PRINTED: 08/14/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER MEADOWWOOD NURSING CENTER MEADOWOOD NURSE CENTER		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
MAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER (XA1) D (XA2)								C
MEADOWWOOD NURSING CENTER			345307	B. WING _			07/	09/2019
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) REGULATORY OR ISC IDENTIFYING INFORMATION REGULATORY OR ISC IDENTIFY INFORMATION REGULATORY OR INFORMATION			ER		4414 WILKINSON BLVD	IP CODE		
A complaint investigation survey and on-site revisit was conducted on July 9, 2019. Two of the three allegations were substantiated. F 636 Comprehensive Assessments & Timing F 636 CFR(s): 483.20(b)(1/2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xii) Skin Conditions. (xiii) Activity pusuit. (xiv) Medications. (xii) Activity pusuit. (xiv) Medications. (xiv) Discharge planning. (xvii) Documentation of summary information	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD B FO THE APPROPRIA		COMPLETION
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§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information		The facility must cond a comprehensive, acreproducible assessn	duct initially and periodically curate, standardized					
		§483.20(b)(1) Reside A facility must make a assessment of a reside goals, life history and resident assessment by CMS. The assess the following: (i) Identification and continuous communication and continuous communication. (v) Vision. (vi) Mood and behaving (vii) Psychological were continuous con	ent Assessment Instrument. a comprehensive dent's needs, strengths, preferences, using the instrument (RAI) specified ment must include at least demographic information e. s. or patterns. ell-being. ning and structural problems. s and health conditions. onal status. ats and procedures. ing.					
	ARORATORY	, ,	<u> </u>	DE	TITLE			(X6) DATE

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

08/02/2019

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:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345307	B. WING		C 07/09/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	1 07/09/2019
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 636	on the care areas trig the Minimum Data Se (xviii) Documentation assessment. The assinclude direct observa with the resident, as viicensed and nonlicer members on all shifts §483.20(b)(2) When it timeframes prescribe chapter, a facility musassessment of a resid timeframes specified through (iii) of this serprescribed in §413.34 apply to CAHs. (i) Within 14 calendar excluding readmission significant change in mental condition. (Fo "readmission" means following a temporary or therapeutic leave.) (iii)Not less than once This REQUIREMENT by: Based on record revifacility failed to compliassessment every 12 Assessment Instrumer residents reviewed (Findings included:	anal assessment performed gered by the completion of et (MDS). of participation in sessment process must ation and communication well as communication with ased direct care staff required. Subject to the din §413.343(b) of this st conduct a comprehensive dent in accordance with the in paragraphs (b)(2)(i) etion. The timeframes (a)(b) of this chapter do not days after admission, as in which there is no the resident's physical or a return to the facility absence for hospitalization are every 12 months. I is not met as evidenced ew and staff interview, the lete a comprehensive months using the Resident ent (RAI) for 1 of 12 sampled desident #2).	F 63	The facility failed to complete an annu Comprehensive Minimum Data Set(MDS)On Resident #2. The annual Comprehensive assessment for reside #2 was completed on 6/25/19 and transmitted on 7/11/2019 by the Corpo MDS Nurse. 2. Residents in the facility have the	nt
	01/15/15 with diagnost Parkinson's disease,	ses that included chronic kidney disease,		potential to be affected by the deficient practice. An audit was completed on	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		345307	B. WING		C	9/2019
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	0770	9/2019
				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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 636	Continued From page	2	F 6	36		
	diabetes, anxiety, and	d depression.		annual assessments by the Admi	nistrator	
				on 7/11/2019 any concerns identi	fied were	
	Review of Resident #			addressed.		
		nost recently completed e assessment had an ARD		3. A experienced RN MDS coordi	inator	
	(Assessment Referen			was hired on 7/22/2019. The MD		
	(, 1000001110111111111111111111111111111	100 2010) 01 00/0 1/10.		coordinator was educated by the		
	Further review of Res			Administrator on 7/24/2019 regar		
		led an incomplete annual		survey results that the facility faile		
	comprehensive Minim	NRD of 06/05/19. The status		complete an annual Comprehens and that the facility must conduct		
		as "in progress" which		comprehensive assessment on re		
	indicated it was not co			in accordance with specific time f		
	An interview was con-	ducted with the		4.Monitoring: The Director of Nur	sing	
	Administrator on 07/0	9/19 at 3:50 PM. The		(DON) and or Administrator will a	-	
		ed the facility currently did		completion status up to five (5) M		
		dinator. The Administrator DS Coordinator's position		week x's 4 weeks then three (3) x's 4 weeks starting 8/2/2019.	er week	
	_	b duties were reassigned to				
		g (DON), but the DON The Administrator stated		5. Data will be summarized and p to the facility Quality Assurance	resented	
	•	was an issue with MDS		Committee one (1) x per month x	's two (2)	
		ng completed or transmitted		months by the Director of Nursing		
	within the regulatory t	imeframe and had		Coordinator. Any issues or trends	5	
		from the corporate office		identified will be addressed by the	-	
		assessments. She added		Assurance Performance improve		
	the facility had not rec	whedged resident MDS		Committee as they arise and the be revised to ensure continued	pian wili	
	assessments were lat	_		compliance.		
				The Director of Nursing and or		
				Administrator is responsible for		
				implementing and maintaining the	e	
				acceptable plan of correction.		
				Corrective action completed by 08/02/2019		

	DF DEFICIENCIES CORRECTION	I DENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345307	B. WING		C 07/00/2040
NAME OF D	ROVIDER OR SUPPLIER	343307	1 3:	STREET ADDRESS, CITY, STATE, ZIP CODE	07/09/2019
NAME OF T	NOVIDER OR SOLT EIER				
MEADOW	WOOD NURSING CENT	ER		4414 WILKINSON BLVD	
				GASTONIA, NC 28056	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 638	Continued From page	e 3	F 63	8	
F 638	Ortly Assessment at I	Least Every 3 Months	F 63	8	8/2/19
SS=E	CFR(s): 483.20(c)				0.2.10
	§483.20(c) Quarterly	Review Assessment			
	A facility must assess	a resident using the			
	quarterly review instri	ument specified by the State			
		S not less frequently than			
	once every 3 months				
		is not met as evidenced			
	by:				
		iew and staff interview, the		The facility completed the quarte	-
		lete quarterly Minimum Data		assessments for resident #3 on 7	
		ents every three months ssessment Instrument (RAI)		and accepted on 7/30/19, resider 7/29/2019 and accepted on 7/30/	
	for 4 of 12 sampled re			resident #12 on 7/25/19 accepted	
	(Residents #3, #6, #1			7/26/19 and resident #10 comple	
	(1 (00) 00) 110, 110, 111	10, and // 12).		8/2/19, by the Facility MDS nurse	
	Findings included:				
	J			2. Residents in the facility have the	ne
	1. Resident #3 was a	admitted to the facility on		potential to be affected by the alle	
	08/26/17 and had mu	Iltiple diagnoses that		deficient practice. An audit was c	ompleted
	included congestive h	neart failure, chronic knee		by the Administrator on 8/2/19 on	1
	pain, diabetes, and cl	hronic renal failure.		quarterly assessments any conce	erns
				identified were addressed.	
		3's electronic medical			
		nost recently completed		3. Education: The RN MDS coord	
	quarterly MDS asses			started employment on 7/22/19.	
	(Assessment Referer	nce Date) of 03/14/19.		coordinator was educated on 7/2	
	Further review of Res	sident #3's electronic		regarding the survey results that facility failed to complete quarterl	
		led an incomplete quarterly		assessments. In addition, the fac	-
		th an ARD of 06/14/19. The		complete timely quarterly assess	-
		ment was "in progress"		and make necessary revisions to	
	which indicated it was	. •		accuracy and once completed tra	
				CMS.	
	An interview was con	ducted with the			
	Administrator on 07/0	09/19 at 3:50 PM. The		4. The Director of nursing (DON)	and or
	Administrator confirm	ned the facility currently did		Administrator will audit the compl	etion of
	not have a MDS Coo	rdinator. The Administrator		quarterly assessments status up	to five

