STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MERIDIAN CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, physician and surgical Physician Assistant (PA) interviews the facility neglected to provide wound treatment to a resident's right above knee amputation, abdominal abscess, right buttock wound and left above knee amputation for 1 of 3 residents (Resident #4) reviewed for wound care. Resident #4 was re-hospitalized on [REDACTED]. Findings included: Resident #4 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. Resident #4's hospital discharge records dated 3-6-20 revealed the following wound care orders; 1. buttocks wound, apply [MEDICATION NAME] AG with allevyn foam and change every other day. 2. Abdominal wound, Dakin's wet to dry dressing daily. 3. Left above knee amputation, saline wet to dry dressing daily. Review of the nursing admission documentation dated 3-6-20 completed by Nurse #2, revealed in part that Resident #4 was alert and oriented to person, place and time with independent decision-making skills for daily routine. The documentation also revealed a skin assessment that included; wound to right buttocks, open left above knee amputation and an abdominal abscess. The nurse documented that she applied Z-guard (barrier cream) to the resident's buttocks, acknowledged staples in the resident's right above knee amputation, gauze wrapping to the residents left above knee amputation and gauze packing to the abdominal abscess. The admission nurse documented that she reviewed the medication orders with the provider and there were no issues identified. During an interview with Nurse #2 on 6-25-20 at 11:09am by telephone, the nurse stated she had admitted Resident #4. She discussed, when a resident is admitted , the admitting nurse will call the physician or hand the orders to the physician for review and once the orders are received, they are transcribed onto the Medication Administration Report (MAR) or the Treatment Administration Report (TAR). She stated she did not remember speaking with the facility physician or know why there were no orders for Resident #4's wounds and could not recall if she saw wound care orders on the resident's discharge paperwork from the hospital. Nurse #2 said once treatment for [REDACTED]. Nursing documentation on 3-7-20 completed by Nurse #6 revealed acknowledgment of the resident's wounds and that her staples were intact but no mention of wound care being completed. An attempt was made on 6-25-20 at 11:10am to contact Nurse #6 and received no response. Nursing documentation on 3-8-20 completed by Nurse #3 revealed the nurse applied z-guard to the resident's buttock wound, changed dressing to her abdominal abscess with no further documentation. During an interview with Nurse #3 on 6-25-20 at 11:39am by telephone, the nurse stated she had not seen any wound care orders for Resident #4 but stated I was told what to do by the admission nurse (Nurse #2). She also said she could not remember what wound care she provided and did not know why there was not documentation to what type of wound care she provided. Review of the nursing note dated 3-9-20 completed by Nurse #7 revealed documentation that Resident #4 had removed her sutures from the left above knee amputation and the facility physician was notified. Resident #4's care plan dated 3-9-20 revealed no goals or interventions for treating the resident's wounds. Review of nursing notes for 3-10-20 completed by Nurse #4 revealed no documentation of wound care being completed. During an interview with nurse #4 on 6-25-20 at 9:32am by telephone, the nurse stated she had worked with Resident #4 on 3-10-20 and remembered the resident had amputation wounds but said she did not remember providing any wound care to Resident #4 and stated we didn't have any wound care orders for her. A review of the Physician orders dated March 2020 for Resident #4 revealed there were no orders for wound care from 3-6-20 to 3-10-20. The facility's nurse practitioner (NP) evaluated Resident #4 on 3-10-20. She documented the right above knee amputation had staples intact and staff had reported the resident would remove her dressing from the left above knee amputation site and touch the wound. The NP also documented that she was about to send the patient back to the hospital for further evaluation but had reviewed Resident #4's discharge summary from the hospital and documented it was noted that there is to be a wet to dry dressing applied but staff reported the resident would remove the dressing. The NP documented Resident #4 was medically stable and referred the resident to the facility's wound care physician. Resident #4's March 2020 TAR and MAR indicated [REDACTED]. Resident #4 was seen by the wound care physician on 3-10-20 with the following wound care measurements; (1) Abdomen abscess measured 16cm (centimeters) long, 5.5cm wide and 3cm deep with moderate drainage. (2) Above knee left amputation measured 16.0cm long, 5.5cm wide and 3.3cm deep with moderate drainage. There was no further measurements or documentation regarding Resident #4's right above knee amputation or her right buttocks wound. The following wound care orders were documented in the physician orders 3-11-20; 1. Abdominal wound, clean with normal saline, apply silver alginate and cover with an ABD pad every other day. 2. Right above knee amputation, clean staples with normal saline and cover with a dry dressing daily. 