CENTERS FO	OR MEDICARE & MEDICAID SERVICES			"A" FORM
STATEMENT OF	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY
NO HARM WIT	H ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:
FOR SNFs AND	MEAND NES ME OF PROVIDER OR SUPPLIER EADOWWOOD NURSING CENTER EFIX G SUMMARY STATEMENT OF DEFICIENCIE SUMMARY STATEMENT OF DEFICIENCIE EFIX G SUMMARY STATEMENT OF DEFICIENCIE (G) Notify of Changes (Injury/Decline/Room, CFR(s): 483.10(g)(14)(i)-(iv)(15) \$483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the consistent with his or her authority, the res (A) An accident involving the resident whi intervention; (B) A significant change in the resident's phealth, mental, or psychosocial status in eit (C) A need to alter treatment significantly adverse consequences, or to commence a n (D) A decision to transfer or discharge the (ii) When making notification under paragipertinent information specified in \$483.15(iii) The facility must also promptly notify (A) A change in room or roommate assignt (B) A change in resident rights under Feder this section. (iv) The facility must record and periodical the resident representative(s). \$483.10(g)(15) Admission to a composite distinct part. A findisclose in its admission agreement its phy the composite distinct part, and must specilocations under \$483.15(c)(9). This REQUIREMENT is not met as evide Based on staff and Guardian Social Worker notification to the legal representative for 1 Findings included: Resident #2 was admitted to the facility on Diagnoses included presence of cardiac packers of the Admission Minimum Data Scognitively impaired. Review of the Admission Minimum Data Scognitively impaired. Resident #2 required extensive assistance was sentenced.	345307	B. WING	4/17/2019
NAME OF PROV	SUMMARY STATEMENT OF DEFICIENCIES Notify of Changes (Injury/Decline/Room, e CFR(s): 483.10(g)(14) (i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the r consistent with his or her authority, the resident which intervention; (B) A significant change in the resident's phealth, mental, or psychosocial status in eith (C) A need to alter treatment significantly (for adverse consequences, or to commence a new (D) A decision to transfer or discharge the remainder (ii) When making notification under paragrate pertinent information specified in §483.15(c) (iii) The facility must also promptly notify the (A) A change in room or roommate assignm (B) A change in resident rights under Federathis section. (iv) The facility must record and periodically the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility must admission agreement its physthe composite distinct part, and must specifications under §483.15(c)(9). This REQUIREMENT is not met as evider Based on staff and Guardian Social Worker notification to the legal representative for 1	STREET ADDRESS, (CITY, STATE, ZIP CODE	
MEADOWW	OOD NURSING CENTER	4414 WILKINSO GASTONIA, NC		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	CIES		
F 580	CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the consistent with his or her authority, the reaction of the consistent with his or her authority, the reaction of the resident wintervention; (B) A significant change in the resident's health, mental, or psychosocial status in (C) A need to alter treatment significantly adverse consequences, or to commence at (D) A decision to transfer or discharge the (ii) When making notification under parapertinent information specified in §483.1 (iii) The facility must also promptly notification to the facility must record and periodic the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A disclose in its admission agreement its plant the composite distinct part, and must spellocations under §483.15(c)(9). This REQUIREMENT is not met as evidence of the second of the legal representative for Findings included: Resident #2 was admitted to the facility of Diagnoses included presence of cardiac presentatively impaired.	the resident; consult with resident representative (so which results in injury at a sphysical, mental, or pseither life-threatening of the state of the state of the state of the resident from the fact agraph (g)(14)(i) of this 15(c)(2) is available and fy the resident and the regiment as specified in § deral or State law or regional configuration, in the state of the policies that agraph (g) the policies that agraph (g	s) when there is- nd has the potential for requiring physician sychosocial status (that is, a deterioration in conditions or clinical complications); continue an existing form of treatment due to t); or illity as specified in §483.15(c)(1)(ii). Is section, the facility must ensure that all d provided upon request to the physician. resident representative, if any, when there is §483.10(e)(6); or gulations as specified in paragraph (e)(10) or s (mailing and email) and phone number of cosite distinct part (as defined in §483.5) must necluding the various locations that comprise copply to room changes between its different ord review, the facility failed to provide dent #2) reviewed for notification. harged to the hospital on 3/27/2019. ation, hypertension, and dementia.	of of