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	PLE CONSTRUCTION G		(X3) DATE SU COMPLE	
		345307	B. WING _			C 07/09	9/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	ER.		4414 WILKINSON B	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	(EACH (OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
F 638	explained when the Moscame vacant the jour the Director of Nursin resigned on 06/27/19 she was aware there assessments not being within the regulatory of requested assistance with completing MDS the facility had not recassistance and acknown assessments were lated. 2. Resident #6 was a 09/26/16 and had murincluded congestive of (difficulty swallowing) diabetes. Review of Resident #7 record revealed the office of the properties of the same of this assessment with status of this assessment w	IDS Coordinator's position b duties were reassigned to g (DON), but the DON. The Administrator stated was an issue with MDS ag completed or transmitted imeframe and had from the corporate office assessments. She added devived the requested awledged resident MDS te. Idmitted to the facility on litiple diagnoses that leart failure, dysphagia, chronic kidney disease and and the coordinate of the completed sment had an ARD and the coordinate of the coordinate	F	(5) quarterly weeks then the weeks starting the facility Quarter of the Director of Coordinator. Identified will assurance of Committee as the revised to compliance. The Director Administrator implementing acceptable properties to the compliance of the properties of the properties of the compliance.	MDS per week x's four (4) three (3) per week X's 4 ng 8/2/19. summarized and presente uality Assurance Committer month x's two (2) months of Nursing or MDS Any issues or trends I be addressed by the Quaterformance improvement as they arise and the plan of ensure continued of Nursing and or is responsible for g and maintaining the plan of correction. ction completed by	d to ee by	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION 3		ATE SURVEY DMPLETED
		345307	B. WING			C 07/09/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	L		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		07709/2019
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 638	assessments not beir within the regulatory to requested assistance with completing MDS the facility had not recassistance and acknown assessments were lated. 3. Resident #10 was 08/05/15 and had multincluded anemia, seiz depression. Review of Resident #10 record revealed the multing model of the model	ing completed or transmitted imeframe and had from the corporate office assessments. She added believed the requested owledged resident MDS te. admitted to the facility on litiple diagnoses that ture disorder, anxiety, and the ture disorder, anxiety, and the ture disorder is an analysis of the corporate of the facility completed is ment had an ARD for and "in progress" but no ents were completed or and "in progress" but no ents were completed or and "in progress" but no ents were completed or and "in progress" but no ents were reassigned to go (DON), but the DON is the Administrator and the corporate office assessments. She added devived the requested owledged resident MDS	F 63	8		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		345307	B. WING			C 07/09/2019
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	<u> </u>	07/09/2019
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 638	Continued From page	e 6	F 6	38		
	09/23/16 and had mu included anemia, hea	admitted to the facility on Itiple diagnoses that rt failure, hypertension, and ack of bladder control).				
	record revealed the n	12's electronic medical nost recently completed sment had an ARD nce Date) of 03/09/19.				
	medical record revea MDS assessment wit	sident #12's electronic led an incomplete quarterly h an ARD of 06/09/19. The nent was "in progress" s not completed.				
F 640 SS=D	Administrator confirm not have a MDS Cool explained when the Moderate vacant the journal to the Director of Nursin resigned on 06/27/19 she was aware there assessments not being within the regulatory for the requested assistance with completing MDS the facility had not recassistance and acknown assessments were later assistance and acknown assessments were later assistance.	9/19 at 3:50 PM. The ed the facility currently did rdinator. The Administrator IDS Coordinator's position b duties were reassigned to g (DON), but the DON . The Administrator stated was an issue with MDS ng completed or transmitted imeframe and had from the corporate office assessments. She added beived the requested weldged resident MDS te. g Resident Assessments	F 6	40		8/2/19
	§483.20(f) Automated requirement-	I data processing				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION IG		(X3) DATE S COMPL	
		345307	B. WING _			07/0	9/2019
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CIT 4414 WILKINSON BLV GASTONIA, NC 280	/D	1 0770	3/2013
(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 PRRECTIVE ACTION SHOULD BI FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	§483.20(f)(1) Encodir a facility completes a facility must encode the each resident in the final facility must encode the each resident in the final facility must encode the each resident in the final facility and assessme (ii) Annual assessme (iii) Significant change (iv) Quarterly review at (v) A subset of items reentry, discharge, and (vi) Background (face is no admission assess §483.20(f)(2) Transmatter a facility comple a facility must be caped CMS System information contained in the MDS standard record layou and that passes standard record layou and th	ng data. Within 7 days after resident's assessment, a he following information for acility: ment. Int updates. In it updates. In it updates. It in status assessments. It in a resident's transfer, and death. It in the same the sa	F	40			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING_			С	
		345307	B. WING_			7/09/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
MEADOW	WOOD NURSING CEN	TFR		4414 WILKINSON BLVD			
	NOOD NONO OZ.			GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 640	Continued From pag	ge 8	F 6	640			
	does not have an ac	dmission assessment.					
	transmit data in the for a State which ha by CMS, in the form approved by CMS. This REQUIREMEN	ormat. The facility must format specified by CMS or, s an alternate RAI approved at specified by the State and					
facility failed to to (Minimum Data)		view and staff interview, the smit a comprehensive MDS within 14 days of the 1 of 12 sampled residents		The Comprehensive Non resident #5 on 6/5/1 on 7/11/19 by the Corp	19 and transmitted		
	reviewed (Resident			2. Residents have the affected by the deficier			
	Findings included:			was completed by the concerns or issues were			
	Resident #5 was ad	mitted to the facility on					
	05/14/15.			3. Education: The MDS educated by the Admin			
		#5's electronic medical last transmitted MDS was		regarding the survey re facility failed to transmi			
		/ assessment with an ARD ence Date) of 04/02/19.		completed assessment must be transmitted wit completion.			
		esident #5's electronic aled an annual MDS					
	as completed on 06	ARD of 04/10/19 was signed /05/19. The status of this kport ready" which indicated it		4. Monitoring: The Dire or Administrator will au of completed assessment MDS per week x's 4 week x's per week x's 4 week	udit the transmission ents up five (5) eeks then three (3)		
	Administrator confirmation not have a MDS Coexplained when the became vacant the	nducted with the //09/19 at 3:50 PM. The med the facility currently did ordinator. The Administrator MDS Coordinator's position job duties were reassigned to ing (DON), but the DON		Data will be summarize the facility Quality Assu- one (1) x per month x's the Director of Nursing Coordinator. Any issue	urance Committee s two (2) months by or MDS		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345307	B. WING _				C /09/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTE	ER .		44	TREET ADDRESS, CITY, STATE, ZIP CODE 114 WILKINSON BLVD ASTONIA, NC 28056	, 017	03/2013
(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 640	she was aware there assessments not beir within the regulatory t requested assistance with completing MDS the facility had not red	The Administrator stated was an issue with MDS ag completed or transmitted imeframe and had from the corporate office assessments. She added believed the requested swledged resident MDS	F	640	identified will be addressed by the Qua Assurance Performance improvement Committee as they arise and the plan of be revised to ensure continued compliance. The Director of Nursing and or Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	-	
F 677 SS=D	S483.24(a)(2) A reside out activities of daily I services to maintain opersonal and oral hygometric REQUIREMENT	ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene;	F	677			8/2/19
	interviews, the facility incontinence care for for assistance with ac (Resident #3). Findings included: Resident #3 was adm 2/27/19 with diagnose chronic renal failure a (CHF). Resident #3 was code Data Set (MDS) dated	1 of 3 residents reviewed tivities of daily living sitted to the facility on es which included anxiety, and congestive heart failure sed on the quarterly Minimum			Resident #3 was provided incontinent care immediately by C.N.A #1 on 7/9/1 once informed by the Administrator regarding the resident need. 2. Residents have the potential to be affected by the deficient practice; however, in order to ensure the facility able to identify other residents the Administrator had conducted an audit of 7/10/19 on five (5)alert and oriented residents on each hall in order to ensure ADL compliance any issues or concernidentified were addressed. 3.In order to ensure the deficient practice.	g is on re is	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345307	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	343307	1		TREET ADDRESS, CITY, STATE, ZIP CODE	1 07/	09/2019
NAIVIE OF PI	ROVIDER OR SUPPLIER						
MEADOW	WOOD NURSING CENTE	ER			414 WILKINSON BLVD		
				G	ASTONIA, NC 28056		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 677	Continued From page	∍ 10	F 6	677			
	activities of daily living incontinent of bowel a	g (ADL) except eating, was and bladder.			does not recur as of 7/10/19 the C.N.A have been informed by the Administrat to ask cognitive residents if they need	or	
		3's care plan with a review			go to the restroom or be changed if		
	I .	ed she was care planned for			wearing a brief. In additions, incontiner		
		nance deficit related to CHF			rounds will be performed by the C.N.A'	S	
		as for the resident to have			during morning ADL care, before		
	I .	nuch assistance from her as			breakfast, after breakfast, before and c		
		review date. The care plan			after lunch, before and or after dinner a as needed.	ına	
		quired extensive physical r incontinence care and			as needed.		
	wore briefs.	i incontinence care and			In addition, the Environmental Service		
	Word bridg.				Director and Business office manager		
	An observation on 7/0	09/19 at 10:55 AM of Nurse			were in-serviced by the Administrator of	n	
		ovided incontinence care			7/30/19 regarding answering residents		
	1 1	s's brief was saturated from			call-lights and addressing their concern		
	front to back with urin	ne and had a medium			immediately to a C.N.A or License Nur		
	amount of soft formed	d brown substance and the			All Nursing Staff were provided in-serv	ice	
	bed pad was wet. Re	sident #3's skin was intact			on 7/26/19 and 7/29/19 by the Director	of	
	with no redness, but i	resident did complain of			Nursing regarding providing incontinen	ce	
	burning and itching.				care in a timely manner, the instruction		
					to provide incontinent care before and		
		ducted on 7/09/19 at 4:59			after every meal and the license Nurse		
		who stated she had rung her			were informed to provide assistance if	the	
	1	s during the afternoon and			C.N.A's are behind.		
	told a housekeeper, t				4 Manitaring to anough that colutions of		
		and the Administrator that anged. Resident #3 indicated			4.Monitoring to ensure that solutions at		
	I .	anged since the morning			sustained the Director of Nursing and of designee will randomly audit five (5) along the control of the control		
		ad observed her being			and oriented residents and resident's the		
	1	ated she wanted to be			are not cognitive intact on each hall 5 >		
	_	ently and felt bad when left to			per week x's 4 weeks then 3x's per we		
		sident #3 reported she had			x's 4 weeks starting 7/29/2019. In		
	1 -	her brief which made her			addition, above in-services will be		
		able. The interview further			included in the new hires orientation		
	1	dministrator answered			package starting 8/02/19.		
		Il the resident had informed					
	the Administrator she	had already asked three			Data will be summarized and presente	d to	
		to notify NA #1 she needed			the facility Quality Assurance Committee		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		345307	B. WING _				C 09/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTI	ER .		44	TREET ADDRESS, CITY, STATE, ZIP CODE 814 WILKINSON BLVD ASTONIA, NC 28056	1 011	03/2013
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	and NA #5 who provirevealed Resident #3 front to back with urin brown substance on no redness, but she oburning. An interview on 7/09/Housekeeper #1 reversedent #3's call light changed. He further had and had forgotten to tell the had requested to be changed. An interview on 7/09/Business Office Mananswered Resident #1 requested to be changed was unsure what time light but stated it was if NA #1 had changed. An interview on 7/09/revealed she had and light twice since lunct times. She stated the requested ice water was easient requested to NA #1. Nurse #1 did changed Resident #3 why she had not changed. An interview on 7/09/Man in	29/19 at 5:00 PM of NA #1 ded incontinence care I's brief was saturated from the and had a smear of dried it. Her skin was intact with did complain of itching and 19 at 5:53 PM with realed he had answered that and she requested to be revealed he was unsure the ene NA #1 that Resident #3 changed. 19 at 5:56 PM with the reager revealed he had 3's call light and she reged and he told NA #1. He reged and he told NA #1. He reged her call reged after lunch. He did not know that Resident #3. 19 at 5:54 PM with Nurse #1 rewered Resident #3's call reged and he resident which she provided and the reged the call light the reged and she told reged and she did not indicate	F	577	one (1) x per month x's two (2) months the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Qual Assurance Performance improvement Committee as they arise and the plan vibe revised to ensure continued compliance. The Director of Nursing is responsible implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	lity	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _			C 07/09/2019
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		01703/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677	needed to be change responsible for reside included Resident #3 busy to change reside was supposed to. NA supposed to work fro worked late. She stat telling her Resident # An interview on 7/09/Administrator reveale #3 had requested to lunch and had not be The Administrator con Resident #3 when sh notified NA #1 that the changed. An interview on 7/09/Administrator revealed the changed. An interview on 7/09/Administrator revealed the changed. An interview on 7/09/Administrator revealed the changed from the cha	e told her the resident d. NA #1 stated she was ents on the hall which but that she had been too ents every 2 hours as she a #1 explained she was m 7:00 AM to 3:00 PM but ed she did not recall anyone d3 needed to be changed. 19 at 6:00 PM with the ed she was aware Resident be changed four times after en changed until 5:00 PM. Infirmed she had talked with e answered her call light and e resident had requested to 19 at 7:01 PM with the ed she expected the staff to incontinent residents every know why Resident #3 had om 10:55 AM until 5:00 PM. Full Time DON -(3) d nurse when waived under f this section, the facility s of a registered nurse for at ours a day, 7 days a week.	F 6			8/2/19

