs (Residents #1 and #7), and failed to implement the care plan for activities of daily living (ADL) sof 2 of 5 residents reviewed for ADLs (Residents #1 and #13). Monitoring the facility Assessment as and or annually and present it to 1 Committee will review for two (2)n concerns are identified The QA review, resident, and staff interviews, the facility failed to provide toileting assistance for 2 of 5 dependent residents reviewed for ACL care (Resident #1). The Plan of Correction will be revi the next scheduled Quality Assume reviewed for ADL care (Resident #1). 16. F-684: Based on observations, record review, staff interviews and physician interviews, the facility failed to provide treatments as scheduled and ensure wound care was done consistent with physician orders for 1 of 1 sampled resident reviewed with a wound infection (Resident #1). The Facility failed to initiate pressure ulcer treatment for 3 days to a resident admitted with pressure ulcers (Resident #1) and failed toromplete

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345307	B. WING		R-C 12/20/2018		
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP COE 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 PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 835 F 838 SS=F	reviews and resident facility failed to provide ensure residents receive wound treatments and incontinence and nail sampled residents (F #13). 1h. F-838: Based or interview the facility f document a facility-wide determine what resound care for the resident for during day to day operemergency situation. During an interview of Administrator agreed identified areas of constarting her employment had been on staffing. work on the rest" on Facility Assessment CFR(s): 483.70(e) Facility as The facility must component facility-wide assessment resources are necessive competently during b and emergencies. The update that assessment facility plans for, any substantial modification	and staff interviews, the de sufficient nursing staff to eived pressure ulcer and d assistance with l care. This affected 4 of 12 Residents #1, #7, #11, and in record review and staff ailed to conduct and ride assessment to urces were necessary to population competently erations and in an in 12/20/18 at 11:14 AM, the there were still issues in the ncern and explained since then on 11/26/18 her focus . She added she "planned to re staffing was stable. -(3) sessment. duct and document a tent to determine what sary to care for its residents oth day-to-day operations the facility must review and ent, as necessary, and at acility must also review and ent whenever there is, or the change that would require a	F 8 F 8			1/18/19	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING			PLETED	
		345307	B. WING			R-C - 12/20/2018		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20/2010	
MEADOW	MEADOWWOOD NURSING CENTER				4414 WILKINSON BLVD			
				GASTONIA, NC 28056				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE		
TAG F 838	Continued From page address or include: §483.70(e)(1) The fac including, but not limit (i) Both the number or resident capacity; (ii) The care required considering the types physical and cognitive and other pertinent fat that population; (iii) The staff compete provide the level and resident population; (iv) The physical envi services, and other pl that are necessary to (v) Any ethnic, culturat may potentially affect facility, including, but food and nutrition ser §483.70(e)(2) The fac but not limited to, (i) All buildings and/or and vehicles; (ii) Equipment (medic (iii) Services provided pharmacy, and specif (iv) All personnel, incl employees and those contract), and volunte education and/or train related to resident can (v) Contracts, memor	e 89 cility's resident population, red to, f residents and the facility's by the resident population of diseases, conditions, e disabilities, overall acuity, cts that are present within encies that are necessary to types of care needed for the ronment, equipment, hysical plant considerations care for this population; and al, or religious factors that the care provided by the not limited to, activities and vices. cility's resources, including to ther physical structures al and non- medical); , such as physical therapy, ic rehabilitation therapies; uding managers, staff (both who provide services under ers, as well as their ing and any competencies		838	DEFICIENCY)	ATE	DATE	
	-	t to the facility during both						

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		TE SURVEY MPLETED	
		345307	B. WING _			R-C 12/20/2018	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
		50	4414 WILKINSON BLVD				
MEADOWWOOD NURSING CENTER			GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVI CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 838	such as systems for e patient records and e information with other §483.70(e)(3) A facilit community-based risil all-hazards approach This REQUIREMENT by: Based on record rev facility failed to condu facility-wide assessm resources were nece population competent operations and in an The findings included A request was made assessment on 12/19 12/20/18 at 11:14 AW when she began worf 11/26/18 she asked the about the facility asses there was not a facilit administrator stated s assessment should b working to create a fac determine what resources	n technology resources, electronically managing electronically sharing r organizations. ty-based and k assessment, utilizing an L. T is not met as evidenced iew and staff interview the uct and document a nent to determine what ssary to care for the resident tly during day to day emergency situation. d: to review the facility 0/18. During an interview on 1 the administrator stated king at the facility on he former administrator essment and was informed ty assessment. The she was aware a facility be in place and was actively acility assessment to urces were necessary to population competently erations and in an	F	 1.No residents were id been affected by the a practice. The requirement and of Facility Assessment we Regional Nurse and th 1/16/19. 2.The Facility Assessm by the Administrator as Casper report was give Administrator by the R add as a key compone Assessment. 3. Department Heads I educated to the facility 1/10/2019. 4.The facility administr assessment as needed basis and will present if Assessment Performat Committee for review a recommendations oncommonths. 	Ilege deficient components of the ere reviewed by the e administrator nent was completed s of 12/26/2018 the egional Nurse to ent to the facility have been assessment as of ator will update the d and on a annual it to the Quality nce Improvement and		
				The Plan of Correction the next scheduled Qu			

