STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, residents, and the dialysis center Nurse Manager, the facility failed to provide transportation back to the facility after hemodialysis was completed which caused the residents to wait up to 2 hours to return. The residents requested they be transported back to the facility and not wait, which made one resident late for dinner. This deficient practice affected 2 of 3 residents reviewed for dialysis (Residents #22 and #8). The findings included:1a.Resident #22 was admitted to the facility on [DATE] with the diagnosis of end stage renal disease (ESRD) dependent on hemodialysis. Resident #22's quarterly Minimum Data Set, dated [DATE] documented the resident had intact cognition. The care plan for Resident #22 dated 7/14/25 documented he had impaired renal function and was at risk for complications of hemodialysis. The interventions were hemodialysis on Monday, Wednesday and Friday and to watch for complications. On 08/12/25 at 9:41 am Resident #22 was interviewed. The resident stated he attends dialysis Monday, Wednesday, and Friday and was usually done at 3:30 pm. Resident #22 indicated at present there was only one van driver to pick up and when she was busy, he could wait up to 2 hours to be picked up to return to the facility and the dialysis center was across the street. Resident #22 stated there used to be two drivers, one for each of the two vans and When there were two drivers, I never had to wait 2 hours. The resident stated he has complained to the van driver that he does not want to wait to return to the facility and this problem had been going on for months. The resident commented he was late for dinner, and his tray was sitting on his table and was cold every time he returned late at 6:00 pm. 1b.Resident #8 was admitted to the facility on [DATE] with the diagnoses of ESRD and diabetes.The annual Minimum Data Set, dated [DATE] documented Resident #8 had an intact cognition. Resident #8's care plan dated 6/18/25 documented she had impaired renal function and was at risk for complication of hemodialysis. The interventions were hemodialysis Monday, Wednesday, and Friday and to watch for complications. On 8/15/25 at 10:25 am Resident #8 was interviewed. Resident #8 stated that her dialysis treatment was completed at about 3:00 pm and she was picked up at 5:00 pm or later and it was a 10-minute return ride back to the facility. The resident stated she had not missed dinner, but it was sitting in her room upon return. The resident commented she has had to wait up to 2 hours for pick up and wants to return after dialysis was completed. Resident #8 indicated the facility provided lunch in an insulated bag.On 8/12/25 at 2:40 pm the Administrator stated that one of the transportation staff that drove the van was absent on extended leave, since about March 2025 and there are two vans but one driver at present. On 08/14/25 at 2:32 pm an interview was conducted with the resident appointment Scheduler. The scheduler stated there was one transportation van driver, and the second driver was absent. The facility was using an outside vendor when there were multiple outside appointments to address. The Scheduler indicated if the facility driver was running late to pick up a resident, the maintenance staff were back up or an outside transport service would be called which would take about 30 to 40 minutes to reach the residents. The Scheduler stated there had not been a report that a resident was waiting for 2 hours to be picked up. On 08/15/25 at 10:17 am an interview was conducted with the dialysis center Nurse Manager. She stated there were three residents from the facility that attended hemodialysis on Monday, Wednesday, and Friday in the afternoon and sometimes the return transportation arrived as late as 6:00 pm. The residents were done with dialysis at approximately 3:30 to 4:00 pm. The Nurse Manager indicated the residents remained in the center with nursing supervision until the van arrived. She stated 6:00 pm was past the dialysis center closure time and the nursing staff had to remain with the residents until they were picked up by the facility transport and the center closed at 4:30 pm when residents were not waiting to be picked up. The Nurse Manager explained the facility was called when the residents were done and ready for pick up. The receptionist and transport person were notified by telephone that the residents were ready for pick up after each dialysis session. The interview further revealed the residents missed dinner, had a diagnosis of diabetes, and this was a concern. The problem of late pickups has gotten more frequent over the past couple of weeks. On 08/15/25 at 10:29 am an interview was conducted with the facility Receptionist. She stated the dialysis center sometimes called the main phone (receptionist) number for the van driver to pick up the residents from the dialysis center and the calls came in close to 4:00 pm. The Receptionist indicated sometimes there was a second request on the same day for pick up when the van driver had not arrived yet. She was not sure how long it was after she received the second call. The Receptionist noted the van driver had a mobile phone and sometimes the dialysis center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to complete an admission Minimum Data Set (MDS) assessment in the 14-day timeframe for 1 of 33 residents (Resident #190) reviewed