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		IPLE CONSTRUCTION (X		(X3) DATE SURVEY COMPLETED	
		345307	B. WING				C	
		345307	B. WING			07/	09/2019	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW	WOOD NURSING CENTI	ER			414 WILKINSON BLVD			
_				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	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 727	Continued From page	e 13	F	727				
	as a charge nurse on average daily occupa This REQUIREMENT by:	ly when the facility has an ancy of 60 or fewer residents.				40		
	facility failed to design (RN) to serve as the limit when the previous DO 06/27/19. The facility RN for at least 8 cons 12 days reviewed (07 07/06/19, and 07/07/7 Findings included: Review of the facility' roster revealed they constructed they constructed the part-time RNs. Other no full-time RNs note Review of the facility' the period 06/27/19 to did not work 8 consections.	s nursing department staff currently employed 3 r than the DON, there were d on the roster. s timecard detail report for 0 07/09/19 revealed a RN cutive hours on the following			The facility hired a new DON on 7/17/ No resident was affected by the deficie practice. No resident was affected by the deficie practice. 2. Residents have the potential to be affected by the deficient practice in ord to ensure that the deficient practice do not recur the facility has also employed RN MDS nurse on 7/22/19 that will be able to fill the role as a charge nurse ur a new DON is selected and hired. In addition, the Company has employed the services of a compliance company that will send a RN to help fill the position if becomes vacant again. In addition, schedules are being monitored daily by the Director of Nursing and Administration.	nt er es l a ntil he it		
	07/07/19. A telephone interview facility's former DON The DON stated she 06/27/19 and was prenotice but was told by not be necessary. She worked at the factory of the property of the proper	•			and re-staffing when call-off occurs. 3. Education: The Corporate Nurse had received in-service by the Corporate Administrator on 7/10/19 on ensuring the Corporate Office will provide support to the facility and provide a RN from how office to assist the facility until a RN is retained for 8hrs 7 days a week or a full-time DON. 4. Monitoring: The Administrator or Director of Nursing will sign off 1 x per Month for three Months that the facility in compliance with RN staffing starting	nat rt me		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		C 07/09/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	1 07/03/2013
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 727	Administrator verified staffing schedules and currently employed by to work certain days. there was no RN coverstaffing Agency to professional principles appropriate accessory instructions, and the eapplicable.	was on 06/30/19. The she was responsible for the d explained the RNs of the facility were only able. She added on the days erage she relied on a local ovide RN staff for the facility. Were conducted with the 9/19 at 5:05 PM and 7:00 or stated she was aware of quired a RN to be as the DON as well as have onsecutive hours per day. Was currently no RN is the DON and upon didetail report along with the poices, she acknowledged by during the time frame of in which the facility had no diministrator added the aware the DON resigned on they have not sent anyone to the Interim DON until the did. did Biologicals (1)(2) of Drugs and Biologicals are used in the facility must be a with currently accepted in the facility and cautionary	F 7:	7/17/19. Data will be summarized and prese the facility Quality Assurance Commone (1) x per month x's three (3) month by the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Committee as they arise and the place of the revised to ensure continued compliance. The Director of Nursing and or Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	mittee onths Quality ent
	J (,	3 - 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED			
		345307	B. WING _			C 07/09/2019		
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 761	Federal laws, the fact biologicals in locked temperature controls personnel to have ac §483.45(h)(2) The fact locked, permanently storage of controlled the Comprehensive Control Act of 1976 abuse, except when package drug distrib quantity stored is minus be readily detected. This REQUIREMEN by: Based on observation interviews, the facility insulin Flexpen when expired bottle of Vita opened bottle of Farreducer) with no expavailable for use in 1 facility also failed to influenza vaccine in room. Findings included: 1. Observation of me 9:45 AM revealed a handwritten name or and no open date waresident use.	ordance with State and collity must store all drugs and compartments under proper s, and permit only authorized coess to the keys. Idility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can T is not met as evidenced on, record review, and staff y failed to date a Novolog on opened, discard an opened min B1 tablets and an notidine (stomach acid iration date that were of 2 medication carts. The discard 3 expired vials of 1 of 1 medication storage	F 7	The facility discarded the Novol Flexpen and the expired bottle of B1 tablets famotidine, and viral vaccine on 7/9/2019. 2. No resident was found to be a the deficient practice; however, the potential for residents to be by the deficient practice. In order ensure that the deficient practice recur an audit of the facility medicants and medication storage roconducted by the Administrator and 7/10/19 any concerns identicated and 7/10/19 any concerns identicated on 7/26/19 and 7/25 date medications when open and 7/25 date medications when open and 3/25 date medicatio	of vitamin influenza affected by there is affected er to e does not lication om was on 7/09/19 iffed were			
	Nurse #2 revealed it	ted on 7/9/19 at 9:45 AM with was her second day at the ot give insulin on her shift, so		expiration dates (Insulins), to ch make sure residents name, dos route of administration is on the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345307	B. WING _				C 09/2019
	ROVIDER OR SUPPLIER WOOD NURSING CENTI	ER		44	TREET ADDRESS, CITY, STATE, ZIP CODE 114 WILKINSON BLVD ASTONIA, 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	further stated she had should have an open well as resident ident not be used unless it An interview conduct with the physician reverse facility to follow the rundications and insurant An interview conduct with the Administrator should have identifier included resident narrow date and she was uninsulin pen did not had the Administrator stated each nurse shan expiration date be night shift nurse was medication carts for emedications. 2. Observation of me 9:15 AM revealed and which expired on 02/resident use. An interview conduct. Nurse #1 revealed shottle of Vitamin B1 vavailable for resident been on the cart. Nurse well as the cart. Nurse was motion of the cart. Nurse was medication carts for emedications.	the insulin pens. She discern taught insulin pens date and a discard date as iffer information and should had that information on it. ed on 7/9/19 at 11:24 AM realed he expected the ules regarding expired lin pens. ed on 7/9/19 at 10:30 AM revealed insulin pens information sticker which ne, open date and discard able to explain why this expected when the nurse opened uld write the open and label. The Administrator ould check medications for fore administering it and the responsible for checking the	F	761	medication card and discarding expired medications by the Director of Nursing. 4 Monitoring: The Director of Nursing, license nurses, and or designee will aud Medication carts and the Medication Storage room 5 x's per week x's 4 week then 4 x's per week x's 4 weeks to ensurcompliance is maintained starting 0n 8/2/19. Data will be summarized and presented the facility Quality Assurance Committed one (1) x per month x's two (2) months the Director of Nursing or MDS Coordinator. Any issues or trends identified will be addressed by the Qual Assurance Performance improvement Committee as they arise and the plan who he revised to ensure continued compliance. The Director of Nursing and Licensed nurses are responsible for implementin and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019	dit ks ure dito ee by lity vill	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345307	B. WING _			C 07/09/2019	
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	.	01703/2013	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 761	with the physician refacility to follow the refacility to follow the refacility to follow the remedications and insurance with the Administrator medications should and should not be given a district medication of the Administrator was unexpired medication of the Administrator stocheck medications for administering it and responsible for check and undated. 3. Observation of medication of the possible for check and undated. 3. Observation of medication of the possible for check and undated. 3. Observation of medication of the possible of the possible observed ready for reface the possible observed ready for reface and undated. Nurse #1 revealed the pottle of Famotidine stated she did not known as legible expiral medication cart availalso revealed she did not with the possible observed and the possible expiral medication cart availalso revealed she did not with the possible possible expiral medication cart availalso revealed she did not with the possible possib	ted on 7/9/19 at 11:24 AM evealed he expected the ules regarding expired ulin pens. ted on 7/9/19 at 10:30 AM or revealed expired not be on the medication cart expired to explain why this expired each nurse should or an expiration date before the night shift nurse was king the medication carts for I medications. edication cart #1 on 7/9/19 at a open bottle of Famotidine expiration date was	F 7	61			
	with the physician re facility to follow the r medications and inst	ted on 7/9/19 at 11:24 AM vealed he expected the ules regarding expired ulin pens.					
	with the Administrate	or revealed medications medication cart without a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345307	B. WING _			C 07/09/2019	