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

Event ID: 0DGQ11

The above isolated deficiencies pose no actual harm to the residents

031099

CENTERS FOR	MEDICARE & MEDICAID SERVICES			"A" FORM			
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH O	NLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:			
FOR SNFs AND NF	An interview was completed with the Gurevealed she was not notification, which contained contact numbers, after h treatment. The Guardian SW further expafter Resident #2 being transferred to the hospinot recall when Resident #2 being transferred to the hospinot recall when they notification, notification to the Guardian SW. An obswhich revealed the Guardian SW in relied on the contact of the Guardian SW in relied on the contact of the Guardian SW in relied on the contact the Guardian SW in relied on the contact of the Guardian SW. An obswhich revealed the family of Resident #2 had Resident #3 had Resident #4 had Re	345307	B. WING	4/17/2019			
NAME OF PROVID	ER OR SUPPLIER	STREET ADDRESS, CITY, STA	TE, ZIP CODE				
MEADOWWO	OD NURSING CENTER	4414 WILKINSON BLVD GASTONIA, NC					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES						
F 580	Continued From Page 1						
F 580	Review of the active medical record revealed 2/28/2019 which read in part: It is ordered th (GOP) Gaston County Department of Health record revealed Letters of Appointment Guard guardian of the person is fully authorized and care and control of the ward, but has no author business affairs of the ward. Review of the Admission Record on the active responsible party and emergency contact. An interview was completed with the Guardia revealed she was not notified of Resident #2 facility had the Guardianship information (which contained contact numbers, after hour treatment. The Guardian SW further explained after Resident #2 had been in the hospital. The Grand of Resident #2 being transferred to the hospital Agency (SA). An interview was completed with Resident #2 recalled when Resident #2 was transferred to Resident #2 being transferred to the hospital. not recall when they notified her. An interview was completed with Nurse #1 or the state of the hospital.	at a guardian be appointed and Human Services. Fur dian of the Person dated 3 entitled under the laws of ority to receive, manage or e chart dated 2/28/2019 rean Social Worker (SW) on being transferred to the honich was provided after the contact numbers, and the ged that she was contacted be Guardian SW expressed al, the Guardianship depart 2's family on 4/17/2019 at the hospital. The family we The family explained the	they this court- Guardian of the Person ther review of the active medical /12/2019 which read in part: The FNorth Carolina to have the custody, administer the property, estate or evealed that family was listed as the evealed that family was listed as the spital. The Guardian SW stated the equardianship hearing on 2/28/2019) guardianship protocols for medical by Resident #2's family, several days at that since notification was not made the them thad to report this on to the State 1:03 PM. The family stated they verbalized the facility notified them of y notified the Guardian SW but could Nurse #1 stated she was the nurse on				
	chest and she was aware Resident #2 had a cardiac pace maker. Nurse #1 further explained she assessed Resident #2, made physician notification, and family notification. Nurse #1 stated she did not make notification to the Guardian SW. An observation was completed with Nurse #1 of the active medical record which revealed the family of Resident #2 listed as the responsible party and emergency contact. Nurse #1 reiterated she contacted the responsible party and made notification. Further review of the active medical record with Nurse #1 revealed the Guardianship paperwork with contact information. Nurse #1 was not aware Resident #2 had a Guardian SW in place and notification needed to be made. Nurse #1 stated she relied on the contact information on the active medical record to be current, so that proper notification could be made. An interview was completed with the Director of Nursing (DON) on 4/17/2019 at 3:59 PM. The DON stated her expectation of nursing staff would be for them to provide notification of any change in condition and/or						
	transfer to the guardian, legal representative,						

PRINTED: 05/22/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345307	B. WING _		04/17/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	: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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 000	INITIAL COMMENTS		F 0	00	
F 695	Regulation, Nursing F Certification Section of While some of the de corrected on 04/01/19 compliance. The man 04/25/19	conducted an onsite revisit.	F 6	95	4/18/19
SS=D	CFR(s): 483.25(i)	torny Care and Suctioning		90	4/10/19
	needs respiratory car care and tracheal suc care, consistent with practice, the compreh care plan, the resider and 483.65 of this sul	d tracheal suctioning. Ire that a resident who e, including tracheostomy tioning, is provided such professional standards of ensive person-centered ts' goals and preferences,			
	interview the facility fa physician ordered rate			Resident #5 orders were reviewed oxygen and the oxygen flow rate to 4 LPM by Licensed Nurse on 4 Resident #5 Oxygen saturation we evaluated by the Nurse Consultar 4/17/19 to ensure compliance.	adjusted 4/17/19. /as
	The findings included	:		Resident's receiving oxygen have	ave the
	obstructive pulmonary The most recent quar	ses which included failure, asthma and chronic disease (COPD). terly Minimum Data Set revealed Resident #5 was		potential to be affected by this de that the facility failed to maintain physician ordered rate of oxygen baseline audit was conducted on by the Director of Nursing for resi receiving oxygen to validate oxygrate per physician order. Any con identified were corrected immedia	eficiency the . A 4/17/19 ident gen flow
ABORATORY	 DIRECTOR'S OR PROVIDER <i>IS</i>	SUPPLIER REPRESENTATIVE'S SIGNATURI	<u> </u> ≣	TITLE	(X6) DATE

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

04/19/2019

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.