for MDS assessments. Findings included:Resident #190 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, type 2 diabetes, and hypertension.During the record review for Resident #190 it was noted the MDS admission assessment had an assessment reference date of 08/06/25, however it was not complete.An interview was conducted on 08/15/25 at 10:13 am with the MDS Coordinator and she verified Resident #190's MDS admission assessment was not completed and should have been completed by 08/12/25. She indicated she was running behind and would get it done.On 08/15/25 at 12:22 pm an interview was conducted with the Administrator, and he indicated that his expectation was for all MDS assessments to be completed on time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to submit a quarterly Minimum Data Set (MDS) assessment within the required time limit for 1 of 4 residents (Resident #75) reviewed for the Resident Assessment facility task.The findings included:Resident #75 was admitted to the facility on [DATE]. The resident's electronic medical record (EMR) revealed her history of Minimum Data Set (MDS) assessments included the following, in part:--A quarterly MDS dated [DATE] was reported as electronically transmitted to the Centers for Medicare and Medicaid Services (CMS) database and accepted;--However, a quarterly MDS dated [DATE] was reported only as completed in Resident #75's EMR.An interview was conducted on 8/13/25 at 11:02 AM with the facility's MDS Coordinator. During the interview, the nurse reviewed Resident #75's history of MDS submissions. Upon this review, the MDS Coordinator noted the 6/11/25 quarterly MDS completed for Resident #75 should have been sent to CMS but was not. She stated, That's an error. The MDS Coordinator reported that although the MDS was completed timely, it was not submitted timely. A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility's Administrator and Director of Nursing (DON). During the interview the Administrator reported he would expect MDS assessments to be transmitted timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect whether anticonvulsant and anticoagulant medications were administered for 1 of 36 residents (Resident #4) whose MDS assessment was reviewed.The findings included:Resident #4 was admitted to the facility on [DATE]. The resident's cumulative diagnoses included diabetes and unspecified convulsions (seizure disorder).The resident's electronic medical record (EMR) included her Physician's Orders. These orders included, in part:--25 milligrams (mg) lamotrigine (an anticonvulsant medication) given as one tablet by mouth in the evening (Initiated 6/4/25). --75 mg pregabalin (an anticonvulsant medication) to be given as one capsule by mouth two times a day (Initiated 6/4/25). Further review of Resident #4's Physician's Orders and Medication Administration Record (MAR) did not reveal the resident received an anticoagulant at any time during the month of June 2025.The resident's admission Minimum Data Set (MDS) was dated 6/10/25. The medication section of this MDS assessment did not indicate Resident #4 received an anticonvulsant medication. Additionally, the assessment reported that she received an anticoagulant medication during the 7-day look back period. An interview was conducted on 8/13/25 at 11:06 AM with the facility's MDS Coordinator related to Resident #4's admission MDS. At that time, the MDS Coordinator reviewed the resident's admission MDS assessment and electronic medical record (EMR). When asked, the MDS Coordinator confirmed the resident did receive anticonvulsant medications but no anticoagulant medication during the 7-day look back period. The MDS Coordinator stated the MDS was inaccurately coded.A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility's Administrator and Director of Nursing (DON). During the interview the Administrator reported he would expect the MDS assessments to be coded accurately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to notify the North Carolina Medicaid Uniform Screening Tool (NC MUST), that is the State Mental Health or Intellectual Disability Authority, when a significant change in condition was identified for a resident with a mental disorder or intellectual disability (Resident #39) and failed to request a Preadmission Screening and Resident Review (PASRR) re-evaluation for PASRR Level II residents identified to have a significant change in his or her physical or mental status (Resident #11 and Resident # 179). This deficient practice affected 3 of 3 residents reviewed who had a significant change in condition. The findings included: 1.Resident #39 was admitted to the facility on [DATE]. His cumulative diagnoses included a diagnosis of schizoaffective disorder. The resident's electronic medical record (EMR) included information from the North Carolina Medicaid Uniform Screening Tool (NC MUST). This record revealed Resident #39 was evaluated and found to have a PASRR Level I determination with a start date of 6/23/24. The PASRR Level I evaluation assessed the resident for the appropriateness of nursing facility placement and no further PASRR screening was required unless a significant change occurred with the individual’s status which suggests a diagnosis of mental illness or mental retardation or, if present, suggests a change in treatment needs for those conditions. The Level II designation specified there was no end date and no