	ROVIDER OR SUPPLIER WOOD NURSING CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	'	3770072010	
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 761	explain why this med expiration date was of Administrator stated medications for an eladministering it and responsible for check expired and undated 4. Observation of the 7/9/19 at 10:15 AM vexpired vials of influeready for resident us vaccine had an expired vials were expired and should not have room. Nurse #1 did responsible for check room for expired medical expired medical expired medical expired and should not have room. Nurse #1 did responsible for check room for expired medical expired medical expired medical expired expired medical expiration of the expired expi	te and she was unable to dication with no legible on the medication cart. The each nurse should check expiration date before the night shift nurse was king the medication carts for medications. The medication storage room on with Nurse #1 revealed 3 enza vaccine were observed to the vials of influenzation date of 6/30/19. The vials of influenzation date of 6/30/19 at 10:15 AM to the 3 influenza vaccine and available for resident use been in the medication to thoo who was king the medication storage dications.	F 7	61			
	with the physician re facility to follow the r medications and insu. An interview conduct with the Administrate expired influenza vac medication storage r know who had put the resident use. She stashould not be given administrator further	ted on 7/9/19 at 10:30 AM or revealed she had removed ocine vials from the com previously and did not em back available for ated expired medications to residents. The stated the night nurse was king the medication storage					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345307	B. WING			C 07/09/2019	
NAME OF P	ROVIDER OR SUPPLIER	0.0001	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		07/09/2019	
INAME OF T	TOVIDER OR OUT FIER				JOBE		
MEADOW	WOOD NURSING CENTI	ER		4414 WILKINSON BLVD			
				GASTONIA, NC 28056			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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) COMPLETION DATE	
F 835	Continued From page	- 10	F8	35			
		5 19				0/0/40	
F 835	Administration		F 8	35		8/2/19	
SS=F	CFR(s): 483.70						
	enables it to use its re efficiently to attain or practicable physical, well-being of each rearthis REQUIREMENT by: Based on record rev facility's administration leadership and overs facility staff complete Minimum Data Set (Not regulatory timeframe residents reviewed (F#10, and #12). The failed to designate a last the Director of Numprevious DON resign Findings included: This tag was cross residents in the previous part of	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced liew and staff interview, the on failed to provide effective light of processes to ensure d and transmitted resident MDS) assessments within the for 6 of 12 sampled Residents #2, #3, #5, #6, facility's administration also Registered Nurse to serve rsing (DON) when the led her position on 06/27/19.		The MDS nurse has comply transmitted resident's MDS for six (6) of 12 sampled reviewed. Residents # 2 con 7/30/19, #5 on 7/11/19, 10 on 8/2/19 and # 12 on Director of Nursing was hit The facility also hired a RN coordinator on 7/22/19. 2. Residents have the potential of the deficient process of the MDS nurse conducted and current Months of residential of the MDS nurse conducted and current MONTHS nurse current MONTHS nurse conducted and current MONTHS nurse curr	S assessments esidents on 7/11/19, #3 ,#6 7/30/19, # 7/26/19. The red on 7/17/19. N MDS ential to be ractice. In order onts were affected does not recur I a audit on past idents MDS on		
				-			
	interview, the facility comprehensive asset	ssment every 12 months		addressed.			
	using the Resident As	ssessment Instrument (RAI)		3. The MDS coordinator w	as educated by		
	for 1 of 12 sampled re	esidents reviewed (Resident		the Administrator on 7/24/	2019 regarding		
	#2).			the survey results that the			
				complete an annual, quart			
	b. F-638: Based on	record review and staff		transmitting Comprehensi	ve MDS and		
	interview, the facility	failed to complete quarterly		that the facility must condu	uct a		
		Set) assessments every		comprehensive assessme			
		12 sampled residents		in accordance with specific			
		#3, #6, #10, and #12).		and when necessary revis			
	Leviewen (Lesinellis	$\pi \cup$, $\pi \cup$, $\pi \cup$, and $\pi \cup J$.		and when hecessary levis	ions are needed	 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345307	B. WING			C	9/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	0770	3/2013	
				4414 WILKINSON BLVD				
MEADOW	WOOD NURSING CEN	ITER		GASTONIA, NC 28056				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIAT		(X5) COMPLETION DATE	
F 835	interview, the facilit comprehensive ME 14 days of the comsampled residents A telephone intervifacility's former Dim 07/09/19 at 1:52 Pher job duties incluses assessments. The have any formal transport of the many form	on record review and staff by failed to transmit a DS (Minimum Data Set) within upletion date for 1 of 12 reviewed (Resident #5). We was conducted with the vector of Nursing (DON) on M. The DON confirmed part of ded completing MDS DON explained she did not vaining and only completed 2 while she was employed. Conducted with the Crop/19 at 3:50 PM. The cred the facility currently did coordinator and acknowledged consumers were late. The valued she was aware there was cassessments not being mitted within the regulatory cuested assistance from the completing MDS and not received the requested A record review and staff by failed to designate a RN) to serve as the Director of cen the previous DON resigned contact and consecutive hours and consecutive hours can be staff and conse	F 8		of Nursing r will audit the e (5) MDS per e (3) per wee 19, quarterly ive (5) s four (4) eek X's 4 will audit the assessments c's 4 weeks x's 4 weeks x's 4 weeks I by the Quali approvement and the plan will approvement approveme	to ee boy		
	07/04/19, 07/05/19 A telephone intervi	-			•			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345307	B. WING _			C 7/09/2019
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	1 0	770372313
(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	(X5) COMPLETION DATE
F 835	The DON stated she 06/27/19 and was prenotice but was told by not be necessary. She worked at the factor of the worked at the factor of the worked at the factor of the worked at the facility of the worked and worked and worked at the regulation that reduces the worked at the regulation that reduces of the worked at the facility of the facility of the worked at the facility of the facilit	turned in her resignation on epared to work a 30-day of the Administrator it would be confirmed the last day sility was on 06/27/19. ducted with the 19/19 at 3:50 PM. The ed the DON resigned her bout stated the last day she was on 06/30/19. The ed the RNs currently ity were only able to work the days there was no RN on a local Staffing Agency to the facility. Were conducted with the 19/19 at 5:05 PM and 7:00 or stated she was aware of quired a RN to be seen the DON as well as have onsecutive hours per day. Was currently no RN as the DON and upon detail report along with the poices, she acknowledged the aware the DON resigned on they have not sent anyone to the Interim DON until the	F8	35		
F 867 SS=D	QAPI/QAA Improvem CFR(s): 483.75(g)(2)	ent Activities	F 8	67		8/2/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345307	B. WING		C 07/09/2019
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/00/2010
				4414 WILKINSON BLVD	
MEADOW	WOOD NURSING CENT	ER		GASTONIA, NC 28056	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 867	Continued From pag	e 22	F 867	7	
	§483.75(g)(2) The gu	uality assessment and			
	assurance committee	-			
		ement appropriate plans of			
	action to correct iden	itified quality deficiencies;			
	This REQUIREMEN	T is not met as evidenced			
	by:				
		ons, record reviews, and		No residents were identified as having]
		erviews the facility's Quality		been affected by the deficient practice	
		surance (QAA) committee		O. The Administrator had a sudveted as	
		plemented procedures and		2.The Administrator had conducted an audit on 7/10/19 on five (5) alert and	
		s that the committee put into omplaint investigation survey		oriented residents on each hall to ensu	ıre
	ı ·	s for two deficiencies that		ADL compliance any issues or concern	-
	were originally cited			identified were addressed.	15
		on the current revisit and		The facility medication carts and	
		on of 07/09/19. The recited		medication storage room was conducted	ed
		the areas of Activities of Daily		by the Administrator on 7/09/19 and	
	Living (ADL) Care Pr	ovided for Dependent		7/10/19 any concerns identified were	
		ing/Storage of Drugs and		addressed.	
	_	tinued failure of the facility			
		rveys of record show a		3. In order to ensure the deficient pract	
	1 '	s inability to sustain an		does not recur as of 7/10/19 the C.N.A	
	effective Quality Assi	urance Program.		have been informed by the Administrat	
	Findings included:			to ask cognitive residents if they need	ıu
	Findings included:			go to the restroom or be changed if wearing a brief. In additions, incontiner	nce
	This tag is cross refe	erenced to:		rounds will be performed by the C.N.A	
	11.10 tag 13 01033 1010			during morning ADL care, before	
	1. a. F 677 ADL Care	e Provided for Dependent		breakfast, after breakfast, before and o	or
		observation, record review		after lunch, before and or after dinner	
		the facility failed to provide		as needed.	
		1 of 3 residents reviewed			
	for assistance with a	ctivities of daily living		The Environmental Service Director ar	
	(Resident #3).			Business office manager were in-servi	
				by the Administrator on 7/30/19 regard	ing
		estigation of 05/24/19 the		answering residents call-lights and	_
	facility was cited for f			addressing their concerns immediately	to
	incontinence care to	two dependent residents.		a C.N.A or License Nurse. All Nursing	