Electronically Signed

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		E SURVEY IPLETED
		0.45007	D WING			С
		345307	B. WING		0-	4/17/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NURSING CENT	FR		4414 WILKINSON BLVD		
IIILADOII	WOOD NONOING OLK II			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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	Continued From page	e 1	F 69	95		
	extensive two-persor mobility, transfers, dr hygiene. Resident #5 supplemental oxyger	essing and personal was coded for requiring		The Director of Nursing or desi- audit the patient MAR monthly to ensure compliance is mainta	x 3 months	
	Review of physician of dated 05/14/18 which minute via nasal can Review of the Medica (MAR) dated April 20 was to be on 4 liters continuously via nasa initiated on 05/14/18.	orders revealed an order named, "O2 at 4 liters per nula continuous". ation Administration Record 19, revealed Resident #5 per minute (lpm) of oxygen al cannula. The order was Further review revealed		3. Director of Nursing re-educa Licensed Nurses on 4/17/19-4/ regarding following the physicia for oxygen administration, includocumentation of the flow rate. included: all nurses will verify the oxygen rate is accurate on eac looking at the patient's oxygen administration set up at eye levensure that the rate is at the present the rate is at the present that the rate is at the present that the rate is at the present that the rate is at the present the rate is at the present that the rate is at the presen	18/19 an's order ading the Education ne patient's h shift by rel to escribed	
	7 AM to 3 PM shift in receiving 4 lpm of su	· ·		order. The nurse will document oxygen rate in the patient's MA physically viewing the rate. In a newly hired Licensed Nursing s	R after addition, staff will	
	observed sitting in he The oxygen concentr wheelchair and in use liters per minute. A la Resident #5's bed ind to be receiving 4 liter to severe COPD.	AM, Resident #5 was er room in her wheelchair. ator located behind her e was observed as set at 3 arge sign was observed over dicating the resident needed is of oxygen at all times due		also receive education during sorientation. 4. The Director of Nursing, MD treatment nurse will be responsional monitoring the residents received for the physician ordered flow roughly mar's 3x's per week x's 4 week one (1)x per week x's 2 months 4/18/19, to ensure compliance	S, or sible for ing oxygen ate and s and then s starting	
	oxygen from an oxyg observed set at 3 lpm also in the room and concentrator was to be An interview with Nur for Resident #5 on 04 2:10 PM. She stated	in her wheelchair receiving en concentrator which was in. Her family member was stated Resident #5's oxygen		maintained. Data will be summarized and p the facility Quality Assurance P Improvement Committee per M Months presented by the DON Designee. Any issues or trends will be addressed by the Qualit Assurance Performance Improvementation Committee as they arise and the prevised to ensure continued.	erformance lonth x's 3 and or s identified y vement ne plan will	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345307	B. WING			77/2040
NAME OF PI	ROVIDER OR SUPPLIER	340007		STREET ADDRESS, CITY, STATE, ZIP CODE	04/	17/2019
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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Continued From page	2	F 69	5		
	responsibility of the n	terview revealed it was the urse to adjust the resident's		compliance.		
	was responsible for coxygen rate. The interinitialed on Resident checked the setting do however, had not wellook at Resident #5's. The interview revealed physician order to recomplemental oxygen #5's room during this oxygen was to be set change the gauge on from 3 lpm to 4 lpm.	e #1. Nurse #1 stated she hecking Resident #5's rview revealed Nurse #1 had #5 's MAR that she had uring first shift on 04/17/19 nt into the room to physically oxygen concentrator setting. At Resident #5 had a seive 4 liters of continuous . Upon entering Resident time Nurse #1 stated the at 4 lpm and proceeded to the oxygen concentrator Jpon request by the otained Resident #5's oxygen		Corrective action will be completed by 4/18/19	y	
	The DON stated she administered as orde	irector of Nursing (DON). expected the oxygen to be red by the physician. She s oxygen concentrator				
F 801 SS=F	04/17/19 at 2:20 PM oxygen to be administ physician. Qualified Dietary State		F 80	1		4/20/19