limitation unless the resident had a change in condition. Resident #39's electronic medical record revealed a change of condition progress note dated 1/26/25 which indicated Resident #39 had a change in behavioral symptoms related to agitation and psychosis. The progress note also indicated that the resident was ordered .5 milligrams of Risperdal, an antipsychotic medication, two times a day for agitation. Physician order dated 1/26/25 revealed a new order for Risperdal .5 milligrams to be administered two times a day for agitation. A psychiatric follow up evaluation note dated 1/27/25 indicated that the psychiatric provider was informed by nursing staff that Resident #39 exhibited manic-like behavior with agitation, paranoia, packing and change in sleep pattern. The provider further indicated that a new order of Xanax .5 milligrams every day was ordered for agitation. Physician order dated 1/27/25 revealed a new order for .5 milligrams of Xanax every day for agitation. An interview was conducted on 8/13/25 at 1:40 PM with the Social Services Director and Social Worker. They indicated that they did not realize Resident #39 had a significant change in condition related to his behaviors and therefore did not initiate a Level II screening. The Social Workers also indicated that a Level II PASRR screening should have been initiated for Resident #39 due to the change in behavior and treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview was conducted with the Administrator on 8/15/2025 at 3:49 PM. He indicated that due to Resident #39 having a diagnosis of a serious mental illness with a change in behaviors and treatment he should have been screened for a level II PASRR. 2. Resident #11 was admitted to the facility on [DATE]. The resident’s cumulative diagnoses included schizophrenia and bipolar disorder. A PASRR Level II Determination Notification letter issued for Resident #11 (dated 2/23/17) was reviewed. The letter noted Resident #11 had a PASRR number ending with the letter “B,” which was indicative of a PASRR Level II determination with “No end date, No limitation unless change in condition. No specialized services required.” The resident’s quarterly Minimum Data Set (MDS) assessment dated [DATE] reported the resident had moderately impaired cognition with a mood severity score of 9 (indicative of mild depression). No signs / symptoms of a possible swallowing disorder were reported. Resident #11 was not assessed as having experienced a significant weight loss. Resident #11 was discharged to the hospital on 6/3/25 with re-entry to the facility on 6/7/25. The hospital Discharge summary dated [DATE] reported his discharge diagnoses included acute respiratory failure with hypoxia, aspiration pneumonia and dysphagia. The resident’s most recent MDS was a significant change in status assessment dated [DATE]. The MDS reported that Resident #11 was a PASRR Level II resident due to serious mental illness. He had moderately impaired cognition and a mood severity score of 15 (indicative of moderately severe depression). The MDS assessment indicated Resident #11 was experiencing signs / symptoms of possible swallowing disorder (coughing or choking during meals or when swallowing medications). The resident was also identified as having a significant weight loss without being on a physician-prescribed weight-loss regimen. A review of Resident #11’s Care Area Assessment (CAA) Worksheet for Functional Abilities (dated 6/25/25) indicated this problem/need was triggered due to the resident’s self-care and mobility deficits. Underlying problems were reported to include a diagnosis of pneumonia, mood decline, and nutritional problems. There was no update PASRR Level II referral after the resident’s significant change assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 8/13/25 at 10:58 AM with the facility’s MDS Coordinator. During the interview, the MDS Coordinator was asked if a referral was made to the State mental health authority for evaluation of a resident after he or she was identified as having a significant change in condition. At that time, the MDS Coordinator reported the facility’s Social Worker assumed responsibility to request a re-evaluation for a PASRR Level II resident having a significant change. The MDS Coordinator confirmed a re-evaluation would need to be done when a significant change in status MDS was completed due to a change in the resident’s mental or physical status. An interview was conducted on 8/13/25 at 12:00 PM with the facility’s Social Worker (SW) and Social Services Director. The SW and Director reported that up to this point, PASRR Level II residents were not referred to the State mental health authority for re-evaluation when an MDS assessment was initiated for a significant change unless there was a change in a psychiatric diagnosis or behavior. Therefore, a PASRR re-evaluation was not requested for Resident #11 after being identified as having a significant change in status. A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility’s Administrator and Director of Nursing (DON). The Administrator reported that he became aware during the survey that a referral for re-evaluation for PASRR Level II residents was not always being made. The Administrator stated he would expect this to be done in accordance with the regulations. 