Event ID: BK8H12

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		OMB NO. 0938-0 (X3) DATE SURVEY		
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED	
		345307		B. WING		R-C 2/20/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		2/20/2010
			4414 WILKINSON BLVD			
MEADOWWOOD NURSING CENTER				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 O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
F 838	Continued From pag	e 01	F 8	38		
1 000	Continued From pag		1 0.	Performance Improvemer 1/22/19.	nt Committee	
F 867	QAPI/QAA Improven		F 80	-		1/18/19
SS=E	CFR(s): 483.75(g)(2)(ii)					
	§483.75(g) Quality assessment and assurance.					
	assurance committee (ii) Develop and impl action to correct ider	uality assessment and e must: ement appropriate plans of tified quality deficiencies; T is not met as evidenced				
	Based on observation interviews, physician reviews the facility's Assurance Committee procedures and mon be implement in Now three recited deficient on October 25, 2018	ons, staff and resident interviews and record Quality Assessment and efailed to implement itor interventions that were to ember 2018. This was for ncies that were originally cited during a complaint survey.		The Statement of Deficie citation and Federal Regu (2) was reviewed in stand department heads on 1/8, that the quality assessme assurance committee mu- implement appropriate pla correct identify quality def	llation 483.75(g) up with the '19.Which states nt and st develop and ans of action to	
	The deficiencies were in the areas of implementation of resident care plans (656), treatment of pressure sores (686) and providing sufficient nursing staffing (725). The continued failure during two federal surveys of record reflects a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included:			In order to ensure other re affected by the alleged de monitoring tools were cre 12/26/2018.	ficient practice ated on	
				The Department heads w 01/8/2019 to the monitorin usefulness of those tools responsibility regarding th	ng tools, and their	
	This tag is cross-refe	erenced to:				
	resident interviews, s	observations, record review, staff interviews, and physician		The Plan of Correction wa the committee on 1/08/19 approve stated intervention	to discuss and ons, monitoring	
		y failed to develop a care y described the wounds for 2		tools, and follow up by the	e committee.	

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					OMB NO.	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SI COMPLE	
					R-C	2
		345307	B. WING			0/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP		
MEADOWWOOD NURSING CENTER				4414 WILKINSON BLVD GASTONIA, NC 28056		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETIO DATE
F 867	Continued From page	92	F 86	7		
	-	plement the care plan for		monitoring tools and audit	data as	
		of 4 residents reviewed for		specified in the Plan of Co		
		1 and #7); and failed to		ensure all monitoring tools		
		lan for activities of daily		completed once per month		
	ADLs (Residents #1 a	5 residents reviewed for		help to ensure continue co	-	
		anu #13).		will provide addition three		
	The facility was recite	ed for failure to implement		review to assist with maint		
	care plans. Tag F- 65	6 was originally cited during		compliance.		
		tion survey on 10/25/18 for				
		are plan interventions for				
	-	d failure to implement care wound dressing changes.				
		bservations, record review				
		n, Hospice Nurse and staff				
		r failed to initiate pressure days to a resident admitted				
		(Resident #11) and failed to				
		cer treatment as ordered				
		lays (Resident #7) for 2 of 3				
	residents reviewed fo	r pressure ulcers.				
	The facility was recite	ed for failure to initiate and				
	-	cer treatments as ordered.				
		ally cited during a complaint				
		on 10/25/18 for failure to				
	· · ·	re ulcers and failure to				
		cer treatments as ordered.				
	c. F-725: Based on ol	bservations, record reviews				
		d physician interviews, the				
		le sufficient nursing staff to				
	wound treatments an	eived pressure ulcer and d assistance with				
		care. This affected 4 of 12				
		esidents #1, #7, #11, and				
	#13). Staff neglected	l to provide Resident #13				
	with incontinence car	e for nearly an 8-hour time				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/31/2019 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING			R-C 12/20/2018	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STAT	E, ZIP CODE		
MEADOW	WOOD NURSING CENTE	R		414 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	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 867	amount of urine and f The facility was recite sufficient nursing staff originally cited during survey on 10/25/18 for nursing staff to ensure assistance with meals care/treatments. A review of the facility notebook on 12/18/18 facility's 10/25/18 com revealed each citation Compliance (AOC) da no monitoring or audit indicated in the facility related to care plans, sufficient nursing staff During an interview of Administrator confirm notebook from the con completed on 10/25/1 monitoring and auditir was in the process of for the areas cited, bu and not yet completed her employment on 1 hiring staff and then " once staffing was staff acknowledged the mo	h the resident lying in a large eccs. d for failure to provide fing. Tag F-725 was a complaint investigation or failure to provide sufficient e residents received s, bathing and wound d's Plan of Correction (POC) B, for citations from the nplaint investigation n contained an Allegation of ate of 11/22/18. There were ting tools completed as y's POC for the areas pressure ulcer care and fing. n 12/20/18 at 11:14 AM, the ed the facility's POC mplaint investigation 8 was inclusive of all ng tools. She explained she creating monitoring forms at it was a work in progress d. She added since starting 1/25/18 she had focused on planned to work on the rest" ole. The Administrator onitoring and auditing plans, pressure ulcer care being completed and she planned to implement	F 867				

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