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345307	B. WING			C 04/17/2019
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	· · · · ·	04/1//2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 801	appropriate compete out the functions of the taking into consideral individual plans of call and diagnoses of the in accordance with the required at §483.70(). This includes: §483.60(a)(1) A qual clinically qualified nutifull-time, part-time, of qualified dietitian or nutrition professional (i) Holds a bachelor's a regionally accredite. United States (or an with completion of the aprogram in nutrition an appropriate nation recognized for this periorical dietetics supervised dietetics supervised dietetics supervised or centrition professional. (iii) Is licensed or centrition professional services are perform provide for licensure will be deemed to have or she is recognized the Commission on I successor organization requirements of parathis section.	coloy sufficient staff with the incies and skills sets to carry the food and nutrition service, ition resident assessments, are and the number, acuity a facility's resident population are facility assessment e) ified dietitian or other trition professional either on a consultant basis. A other clinically qualified to so higher degree granted by and college or university in the equivalent foreign degree) academic requirements of an or dietetics accredited by and accreditation organization surpose. I least 900 hours of practice under the stered dietitian or nutrition tified as a dietitian or laby the State in which the ed. In a State that does not or certification, the individual ve met this requirement if he as a "registered dietitian" by Dietetic Registration or its	F 80	01		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345307	B. WING		C 04/17/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	1 04/1//2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 801	no later than 5 years as required by state §483.60(a)(2) If a question clinically qualified nuemployed full-time, the person to serve as the nutrition services who (i) For designations meets the following regars after November 28, 22 (A) A certified dietary (B) A certified food so (C) Has similar nations service management certifying body; or D) Has an associated service management course study include management, from a higher learning; and (ii) In States that have food service managements State requirem managers or dietary (iii) Receives frequer from a qualified dietification qualified nutrition profits REQUIREMENT by: Based on staff internal facility failed to employ manager with requirements.	meets these requirements after November 28, 2016 or law. alified dietitian or other trition professional is not the facility must designate a the director of food and corprior to November 28, 2016, requirements no later than 5 to 28, 2016, or no later than 1 28, 2016 for designations 2016, is: I manager; or revice manager; or mal certification for food and safety from a national as or higher degree in food and safety from a national as or higher degree in food an accredited institution of the established standards for the same for food service managers, and the same for food service managers and the same for food service managers, and the same for food service managers and service managers	F 80	No residents were identified as having been affected by the deficient practice 2. The facility as of 4/18/19 has hired a full-time (30hrs per week to 40hrs per	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		C
		345307	B. WING		04/17/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
				4414 WILKINSON BLVD	
MEADOW	WOOD NURSING CENTE	ER .		GASTONIA, NC 28056	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 801	manager. The manage worked in the facility fasked by the Administ as Dietary Manager and The designated dietarshe was not a certified registered and started course on 04/15/19. The manager reported she manager had been hit taking the position who stated the facility had dietary manager since the facility once a more focus was clinical. On 04/17/19 at 3:23 Finterviewed and report made attempts to hire	:	F 80	week) Certified Dietary Manager who we start on 4/20/19. The RD currently work hrs. per month and will be working a additional 4 hours per Month beginning 4/23/19. The Certified Dietary Manger oversee the dietary department day to operations. 3. The Corporate Administrator re-educated the Administrator on 4/18/on ensuring that a qualified dietitian or other clinically qualified and or a certified dietary Manager is employ full-time to manage the Dietary department. 4. Monitoring to ensure compliance the HR director or Designee will sign off 1 per Month for four (4) Months that Dietateffing Compliance for a Certified Dietate Manager and or a Certified food service Manager is achieved starting 4/20/19. Data will be summarized and presented the facility Quality Assurance Committee per Month x's 4 Months presented by the HR Director and or Designee. Any issue or trends identified will be addressed by the starting defense of the s	s 8 ywill day 19 ed x ary ary e d to ee he es
F 803	designated dietary ma stated that the design SERV Safe Certified a training to be a certified Administrator she felt requirement for a cert Menus Meet Residen	anager into the role. She ated dietary manager was and had started her on-line ed dietary manager. The that satisfied the regulatory ified dietary manager. those was a start of the that satisfied the regulatory if the thick of the regulatory and the thick of the regulatory if the thick of the regulatory and the thick of the regulatory and the thick of the regulatory and t	F 80	the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. Corrective action will be completed by 4/20/19.	4/20/19
SS=E		(7) d nutritional adequacy.			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	COMPLETED
		345307	B. WING		C 04/17/2019
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	04/1/12013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 803	residents in accordar guidelines.; §483.60(c)(2) Be pre §483.60(c)(3) Be folio §483.60(c)(4) Reflect reasonable efforts, the ethnic needs of the reinput received from regroups; §483.60(c)(5) Be upon groups; §483.60(c)(6) Be revidentian or other clinic professional for nutritive professional for nutritive professional dietary choing the professio	ne nutritional needs of nee with established national pared in advance; pwed; the religious, cultural and esident population, as well as esidents and resident lated periodically; fewed by the facility's cally qualified nutrition ional adequacy; and g in this paragraph should be resident's right to make ces. The is not met as evidenced ans, interviews and recorded to follow a recipe for the omitting ground beef. This intial to affect all residents.	F 80	No residents were identified as have been affected by the deficient practice. 2.On 4/17/19 The Administrator has printed off and placed in the Dietary Department all of the recipes for the residents' menus from the optima sy and created a binder containing all cresident's meals, so that the dietary	estem of the cooks
	was baked ziti. Obse	unch's menu main entrée ervations of the baked ziti consisted of pasta, tomato		will be able to follow the established recipes for the resident meals.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		TE SURVEY MPLETED
		345307	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	0.000.		STREET ADDRESS, CITY, STATE, ZIP CODE		14/17/2019
TWANE OF TH	TO VIDER OR OUT FEEL			4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENTE	ER .				
				GASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 803	Continued From page	÷ 7	F 80	13		
	sauce and shredded	cheese.		3. Education was provided by t	he	
				Administrator on 4/17/19 and 4		
	On 04/17/19 at 12:02			the dietary Cooks regarding the		
		d the baked ziti included		Book and preparing meals in a	•	
	noodles, sauce and c			prepping the meals for each sh		
		ay. The cook reported that u to tell her what was being		to ensure that the correct amou		
		e cook was unaware if there		protein is given and the recipes followed. The Administrator wil		
		led that she relied on the		review the above education with		
	•	what to cook and that		Dietary Manager on 4/20/19. Ir		
		cify meat, so she did not		newly hired dietary staff will als		
	include meat in the er	ntrée. The cook also stated		education during subsequent of	rientation.	
	that no other protein v	was being provided for the				
	lunch meal.			4. Monitoring to ensure that the		
				does not recur, the Administrat		
		PM the Dietary Manager		Designees (Certified Dietary M		
		ne recipe for baked ziti. The		or RD) will check the meals wit		
	-	e wasn't familiar with the was new in her role. And		to ensure that recipes are follow cooking meals 5 x's per week I		
	-	t know how to print the		Dinner for 8 weeks starting 4/1		
		e to request the recipe from			o	
	-	e added that she had not		Data will be summarized and p	resented to	
	used recipes and price	r to being the DM she was a		the facility Quality Assurance P		
	cook for the facility ar	nd had been told by the		Improvement Committee per M	lonth x's 2	
		ger to make baked ziti using		Months presented by the Dieta		
	noodles, sauce and c	heese.		and or Designee. Any issues o		
	0 044740 44000	D1441 D144 14		identified will be addressed by	•	
		PM the Dietary Manager		Assurance Performance Impro		
		e recipe for baked ziti that eef Ziti" and called for 16		Committee as they arise and the be revised to ensure continued		
		ef to be used. The DM		compliance.		
		a the recipe called for		Compilarios.		
	ground beef.	2. 2.2. 2.5.p. 2.30u 101		Corrective action will be comple 4/20/19.	eted by	
	On 04/17/19 at 1:55 F	PM the Registered Dietitian				
		on the telephone and				
	explained that she ha					
	system with the new I	Dietary Manager and shown				
	her how to access me	enus and recipes during a				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345307	B. WING				C 17/2019
	ROVIDER OR SUPPLIER			441	REET ADDRESS, CITY, STATE, ZIP CODE 14 WILKINSON BLVD ASTONIA, NC 28056	1 04/	1772019
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812 SS=E	ground beef was improprotein needs of the remenus were developed residents for a whole called for beef, then it. On 04/17/19 at 12:45 interviewed and proviand ground beef was stock." The Administ ordered all the food a she needed ground be money and bought the recipe. Food Procurement, St. CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procure approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regulii) This provision doef facilities from using period growing and food (iii) This provision doef from consuming food from consuming food standards for food seal standards for food	lity. The RD stated that the ortant to the overall daily residents because the ed to meet the needs of day and that if a recipe to should be provided. PM the Administrator was ded the food purchase order listed as "temporarily out of rator explained that she and if the DM had told her eef, she would have taken to e ground beef herself for the expression of the editions. The food from sources are distincted as satisfactory by federal, ties. The food from sources are distincted by subject to applicable State color of the editions. The food from sources are distincted directly subject to applicable State color of the editions. The food from sources are so to prohibit or prevent roduce grown in facility compliance with applicable dehandling practices. The food from sources are so to procure by the facility. The food from sources are so to procure by the facility. The food from sources are food from sources are not procured by the facility.		803			4/18/19