3. Resident #179 was admitted to the facility on [DATE] with re-entry to the facility on 1/15/24 from a hospital. His cumulative diagnoses included schizophrenia, bipolar disorder, and adult failure to thrive. A PASRR Level II Determination Notification letter issued for Resident #179 (dated 2/8/24) was reviewed. The letter noted Resident #179 had a PASRR number ending with the letter “B,” which was indicative of a PASRR Level II determination with “No end date, No limitation unless change in condition. No specialized services required.” The resident’s most recent Minimum Data Set (MDS) was a significant change in status assessment dated [DATE]. The MDS reported that Resident #179 was a PASRR Level II resident due to serious mental illness. The resident was identified as having a significant weight loss without being on a physician-prescribed weight-loss regimen. A review of Resident #179’s Care Area Assessment (CAA) Worksheet for Functional Abilities (dated 4/17/25) indicated the resident was reported to have a declining change in condition related to “adult failure to thrive, multiple other health conditions.” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no update PASRR Level II referral after the resident’s significant change assessment. An interview was conducted on 8/13/25 at 10:58 AM with the facility’s MDS Coordinator. During the interview, the MDS Coordinator was asked if a referral was made to the State mental health authority for evaluation of a resident after he or she was identified as having a significant change in condition. At that time, the MDS Coordinator reported the facility’s Social Worker assumed responsibility to request a re-evaluation for a PASRR Level II resident having a significant change. The MDS Coordinator confirmed a re-evaluation would need to be done when a significant change in status MDS was completed due to a change in the resident’s mental or physical status. An interview was conducted on 8/13/25 at 12:00 PM with the facility’s Social Worker (SW) and Social Services Director. The SW and Director reported that up to this point, PASRR Level II residents were not referred to the State mental health authority for re-evaluation when an MDS assessment was initiated for a significant change unless there was a change in a psychiatric diagnosis or behavior. Therefore, a PASRR re-evaluation was not requested for Resident #179 after being identified as having a significant change in status. A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility’s Administrator and Director of Nursing (DON). The Administrator reported that he became aware during the survey that a referral for re-evaluation for PASRR Level II residents was not always being made. The Administrator stated he would expect this to be done in accordance with the regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to develop a comprehensive care plan to address a resident's needs as identified in the admission assessment for 1 of 36 residents (Resident #4) whose care plans were reviewed.The findings included: Resident #4 was admitted to the facility on [DATE]. The resident's cumulative diagnoses included diabetes and unspecified convulsions (seizure disorder).The resident's most recent Minimum Data Set (MDS) assessment was a comprehensive admission assessment dated [DATE]. A review of the MDS revealed the resident had intact cognition. She had impairment of range of motion of her upper and lower extremities on both sides of her body and utilized a walker for mobility. The resident required set-up or clean-up assistance for eating and personal hygiene; partial/moderate assistance for bed mobility and sit to stand; substantial/maximum assistance for bathing and dressing her upper body; and was dependent on staff for toileting and transfers. Resident #4 was assessed as always incontinent of bladder and bowel. She did not receive either a therapeutic diet or mechanically altered diet but was reported to be edentulous (had no natural teeth). Resident #4 was reported to be at risk for developing pressure ulcers/injuries but did not have an unhealed pressure ulcer/injury at the time of the MDS assessment. Resident #4's Care Area Assessments (CAAs) were reviewed and noted the following care areas were triggered:--Communication (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, Will Communication - Functional Status be addressed in the care plan? Yes.--Functional Abilities (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, Will Functional Abilities (Self-Care and Mobility) - Functional Status be addressed in the care plan? Yes.--Urinary Incontinence and Indwelling Catheter (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, Will Urinary Incontinence and Indwelling Catheter - Functional Status be addressed in the care plan? Yes.--Nutritional Status (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, Will Nutritional Status - Functional Status be addressed in the care plan? Yes. --Dehydration/Fluid Maintenance (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, Will Dehydration/Fluid Maintenance - Functional Status be addressed in the care plan? Yes. --Dental Care (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, Will Care - Functional Status be addressed in the care plan? Yes.