3. Right buttock, clean with soap and water, apply [MEDICATION NAME] and cover with a dry dressing daily. There were no orders documented in the physician orders for wound care to the left above knee amputation. The facility's wound care physician was interviewed on 7-14-20 at 10:12am. The physician said he had not mentioned or written orders for Resident #4's left above knee amputation because the resident had pre-existing orders from when the resident was discharged from the hospital, and he had not planned on changing them. He also stated he would consult on new surgical wounds, but the resident should have had a follow up visit with the surgeon and if there were issues with Resident #4's wounds, the facility should have contacted the surgeon. Nursing note dated 3-11-20 completed by Nurse #5 revealed wound care being completed to the left above knee amputation with Dakin's moistened gauze, cover with ABD pad, wrap with gauze and ace bandage. Nurse #5 was interviewed on 6-25-20 at 3:22pm by telephone. The nurse stated she remembered seeing orders from Resident #4's hospital discharge summary for wound care to her amputation sites and performed wound care as ordered but denied remembering that Resident #4 had an abdominal abscess or wound to her right buttocks. The nurse stated she did not perform wound care to those areas. Resident #4 was seen by the wound care nurse on 3-12-20. The documentation dated 3-12-20 from the wound care nurse was as follows; 1. Left above knee amputation had partial thickness skin loss with a moderate amount of drainage. The wound measured 16.0 centimeters (CM) long, 5.5cm wide and 3.3cm deep. 2. Abdomen abscess had partial thickness skin loss with moderate amount of drainage. The wound measured 31cm long, 0.3cm wide and 3.0cm deep. 3. Stage 3 pressure ulcer to right buttocks with a moderate amount of drainage. The wound measured 2.0cm long, 1.6cm wide and 0.1cm deep. There was no documentation regarding Resident #4's right above knee amputation. The March 2020 TAR for Resident #4 revealed consistent wound care was being completed as ordered for the residents abdominal wound, right buttocks wound and right above knee amputation from 3-12-20 until resident was discharged to the hospital on 3-15-20. The TAR/nursing documentation did not reflect wound care being completed to the left above knee amputation from 3-6-20 to 3-10-20 and then from 3-12-20 to 3-15-20 The facility's physician was interviewed by phone on 6-25-20 at 3:10pm. The physician stated if a resident came from the hospital with wound care orders, then those orders were carried over until the resident could be seen by the wound care physician. He also said he did not know if the facility nurses were providing wound care but felt the facility nurses were attempting to do wound care and stated, per the NP note the resident kept removing the dressings. The physician said he was not notified of the resident removing her dressings and stated the resident was discharged before he was able to complete his assessment.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) The Director of Nursing (DON) was interviewed on 6-25-20 by telephone at 3:57pm. The DON stated she did not know about Resident #4's MAR indicated [REDACTED]. Resident #4 was hospitalized on [DATE] with a [DIAGNOSES REDACTED].#4's hospital discharge summary dated 4-16-20, the physician documented that upon residents admission on 3-15-20 to the hospital that it appeared the resident had not received wound care to her bilateral amputations or abdominal wound and was taken directly to the operating room where Resident #4 received wound washouts and debridement's to her left and right above knee amputations and abdominal wound. The discharge summary also documented Resident #4 had multiple surgical interventions for wound washouts and wound vac placements during her hospitalization . The resident was subsequently discharged on [DATE] to a rehabilitation facility. The resident's hospital surgical physician assistant (PA) was interviewed on 7-9-20 at 10:29am by telephone. The PA stated she had cared for Resident #4 during her hospitalization from [DATE] to 3-6-20 and cared for the resident during her last