c	
345307 B. WING 07/09	9/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	3/2013
MEADOWWOOD NURSING CENTER 4414 WILKINSON BLVD	
GASTONIA, NC 28056	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
b. F 761 Labeling/Storage of Drugs and Biologicals: Based on observation, record review and staff interviews, the facility failed to date a Novolog insulin Flexpen when opened, discard an opened expired bottle of Vitamin B1 tablets and an opened bottle of Famotidine (stomach acid reducer) with no expiration date that were available for use in 1 of 2 medication carts. The facility also failled to discard 3 expired vials of influenza vaccine in 1 of 1 medication storage room. During the complaint investigation of 05/24/19 the facility was cited for failure to discard opened and expired Vitamin B1 tablets and B Liquid Complex capsules from the medication storage room and carts. During an interview on 07/09/19 at 3:50 PM the Administrator explained staffing had been an issue since starting her employment at the facility and she felt the systems put into place to correct the deficiencies broke down due to the difficulties finding and hiring qualified staff that would stay. All licensed nursing staff were re-educated on 7/26/19 and 7/29/19 to date medications at many discarding expired medications by the Director of Nursing. All licensed nursing staff were re-educated on 7/26/19 and 7/29/19 to date medications at name, dosage, and route of administration is on the medication card and discarding expired medications by the Director of Nursing. 4.Monitoring to ensure that solutions are sustained the Director of Nursing and or designee will audit five (6) alert and oriented residents and resident's that are not cognitive intact on each hall 5 x's per week x's 4 weeks then 4x's per week x's	