--Pressure Ulcer/Injury (CAA Worksheet dated 6/17/25). A question and answer posed on the CAA Worksheet read, Will Pressure Ulcer/Injury - Functional Status be addressed in the care plan? Yes.A review of Resident #4's current care plan revealed the areas of focus identified in her comprehensive assessment and in accordance with the information provided by the CAAs were not included. The areas of focus which were not addressed or completed in the resident's current care plan included: Communication, Functional Abilities (Self-Care and Mobility), Urinary Incontinence, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, and Pressure Ulcer/Injury.An interview was conducted on 8/13/25 at 11:06 AM with the facility's MDS Coordinator related to Resident #4's care plan. Upon request, the MDS Coordinator reviewed Resident #4's. When asked, the MDS Coordinator reported the nursing staff typically completed an initial assessment and plan related to the resident's care upon his or her admission, and the MDS nurse would add to the care plan. Upon review of Resident #4's care plan, the MDS Coordinator confirmed the CAAs triggered for this resident indicated there were several areas of focus which still needed to be addressed in the care plan. She further explained by stating that when the CAA indicated a particular area of focus would be included in a care plan, then the comprehensive care plan needed to include it. The MDS Coordinator reported Resident #4's comprehensive care plan should have been completed by 6/24/25. When asked if Resident #4's comprehensive care plan was completed, the MDS Coordinator stated, No.A telephone interview was conducted on 8/15/25 at 2:32 PM with the facility's Administrator and Director of Nursing (DON). Upon inquiry, the Administrator reported he would expect a comprehensive care plan to be developed in a timely manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews with staff, resident, and the Medical Director, the facility failed to ensure safe securement per manufacturer recommendations of a resident during a van transport. On 2/21/25, Resident #8 was being transferred to dialysis in the facility's transportation van. When Transportation Driver #1 made a left turn, Resident #8 and the wheelchair she was seated in tipped over onto the floor of the van. The Transportation Driver called 911. Resident #8 complained of pain to the right side of her neck and face and was transported to the hospital via Emergency Medical Services (EMS). Resident #8 was receiving a blood thinner which increased her risk of bleeding. While at the hospital, Resident #8 was found to not have sustained any injuries but was admitted for one day to receive her missed dialysis treatment before returning to the facility. This practice had a high likelihood of causing a serious adverse outcome, including death or serious injury. This deficient practice was for 1 of 7 residents reviewed for accidents (Resident #8).Findings included: Review of the manufacturer's operating instructions dated 2014 for the facility's securement system used in the transportation van showed the following instructions for the use of the 4-Point Wheelchair Securement System: 1. Center wheelchair facing forward in Securement Zone and lock wheelchair brakes (or power off electric chair). 2. Attach four retractors into Floor Anchorage points and lock them in place, with an approximate distance of 48 to 54 between the front and rear retractors. 3. Completely pull out each webbing and attach J-hooks to compliant WC19 (a WC19 is a term used to describe a standard wheelchair designed to be used in vehicles) Chair Securement Points near seat level (or solid frame members) at an approximate 45-degree side angle. 4. Move wheelchair forward and back to remove webbing slack or manually tension webbing with retractor knobs. Resident #8 was admitted to the facility on [DATE] with diagnoses which included End-Stage Renal Disease (ESRD), congestive heart failure and atrial fibrillation. The physician's order dated 12/8/23 and the current medication administration records revealed Resident #8 received 2.5mg (milligrams) apixaban two times per day. Apixaban is an anticoagulant medication (blood thinner). The quarterly minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was cognitively intact, received anticoagulant medication, had no falls, and received dialysis therapy. The review of the Incident Report prepared by Unit Manager #1 and the Interdisciplinary Team Review completed by Nurse #6, both dated 2/21/25 documented that as Resident #8 was transported to the dialysis center in the facility's transportation van, the resident's wheelchair turned over, onto its side. The Resident was assessed and transported to the Emergency Department for further evaluation. The Resident was unable to give a description of what had happened. There were no witnesses. There were no injuries observed at the time of the incident. Review of the Emergency Medical Services (EMS) Report dated 2/21/25 documented that upon EMS arrival on the scene, Resident #8 was observed on the floor of the transport van with a wheelchair turned on its' side and underneath the resident. The Resident was alert, speaking full sentences. Transportation Driver #1 informed EMS that he was transporting the Resident in her wheelchair in the van to the dialysis center and when the van turned a corner the Resident and her wheelchair overturned. The Resident complained of pain to the right side of her face and the right side of her neck. EMS freed the wheelchair from the safety straps and removed the wheelchair from under the resident. A cervical collar was placed on the Resident, and she was transferred to a stretcher