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			71. 501251			، ا	С
		345307	B. WING				17/2019
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WOOD NUIDOING OFNIT			44	114 WILKINSON BLVD		
MEADOW	WOOD NURSING CENT	ER		G	ASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812		ons, staff interviews and	F	312	No residents were identified as being		
	within safe temperate hair covered when so meal observations.	cility failed to serve milk ure range and failed to keep erving food for 1 of 1 lunch The practice of not covering I to affect food being served			affected by the deficient practice.2.The Administrator conducted a audit 4/17/-4/18/19 in the Dietary Departmen on the food temperatures and hair nets order to ensure food safety compliance	it in	
	made of the kitchen of preparation with the During the observation to be preparing meal by placing condimentrays. Individual milk other beverages such beverages were not to air. The ice inside partially melted. On 04/17/19 at 11:54 noted to place milk c	d: 2:41 AM observations were during the lunch meal Dietary Manager (DM). ons, a dietary aide was noted trays for the lunch service ts and beverages on the cartons were on a cart with has iced tea and water. The being chilled and stored open the tea was noted to be 4: AM the dietary aide was artons on residents' meal milk cartons placed on meal			 Education regarding the food temperature policy, the food serving policy, and the infection control policy which includes wearing a hairnet in ord to ensure compliance in the dietary department with the dietary staff were conducted on 4/18/19 by the Administrator. Monitoring performance to make sur that solutions are sustained in the Dietary Department the Dietary manager and or Designee will randomly audit five residents trays for serving temperature on drinks and meals 3 x's per week x's two(2) month and 2 x's per week x's on (1)month starting 4/18/19. Hairnets will 	er e ary or s	
	trays. The meal tray rack. The dietary aid tray tickers to "count" waters she needed for On 04/17/19 at 12:02 a digital thermomete temperature of hot for interviewed and asked temperature of milk a measure the temperarelied on the "milk bottoms".	s were stored on an open-air le reported that she used the ' how many milks, teas and			monitored 3x's per week x's two (2) months and 2 x's per week x's one (1) month starting 4/18/19 on all three shift by the Dietary manager and or Designed Data will be summarized and presented the facility Quality Assurance Performa Improvement Committee per Month x's Months presented by the Dietary Manager and or Designee. Any issues trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise	ts ee. d to nce 3 or	