hospitalization from [DATE] to 4-16-20. She discussed not having any contact with the facility from 3-6-20 to 3-15-20 and was not aware of the facility contacting the office regarding Resident #4's wounds. The PA stated there were wound care orders provided for the facility upon the residents discharge from the hospital but that upon Resident #4's readmission on 3-15-20 it had not appeared that wound care had been provided. She stated, the wounds to her amputations and abdomen were terrible with skin breakdown and infection. She also said the resident had to have multiple surgeries to remove the infection and dead skin tissue. The PA discussed the amount of skin damage and infection present could not have happened in 1-2 days. She also stated the resident had advanced [MEDICAL CONDITION] and stated, which made consistent daily wound care even more important.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review the facility failed to submit an initial allegation report to the State Agency within the required 2-hour timeframe for allegations of staff to resident abuse for 2 of 3 residents (Resident #1 and Resident #2) reviewed for abuse. Findings Included: 1. Resident #1 was admitted to the facility 6/22/18 and [DIAGNOSES REDACTED]. A quarterly minimum data set ((MDS) dated [DATE] for Resident #1 identified his cognition was intact, had not displayed any behaviors during the look-back period, required extensive two-person assistance with transfers and extensive one-person assistance with toileting. Review of facility ' s abuse investigation revealed a nurse witnessed a nursing assistant (NA) verbally taunting Resident #1. The NA was not assigned to the resident, but she was sitting across from his room and called him names, told him he was too much and entered his bathroom and told him to pick that diaper up off the floor. The nurse reported the incident to the Assistant Director of Nursing (ADON). The initial allegation report was completed by the ADON and identified the facility became aware of the alleged abuse incident on 6/18/20 at 4:00 pm. The initial allegation report was signed by the ADON on 6/19/20. A fax activity log revealed the initial allegation was sent to the state agency on 6/19/20 at 3:39 pm (result busy), sent at 3:45 pm (result communication error 344), sent at 7:23 pm (stop) and sent at 7:44 pm (result busy). An interview on 6/23/20 at 11:30 am with Resident #1 revealed he had an encounter with a NA a few days ago, but he couldn ' t remember the NA ' s name. He stated the NA was trying to get me to drink that thick stuff and I tried to explain to her that I didn ' t like it and we kind of argued about that. He explained the NA got him up out of bed into his wheelchair to go to the bathroom and he felt like she used her foot on the back of his wheelchair to roll him into the bathroom. Resident #1 added she told him to stop doing that and she did. He added it didn ' t hurt me; it more so insulted me. He stated he didn ' t feel the NA was being abusive, but she was very young and didn ' t know any better. Resident #1 added he really didn ' t want to see the NA lose her job and he shared that with the staff here. He stated the NA probably needed to be taught how to properly treat the residents. An interview with the ADON on 6/23/20 at 1:16 pm revealed she had been notified by Resident #1 ' s nurse about the alleged abuse incident on 6/18/20. The ADON instructed the nurse to obtain a statement from the accused employee and have the employee leave the facility. She stated when she came into the facility on [DATE] she completed the initial allegation report and started faxing the report to the State Agency around 3:30 pm. The ADON added she didn ' t think the report went through to the State Agency until 7:44 pm on 6/19/20. She stated it was her understanding the facility had 24 hours to notify the State Agency of any abuse allegations. During a follow-up interview with the ADON on 6/23/20 at 1:27 pm she provided the facility Abuse Policy and Abuse Information Sheet for North Carolina. The facility Abuse Policy had a revision date of 7/1/19 and stated 7. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment or neglect the CED (Center Executive Director) or designee will perform the following: 7.1 Enter allegation into the Risk Management System and 7.2 Report allegations involving abuse (physical, verbal, sexual, mental) no later than two hours after the allegation is made. The ADON stated she thought the facility only had to report alleged abuse within 2 hours of the incident if there was a physical injury. An interview with the Director of Nursing (DON) on 6/23/20 at 1:34 pm confirmed the facility Abuse Policy was correct. She stated all abuse allegations should be reported to the State Agency within 2 hours of the facility becoming aware of the incident. The DON added the abuse allegation for Resident #1 should have been submitted by 6:00 pm on 6/18/20. An interview on 6/24/20 at 11:20 am with the Administrator revealed it was her understanding initial abuse allegation reports only needed to be reported within 2 hours if harm or injury occurred to the resident. She added she had misunderstood the reporting times. 