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 _			07/0	
	NAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER			STREET ADDRESS, CITY, S 4414 WILKINSON BLVD GASTONIA, NC 28056		<u> 07/C</u>	09/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	e 24	F8	one (1) x per mon the Director of Nul Coordinator. Any identified will be a Assurance Perfort Committee as the be revised to ensul compliance.	issues or trends ddressed by the Qua mance improvement y arise and the plan v ure continued ursing, licensed Nurse tor is responsible for maintaining the f correction.	vill	

PRINTED: 08/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	COMPLETED	
		345307	B. WING _		R-C 07/09/2019
NAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056	, 6176612616
(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 APPROFICIENCY)	D BE COMPLETION
F 000	INITIAL COMMENTS		F 0	00	
{F 677} SS=D	Tags F 561, F 568, F corrected July 9, 201 New tags were also complaint investigation conducted at the samfacility is still out of conducted for the samfacility	ne time as the revisit. The ompliance. or Dependent Residents	{F 67	77}	8/2/19
	out activities of daily services to maintain of personal and oral hyd. This REQUIREMENT by: Based on observation interviews, the facility incontinence care for for assistance with active (Resident #3). Findings included: Resident #3 was adm 2/27/19 with diagnostic chronic renal failure at (CHF). Resident #3 was cod Data Set (MDS) date cognitively intact, required.	is not met as evidenced n, record review, and staff failed to provide 1 of 3 residents reviewed ctivities of daily living nitted to the facility on es which included anxiety, and congestive heart failure ed on the quarterly Minimum d 3/14/19 as being uired total assistance with all g (ADL) except eating, was		Resident #3 was provided incontine care immediately by C.N.A #1 on 7/5 once informed by the Administrator regarding the resident need. 2. Residents have the potential to be affected by the deficient practice; however, in order to ensure the faciliable to identify other residents the Administrator had conducted an aud 7/10/19 on five (5)alert and oriented residents on each hall in order to enamed the ADL compliance any issues or conceidentified were addressed. 3.In order to ensure the deficient practice and recur as of 7/10/19 the C.N. have been informed by the Administ	etity is lit on sure erns actice I.A's rator
		3's care plan with a review ed she was care planned for		to ask cognitive residents if they nee go to the restroom or be changed if wearing a brief. In additions, incontir	
APODATODY	NIDECTOR'S OR DROVINER!	SLIPPLIER REPRESENTATIVE'S SIGNATUR)E	TITI F	(X6) DATE