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
	345307	B. WING _		04	C 4/17/2019		
NAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP C 4414 WILKINSON BLVD GASTONIA, NC 28056	•	7172010		
PREFIX (EACH DEFICIENCY MUST BE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
The cook was asked to measure of one of the milk cartons out service. She used the digital and the thermometer read 61 Fahrenheit. The cook proceed carton of milk from the "milk be the internal temperature of the degrees Fahrenheit and stated that reading." The 9 cartons of been unrefrigerated remained meal service and were served. On 04/17/19 at 12:20 PM the temperature logs for meal service and were served. The DM was interviewed about beverages' temperature and not temperature was the internal temperature. Observations were made of the contained an internal thermomodegrees Fahrenheit. Inside the cardboard box of individual minutation outside of the cardboard milk with instructions that read, "Ke between 34 - 40 degrees." On 04/17/19 at 1:55 PM the R (RD) was interviewed on the texplained she was responsible aspects but was helping the D kitchen operations since the D role. The RD stated that milk	for the lunch meal thermometer to the degrees ded to remove a fox" and measure emilk carton at 40 dt, "see we go by of milk that had in use for the lunch to residents. DM provided the vice, review of the ages" temperature degrees Fahrenheit. It the cold apported that the hermometer's actual the wide milk box was a lik carts. The box was stamped apported the degree faitheauthous actual the emilk box was a lik carts. The box was stamped apported the clinical degree of the clinic	F8	and the plan will be revised continued compliance. Corrective action will be continued action will be continued action.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING _				C 17/2019	
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COI 4414 WILKINSON BLVD GASTONIA, NC 28056	DE	1 0-11	1172010	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE	
F 812	interviewed and state facility for 5 years and milk getting hot by plathe start of tray line. and did not recall who out of the "milk box." During the lunch measures and set to 62 degaddition, the kitchen a screen door was in the screen door was because it was so how the first time she had temperature measures were pulled directly for She added that she in the "milk box" to be the milk cartons. The DN cartons had been left recorded 61 degrees that the milk cartons away and not used for should have been se added that she also epull from the "milk bomilk cold. On 04/17/19 at 2:46 interviewed and states same as the RD's.	PM the dietary aide was ad she had worked in the dinever thought about the acing it on the trays prior to The dietary aide was asked en she took the milk cartons all observation, the kitchen air condition window unit in grees Fahrenheit. In s back door was open and use. The cook stated that to help cool off the kitchen t inside. PM a follow-up interview was M and she reported that was ever had a milk carton's ed because the milk cartons or use from the "milk box." elied on the temperature of ne same temperature as the	F	312				

AND DEAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245207	B. WING			С
	ROVIDER OR SUPPLIER	345307 ER	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	10	04/17/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 812	lunch meal service we cook was noted to ha top of head, leaving the exposed. The cook we tray line during the observation of the cook we tray line during the observation of the cook was all the explanation why her had to cover all hexplanation why her had training to clock out and control of the cook out and training on hairnets, be wear them to cover all on 04/17/19 at 2:46 Finterviewed and report	ere made that revealed the ve a hairnet secured on the ne bottom half of her hair vas serving food from the eservation. PM the cook was interviewed usually had to wear two er hair and offered no nair was not fully covered service because, "she was	F8	12		

PRINTED: 05/22/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT (AND PLAN OF			(X3) DATE SURVEY COMPLETED		
					R-C
		345307	B. WING		04/17/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 000	INITIAL COMMENTS		F 00	00	
{F 801} SS=F	Regulation, Nursing F Certification Section of While some of the de corrected on 04/01/19 compliance. The man 04/25/19. Qualified Dietary Staf	conducted an onsite revisit. ficiencies cited were fice the facility remains out of adatory termination date is	{F 80	1}	4/20/19
	appropriate competer out the functions of the taking into considerate individual plans of cal				
	full-time, part-time, or qualified dietitian or or nutrition professional (i) Holds a bachelor's a regionally accredite United States (or an exist with completion of the a program in nutrition an appropriate nation recognized for this put (ii) Has completed at supervised dietetics particles.	rition professional either on a consultant basis. A ther clinically qualified is one who- or higher degree granted by d college or university in the equivalent foreign degree) e academic requirements of or dietetics accredited by al accreditation organization irpose. least 900 hours of			
ABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u> RE	TITLE	(X6) DATE