2. Resident #2 was admitted to the facility on [DATE] and [DIAGNOSES REDACTED]. A quarterly minimum data set ((MDS) dated [DATE] for Resident #2 identified his cognition was intact, displayed no behaviors during the look-back period and required extensive one-person assistance with activities of daily living except for eating he required supervision and set-up. Review of the facility ' s abuse investigation revealed Resident #2 reported to his nurse the nursing assistant (NA) that took care of him during 2nd and 3rd shift on 5/30/20 had called him gay and pissy. The resident also said the NA refused to change him until later during the night shift. The initial allegation report was completed by Nurse #1 who was the nurse supervisor for Resident #2 on 5/31/20. The initial allegation report identified the facility became aware of the alleged abuse incident on 5/31/20 at 3:10 pm. A transmission verification report identified the initial abuse allegation report was faxed to the State Agency on 5/31/20 at 7:29 pm. Resident #2 had been discharged from the facility and was not available for an interview. An interview with Nurse #1 on 6/24/20 at 11:33 am revealed she had completed the initial abuse allegation report for Resident #2 that occurred on 5/31/20. She stated she had trouble accessing the report on the computer because only management had access to that form. Nurse #1 explained she contacted the Assistant Director of Nursing (ADON) who came to the facility and got access to the report for her. She stated her inability to access the report form resulted in it being sent in late. During an interview with the ADON on 6/23/20 at 1:27 pm she provided the facility Abuse Policy and Abuse Information Sheet for North Carolina. The facility Abuse Policy had a revision date of 7/1/19 and stated 7. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment or neglect the CED (Center Executive Director) or designee will perform the following: 7.1 Enter allegation into the Risk Management System and 7.2 Report allegations involving abuse (physical, verbal, sexual, mental) no later than two hours after the allegation is made. The ADON stated she thought the facility only had to report alleged abuse within 2 hours of the incident if there was a physical injury. An interview with the Director of Nursing (DON) on 6/23/20 at 1:34 pm confirmed the facility Abuse Policy was correct. She stated all abuse allegations should be reported to the State Agency within 2 hours of the facility becoming aware of the incident. The DON added the abuse allegation for Resident #2 should have been submitted by 5:10 pm on 5/31/20. An interview on 6/24/20 at 11:20 am with the Administrator revealed it was her understanding initial abuse allegation reports only needed to be reported within 2 hours if harm or injury occurred to the resident. She added she had misunderstood the reporting times.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and staff interviews the facility failed to ensure plates were clean before being placed on the serving line for use. This was evident in 1 of 1 observation. Findings included: The dietary manager was interviewed on 6-24-20 at 10:09am. The dietary manager stated the water for the wash cycle needed to be 160 degrees and the water for the rinse cycle needed to be 140 degrees. He also stated the dishes were still not cleaned from breakfast but had a small amount that were clean for observation on the tray line. He confirmed the dishes on the tray line were ready to be used for

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) the lunch meal. During an observation on 6-24-20 at 10:10am of 28 9-inch china plates and 1 plastic divided plate that were on the tray line, it was noted there were yellow/orange and black flecks on 4 of the 28 9-inch china plates and the plastic divided plate had food residue in the corners. The dietary manager removed the plates and placed them back at the dishwasher to be rewashed. The dietary manager was re-interviewed at 10:13am on 6-24-20. He stated it was the job of the dishwasher to make sure the dishware was being cleaned appropriately but that the staff serving the meals also looks at each plate before serving the meal. The dietary manager said he had not received any complaints from residents of the dishes being dirty when they received their meal. He also stated he expected the dishes to be clean and sanitized before being placed on the serving line.