08/06/2019 **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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						F	R-C
		345307	B. WING _			07	/09/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				44	14 WILKINSON BLVD		
MEADOW	WOOD NURSING CEN	ITER		G	ASTONIA, NC 28056		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 677}	Continued From pa	age 1	{F 6	77}			
,	· ·	ormance deficit related to CHF	, ,	٠٠,	rounds will be performed by the C.N.A	'c	
		was for the resident to have			during morning ADL care, before	5	
		much assistance from her as			breakfast, after breakfast, before and o	or	
		e review date. The care plan			after lunch, before and or after dinner		
	, ·	equired extensive physical			as needed.	טווג	
		for incontinence care and			as needed.		
	wore briefs.	ioi incontinence care and			In addition, the Environmental Service		
	Word Briefs.			Director and Business office manager			
	An observation on	7/09/19 at 10:55 AM of Nurse			were in-serviced by the Administrator of	าท	
		provided incontinence care			7/30/19 regarding answering residents		
	, , ,	#3's brief was saturated from			call-lights and addressing their concern		
		rine and had a medium			immediately to a C.N.A or License Nur		
		ned brown substance and the			All Nursing Staff were provided in-serv		
		Resident #3's skin was intact			on 7/26/19 and 7/29/19 by the Director		
	1 .	ut resident did complain of			Nursing regarding providing incontiner		
	burning and itching				care in a timely manner, the instruction		
	and norming	•			to provide incontinent care before and		
	An interview was co	onducted on 7/09/19 at 4:59			after every meal and the license Nurse		
	PM with Resident #	#3 who stated she had rung her			were informed to provide assistance if		
		nes during the afternoon and			C.N.A's are behind.		
		r, the Business Officer					
		, and the Administrator that			4. Monitoring to ensure that solutions a	re	
	_	changed. Resident #3 indicated			sustained the Director of Nursing and		
		changed since the morning			designee will randomly audit five (5) al		
		had observed her being			and oriented residents and resident's t		
	changed. She also	stated she wanted to be			are not cognitive intact on each hall 5	x's	
	changed more freq	uently and felt bad when left to			per week x's 4 weeks then 3x's per we	ek	
	lay in a wet brief. R	lesident #3 reported she had			x's 4 weeks starting 7/29/2019. In		
	severe itching under	er her brief which made her			addition, above in-services will be		
	physically uncomfo	rtable. The interview further			included in the new hires orientation		
	revealed when the	Administrator answered			package starting 8/02/19.		
	Resident #3's call b	pell the resident had informed					
	the Administrator sl	he had already asked 3 other			Data will be summarized and presente	d to	
	people to notify NA	#1 she needed to be			the facility Quality Assurance Committee	э е	
	changed.				one (1) x per month x's two (2) months	by	
					the Director of Nursing or MDS		
	An observation on	7/09/19 at 5:00 PM of NA #1			Coordinator. Any issues or trends		
	and NA #5 who pro	vided incontinence care			identified will be addressed by the Qua	ality	
	revealed Resident	#3's brief was saturated from			Assurance Performance improvement		

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 / 09/2019
	ROVIDER OR SUPPLIER			44	REET ADDRESS, CITY, STATE, ZIP CODE 14 WILKINSON BLVD ASTONIA, NC 28056	1 01	109/2019
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 677}	brown substance on a no redness, but she of burning. An interview on 7/09/Housekeeper #1 reverse Resident #3's call light changed. He further in what time he had anshad forgotten to tell the had requested to be of the An interview on 7/09/Business Office Management and the substant of	t. Her skin was intact with lid complain of itching and saled he had answered at and she requested to be evealed he was unsure wered her call light, but he he NA #1 that Resident #3 changed. 19 at 5:56 PM with the ager revealed he had 3's call light and she ged and he told NA #1. He he had answered her call after lunch. He did not know I Resident #3. 19 at 5:54 PM with Nurse #1 wered Resident #3's call hout did not remember the first time the resident which she provided and the wered the call light the be changed and she told not know if NA #1 had and she did not indicate nged her. 19 at 5:00 PM with NA #1 changed Resident #3 since told her the resident d. NA #1 stated she was	{F 6	77}	Committee as they arise and the plan of be revised to ensure continued compliance. The Director of Nursing is responsible implementing and maintaining the acceptable plan of correction. Corrective action completed by 08/02/2019		

AND DI AN OF CORRECTION IDENTIFICATION NUMBER) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED			
		345307	B. WING			l	-C
NAME OF D	ROVIDER OR SUPPLIER	343307	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	07/	09/2019
MEADOWWOOD NURSING CENTER		ER		4	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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 761} SS=D	supposed to work from worked late. She state telling her Resident # An interview on 7/09// Administrator reveale #3 had requested to be lunch and had not been the Administrator con Resident #3 when shoutified NA #1 that the be changed. An interview on 7/09// Administrator reveale check and/or change 2 hours. She did not knot been changed fro Label/Store Drugs an CFR(s): 483.45(g)(h)(s) \$483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable. §483.45(h) Storage of \$483.45(h)(1) In according the storage of \$483.45(h)(1) In according to the storage of \$483.45(h)(1) In	#1 explained she was m 7:00 AM to 3:00 PM but ed she did not recall anyone 3 needed to be changed. 19 at 6:00 PM with the d she was aware Resident be changed four times after en changed until 5:00 PM. Infirmed she had talked with e answered her call light and e resident had requested to a resident had requested to a resident had requested to a she expected the staff to incontinent residents every know why Resident #3 had m 10:55 AM until 5:00 PM. In the discolor of Drugs and Biologicals (1)(2) If Drugs and Biologicals are with currently accepted so, and include the year of cautionary expiration date when the formula of Drugs and Biologicals ordance with State and compartments under proper and permit only authorized	{F 6	761}			8/2/19