Electronically Signed 04/19/2019

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

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345307	B. WING			l	-C
		343307	D. WING	_		04/	17/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	ER		4	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 801}	services are performed provide for licensure of will be deemed to have or she is recognized at the Commission on Disuccessor organization requirements of paragethis section. (iv) For dietitians hirror November 28, 2016, no later than 5 years as required by state laward with the person to serve as the nutrition services who (i) For designations provided full-time, the person to serve as the nutrition services who (i) For designations provided full-time, the person to serve as the nutrition services who (i) For designations provided full-time, the person to serve as the nutrition services who (i) For designations provided full-time, the person to serve as the nutrition service who (ii) For designations provided for the full service was after November 28, 2 (A) A certified dietary (B) A certified food set (C) Has similar nation service management certifying body; or D) Has an associate's service management course study includes management, from a higher learning; and (ii) In States that have	ified as a dietitian or by the State in which the ad. In a State that does not or certification, the individual of met this requirement if he as a "registered dietitian" by itetetic Registration or its on, or meets the graphs (a)(1)(i) and (ii) of ad or contracted with prior to meets these requirements after November 28, 2016 or aw. Alified dietitian or other rition professional is not be facility must designate a be director of food and or or on later than 5 and 28, 2016, or no later than 128, 2016 for designations on the contraction of the rition professional is not be a contracted with prior to November 28, 2016, or no later than 128, 2016 for designations on the contracted with prior to November 28, 2016, or no later than 128, 2016 for designations on the contracted with prior to November 28, 2016, or no later than 128, 2016 for designations on the contracted with prior to November 28, 2016, or no later than 128, 2016 for designations on the contracted with prior to November 28, 2016, or no later than 128, 2016 for designations on the contracted with prior to November 28, 2016, or no later than 128, 2016 for designations on the contracted with prior to November 28, 2016, or no later than 128, 2016 for designations on the contracted with prior to November 28, 2016, or no later than 128, 2016 for designations on the contracted with prior to November 28, 2016, or no later than 128, 2016, or no later than	{F 8	801)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		l	R-C / 17/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04	11112019	
NAME OF T	NOVIDEN ON OUT FEEL			4414 WILKINSON BLVD			
MEADOW	WOOD NURSING CE	NTER					
				GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 801}	Continued From p	page 2	{F 801	}			
	managers or dieta	ary managers, and					
		uently scheduled consultations					
	1 ' '	etitian or other clinically					
	qualified nutrition	professional.					
	This REQUIREME	ENT is not met as evidenced					
	by:						
	Based on staff in	terviews and record review the		No residents were identified as	having		
		nployee a certified dietary		been affected by the deficient pr	actice.		
		uired competencies and skills					
		rough 04/17/19 for 1 of 1					
	certified dietary m	anager positions.		2.The facility as of 4/18/19 has h			
	T. C			full-time (30hrs per week to 40hr			
	The findings included:			week) Certified Dietary Manager			
	Op 04/17/10 at 10	0:02 AM an interview was		start on 4/20/19. The RD currently hrs. per month and will be working	-		
		e facility's designated dietary		additional 4 hours per Month be	-		
		anager explained that she had		4/23/19. The Certified Dietary M			
	_	lity for years as a cook and was		oversee the dietary department	-		
		inistrator to take over the role		operations.	day to day		
		er "around the first of April."					
		ietary manager explained that		3. The Corporate Administrator			
		tified dietary manager but had		re-educated the Administrator or	า 4/18/19		
	registered and sta	rted an 8-week on-line training		on ensuring that a qualified dieti	tian or		
	course on 04/15/1	9. The designated dietary		other clinically qualified and or a	certified		
		she thought a certified dietary		dietary Manager is employ full-ti			
	_	n hired but then ended up not		manage the Dietary department.			
		which left the vacancy. She					
		had been without a certified		4. Monitoring to ensure compliar			
	dietary manager s	since the previous survey.		HR director or Designee will sign			
				per Month for four (4) Months th	•		
		55 PM the Registered Dietitian		staffing Compliance for a Certified			
	' '	wed on the telephone and		Manager and or a Certified food			
	· •	s a consultant RD and came to		Manager is achieved starting 4/2	20/19.		
	focus was clinical	month. She explained her		Data will be summarized and pre	esented to		
	locus was cillical			the facility Quality Assurance Co			
	On 04/17/10 at 3.5	23 PM the Administrator was		per Month x's 4 Months presente			
		eported that the facility had		HR Director and or Designee. A	•		
		hire a certified dietary manager		or trends identified will be addre			

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 04/17/2019
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP 4414 WILKINSON BLVD GASTONIA, NC 28056	CODE	04/1//2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 812} SS=E	designated dietary m stated that the design SERV Safe Certified training to be a certification and the design of the state	decided to promote the anager into the role. She nated dietary manager was and had started her on-line ed dietary manager. The that satisfied the regulatory tified dietary manager. tore/Prepare/Serve-Sanitary 2) by requirements. re food from sources ed satisfactory by federal, ies. bood items obtained directly subject to applicable State clations. It is not prohibit or prevent roduce grown in facility compliance with applicable d-handling practices. It is not procured by the facility. prepare, distribute and ance with professional	{F 8	the Quality Assurance Pe Improvement Committee and the plan will be revise continued compliance. Corrective action will be of 4/20/19.	as they arise ed to ensure completed by fied as being practice. Succeed a audit on ry Department and hair nets in	4/18/19