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
					3		R-C	
		345307	B. WING _			07/	09/2019	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW	WOOD NURSING CE	NTER		441	4 WILKINSON BLVD			
MLADOW	WOOD NORSING CL	NILK		GA	STONIA, NC 28056			
(X4) ID PREFIX		/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID PREFI)	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION	
TAG	,	OR LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
{F 761}	Continued From p	age 4	{F 7	61}				
	§483.45(h)(2) The	facility must provide separately	,	-				
		tly affixed compartments for						
		ed drugs listed in Schedule II of						
	_	e Drug Abuse Prevention and						
	-	6 and other drugs subject to						
		en the facility uses single unit						
		ribution systems in which the						
	quantity stored is i							
	be readily detected							
	This REQUIREME							
	by:							
	Based on observa			The facility discarded the Novolog insu	ılin			
	interviews, the fac			Flexpen and the expired bottle of vitam				
		nen opened, discard an opened			B1 tablets famotidine, and viral influen			
		itamin B1 tablets and an			vaccine on 7/9/2019.			
		amotidine (stomach acid						
	-	xpiration date that were			2. No resident was found to be affected	d by		
		n 1 of 2 medication carts. The			the deficient practice; however, there is	-		
	facility also failed t	to discard 3 expired vials of		- 1	the potential for residents to be affected			
		in 1 of 1 medication storage		- 1	by the deficient practice. In order to			
	room.	C			ensure that the deficient practice does	not		
				- 1	recur an audit of the facility medication			
	Findings included:				carts and medication storage room was			
				- 1	conducted by the Administrator on 7/09			
	1. Observation of	medication cart #2 on 7/9/19 at		- 1	and 7/10/19 any concerns identified we			
	9:45 AM revealed	a Novolog Flexpen had a			addressed.			
		on it with no other identifiers						
	and no open date	was observed on ready for			3. All licensed nursing staff were			
	resident use.	, -		- 1	re-educated on 7/26/19 and 7/29/19 to			
					date medications when open and			
	An interview cond	ucted on 7/9/19 at 9:45 AM with		- 1	expiration dates (Insulins), to check to			
		I it was her second day at the			make sure residents name, dosage, an	ıd		
		I not give insulin on her shift, so		- 1	route of administration is on the			
		d at the insulin pens. She			medication card and discarding expired	t		
		had been taught insulin pens			medications by the Director of Nursing.			
		pen date and a discard date as			,			
		entifier information and should			4 Monitoring: The Director of Nursing,			
		s it had that information on it.		- 1	license nurses, and or designee will au	dit		
				- 1	Medication carts and the Medication	-		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345307	B. WING _	R-C 07/09/		-	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 011	09/2019
					114 WILKINSON BLVD		
MEADOWWOOD NURSING CENTER		ER .			ASTONIA, 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 761}	Continued From page An interview conducte with the physician reverse facility to follow the reconducte medications and insue An interview conducte with the Administrator should have identifier included resident nand date and she was una insulin pen did not ha The Administrator sta the flexpen they should discard dates on the stated each nurse should an expiration date be night shift nurse was medication carts for exmedications. 2. Observation of me 9:15 AM revealed an which expired on 02/2 resident use. An interview conducte Nurse #1 revealed sh bottle of Vitamin B1 v available for resident been on the cart. Nur	e 5 ed on 7/9/19 at 11:24 AM realed he expected the ales regarding expired lin pens. ed on 7/9/19 at 10:30 AM revealed insulin pens information sticker which ne, open date and discard able to explain why this ve that information on it. ted when the nurse opened ald write the open and label. The Administrator ould check medications for fore administering it and the responsible for checking the	{F 70	61}		ks ure d to ee by lity will	
	with the physician rev facility to follow the ru medications and insu	ed on 7/9/19 at 11:24 AM realed he expected the alles regarding expired lin pens. ed on 7/9/19 at 10:30 AM					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION G	· /	DATE SURVEY COMPLETED	
		345307	B. WING _			R-C 07/09/2019
	NAME OF PROVIDER OR SUPPLIER MEADOWWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4414 WILKINSON BLVD GASTONIA, NC 28056		01103/2013
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 761}	and should not be giral Administrator was un expired medication of the Administrator state check medications for administering it and responsible for check expired and undated. 3. Observation of medications and interview conductions are already for responsible for check expired and undated. An interview conduction of the posserved ready for responsible for check expired and undated. An interview conduction of the posserved ready for responsible for check expired and interview conduction cart availals also revealed the posserved ready for responsible expiration carts for an interview conduction carts for an interview conduction of the posserved ready in the physician responsible for an explain why this medication date was a conduction of the properties of	revealed expired not be on the medication cart wen to residents. The nable to explain why this was on the medication cart. Atted each nurse should or an expiration date before the night shift nurse was king the medication carts for medications. Addication cart #1 on 7/9/19 at open bottle of Famotidine expiration date was esident use. Atted on 7/9/19 at 9:30 AM with the expiration date on the was not legible. She further low why the bottle did not attend to date and was on the able for resident use. She do not know who checked the expired medications. Atted on 7/9/19 at 11:24 AM wealed he expected the ules regarding expired ulin pens. Atted on 7/9/19 at 10:30 AM or revealed medications medication cart without a see and she was unable to dication with no legible on the medication cart. The each nurse should check	{F 76	51}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
						R-C	
		345307	B. WING _			07/09/2019	
	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 CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 761}	responsible for check expired and undated 4. Observation of the 7/9/19 at 10:15 AM wexpired vials of influer ready for resident use vaccine had an expiration of the aninterview conducted with Nurse #1 revealed vials were expired and should not have be room. Nurse #1 did not responsible for check room for expired med. An interview conducted with the physician reverse facility to follow the rumedications and insultant interview conducted with the Administrator expired influenza vaccined influenza vacci	ing the medication carts for medications. medication storage room on ith Nurse #1 revealed 3 haza vaccine were observed attion date of 6/30/19. and on 7/9/19 at 10:15 AM and the 3 influenza vaccine davailable for resident use observed in the medication of know who was ing the medication storage ications. and on 7/9/19 at 11:24 AM and the expected the les regarding expired the les regarding expired the les reduced she had removed come vials from the som previously and did not the expected medications or residents. The stated the night nurse was ing the medication storage ing the medication storage ing the medication storage	{F 76	51}			

(X6) DATE

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 414 WILKINSON BLVD GASTONIA, NC 20056 SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG INTITIAL COMMENTS L 000 INTITIAL COMMENTS State Licensure tag 0006 was corrected as of July 9, 2019. State Licensure tag 0006 was corrected as of July 9, 2019. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 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) L 000 INITIAL COMMENTS An on-site revisit was conducted on July 9, 2019. State Licensure tag 0006 was corrected as of July 9, 2019. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of				D WILLO		
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Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE **Electronically Signed** 08/02/19

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