STATEMENT OF	CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLE		DATE SURVEY COMPLETED			
		345307	B. WING			R-C 04/17/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	04/11/2019
				4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CE	NTER		GASTONIA, NC 28056		
				·		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
{F 812}	Continued From pa	age 4	{F 812	2}		
	made of the kitchee preparation with the During the observato be preparing methy placing condimetrays. Individual mother beverages subseverages were not oair. The ice insipartially melted. On 04/17/19 at 11: noted to place milk trays. There were trays. The meal trays. The meal trays. The dietary at tray tickers to "cou waters she needed on 04/17/19 at 12: a digital thermome temperature of hot interviewed and as temperature of milk cartons) thermome. The cook was asked of one of the milk oservice. She used measure the intermand the thermome	11:41 AM observations were in during the lunch meal in Dietary Manager (DM). Ations, a dietary aide was noted at trays for the lunch service ents and beverages on the stilk cartons were on a cart with such as iced tea and water. The object of the tea was noted to be service ents and beverages on the stilk cartons were on a cart with such as iced tea and water. The object of the tea was noted to be service ents and stored open de the tea was noted to be service on an open-air enter reported that she used the ent" how many milks, teas and it for the meal trays. Of the cook proceeded to use the territory of the cook was sked about measuring the extended at a cook in cooler for milk enter for the temperature of milk enter for the temperature of milk. The digital thermometer to service enter to measure the inner meal the digital thermometer to service enter of a milk carton the read 61 degrees took proceeded to remove a		3. Education regarding the fortemperature policy, the food policy, and the infection confidence which includes wearing a has to ensure compliance in the department with the dietary sconducted on 4/18/19 by the Administrator. 4. Monitoring performance to that solutions are sustained Department the Dietary mann Designee will randomly audit residents trays for serving te on drinks and meals 3 x's per two(2) month and 2 x's per w (1)month starting 4/18/19. He monitored 3x's per week x's months and 2 x's per week x's months and 2 x's per week x's month starting 4/18/19 on all by the Dietary manager and Data will be summarized and the facility Quality Assurance Improvement Committee per Months presented by the Di Manager and or Designee. A trends identified will be addrequality Assurance Performa Improvement Committee as and the plan will be revised to continued compliance. Corrective action will be com 4/18/19	serving trol policy irnet in order dietary staff were o make sure in the Dietary agger and or t five emperatures er week x's one airnets will be two (2) c's one (1) I three shifts or Designee. d presented to e Performance r Month x's 3 fetary Any issues or essed by the nce they arise to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	OATE SURVEY COMPLETED			
		345307	B. WING			R-C 04/17/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENT			STREET ADDRESS, CITY, STATE, ZIP COD 4414 WILKINSON BLVD GASTONIA, NC 28056	E	04/1//2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
{F 812}	that reading." The 9 been unrefrigerated meal service and we On 04/17/19 at 12:20 temperature logs for logs revealed the "co was measured daily The DM was intervie beverages ' temperature was the temperature and not temperature. Observations were in contained an internate degrees Fahrenheit. cardboard box of indoutside of the cardbowith instructions that between 34 - 40 deg On 04/17/19 at 1:55 (RD) was interviewed explained she was reaspects but was help kitchen operations sirole. The RD stated kept cold and should residents at 61 degree on 04/17/19 at 2:13 interviewed and stated	and stated, "see we go by cartons of milk that had remained in use for the lunch re served to residents." DPM the DM provided the meal service, review of the old beverages" temperature to be 40 degrees Fahrenheit. We about the cold ature and reported that the internal thermometer's the milk's actual The made of the "milk box" that the internal thermometer that read 40 and the milk box was a dividual milk carts. The ford milk box was stamped read, "Keep Refrigerated rees." The made of the telephone and esponsible for the clinical bing the DM with some basic made the DM was new in her that milk was expected to be not have been served to	{F 8	12}		
	the start of tray line.	acing it on the trays prior to The dietary aide was asked en she took the milk cartons				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COI	TE SURVEY MPLETED	
		345307	B. WING _			R-C 4/17/2019	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		0.1.1.20.10	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{F 812}	was noted to have use and set to 62 addition, the kitch screen door was screen door was because it was so. On 04/17/19 at 2: conducted with the first time she temperature measure pulled direct She added that sl the "milk box" to be milk cartons. The cartons had been recorded 61 degree that the milk cartons had been recorded that she all pull from the "milk milk cold. On 04/17/19 at 2:	meal observation, the kitchen e an air condition window unit in degrees Fahrenheit. In en's back door was open and a n use. The cook stated that the to help cool off the kitchen	{F 8	12}			
	lunch meal servic cook was noted to top of head, leaving exposed. The co tray line during th On 04/17/19 at 2:	t 12:15 PM observations of the e were made that revealed the o have a hairnet secured on the ng the bottom half of her hair ook was serving food from the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345307	B. WING_			R-	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CC 4414 WILKINSON BLVD GASTONIA, NC 28056	DDE	U 4/	17/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
{F 812}	explanation why her haduring the lunch meal fixing to clock out and On 04/17/19 at 2:22P interviewed and explatraining on hairnets, because them to cover all On 04/17/19 at 2:46 Finterviewed and report	er hair and offered no nair was not fully covered I service because, "she was	{F 8	12}			

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345307	B. WING _		1	I-C 17/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	1772019
MEADOW	WOOD NUIDOING OFNIT			4414 WILKINSON BLVD		
MEADOW	WOOD NURSING CENT	= K		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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	On 04/17/19, the Div Regulation, Nursing H Certification Section of While some of the de corrected on 04/01/19	rision of Health Service Home Licensure and conducted an onsite revisit.				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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

TITLE (X6) DATE

Electronically Signed 04/29/2019

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307 B. WING			R-C 04/17/2019		
NAME OF PR	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD	ÞΕ	04/	1772019
MEADOW	WOOD NUDEING CENT	ED.		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	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI APPROPRIA		(X5) COMPLETION DATE
F 000	REGULATORY OR LSC IDENTIFYING INFORMATION)					TE .	DAIE
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	RF	TITLE			(X6) DATE

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		345307 B. WING			R-C 04/17/2019			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE	1 0-4/	1772013	
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)			(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 000	Regulation, Nursing H Certification Section of While some of the de corrected on 04/01/19 compliance. The man 04/25/19.	rision of Health Service Home Licensure and conducted an onsite revisit. ficiencies cited were 0, the facility remains out of indatory termination date is						
I ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	 RF	TITLE			(X6) DATE	

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Electronically Signed

Facility ID: 923314

04/29/2019