and in the EMS unit where assessment and interview were completed. The Resident denied loss of consciousness, chest pain, shortness of breath, nausea and vomiting. The Resident revealed she was enroute to the dialysis center and her last dialysis treatment was on Wednesday, 2/19/25. The Resident denied any other injuries and was able to move lower extremities with no pain to pelvis/hips and had equal hand grip. The duration of head and neck pain was ten minutes. The Resident was transferred to the Emergency Department of the hospital, answering questions appropriately. Transportation Driver #1 was not available for interview during the survey. Review of the hospital Emergency Department assessment and plan dated 2/21/25 revealed Resident #8 was evaluated for right-sided head/neck pain due to resident stating her head and neck were injured by striking something inside the transport van on her way to the dialysis center. The result of the computed tomography (CT) scan of the resident's head and neck showed no acute intracranial pathology or cervical spine pathology. The Emergency Department physician contacted the resident's outpatient nephrologist and it was decided that it was too late in the day for the Resident to go to the dialysis center this day. Also, there was no indication that the Resident would be able to be transported from the nursing home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to ensure 1 of 2 kitchen icemakers was free from black and gray debris and wet mixing bowls were not stacked together before they were fully dry. This had the potential to affect all residents who received ice and/or food that came into contact with the mixing bowls. An observation completed on 08/11/25 at 9:38 AM revealed 1 of the facility's 2 icemakers in the kitchen had black and gray debris running down the ice divider inside of the ice maker and then along the top ridge of the icemaker where the door opened and closed. The black and gray debris was wet in nature and appeared to be running down the divider and potentially dripping onto the ice. Additional observations at this time revealed 3 large metal mixing bowls that had recently been washed, nested together on a storage shelf. When pulled apart visible liquid drained from each of the bowls and onto the floor.An interview with the Dietary Manager on 08/11/25 at 9:46 AM revealed the ice maker was scheduled to be cleaned monthly by the maintenance department. The Dietary Manager stated he believed it was scheduled to be cleaned later that week. He also reported he did not know the ice machine was dirty and indicated he did not know what the black and gray substance was on the ice machine's divider and that he would not want that substance dripping into ice he was going to use. The Dietary Manager also reported that he tries to keep metalware separated until fully dry but insisted that there was not a lot of space to store the wet dishes. The Dietary Manager reported that the ice machine should be free from dirt and debris and that metalware should not be nested while still wet and should be fully dry before being stacked.An interview with the Maintenance Director on 08/12/25 at 1:02 PM revealed he was the staff member responsible for the routine maintenance and cleaning of the ice machines located in the kitchen. He reported he completed a deep cleaning of the ice machine once every 6 months and if requested through the maintenance service request system the facility utilized. He reported he believed it was the responsibility of the Dietary Manager and his staff to ensure that the ice machine was clean on a daily basis. The Maintenance Director reported he had most recently deep cleaned the ice machine approximately 3 weeks ago but stated be must have missed pulling out the divider panel and stated it had not been cleaned.An interview with the Administrator on 08/12/25 at 1:20 PM revealed he expected the ice machine to be cleaned as needed and to be free from dirt and debris. He also reported that metalware should be fully dry before being stacked or nested together.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observations, record reviews, and staff and Medical Director interviews, the facility staff failed to disinfect a shared blood glucose meter (glucometer) between residents in accordance with the instructions provided by the manufacturer of the disinfectant wipes used for 1 of 2 residents whose blood glucose levels were checked (Residents #135). This occurred while there was at least one resident with a known bloodborne pathogen in the facility. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer potentially exposes residents to the spread of blood borne infections. Care must also be taken by personnel handling glucometers to protect the glucometers against cross-contamination via contact with other surfaces. Immediate Jeopardy began on 8/14/25 when Nurse #1 was observed performing blood glucose checks on residents using a shared glucometer without disinfecting per manufacturer's instructions. Immediate Jeopardy was removed on 8/20/25 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included:The facility's document entitled, Procedure: Fingerstick Glucose Measurement (Reviewed and Revised on 7/15/25) outlined the following process, in part:Step #22 (of 27): Clean and disinfect the blood glucose meter [glucometer] after use with EPA approved disinfectant, following manufacturer's instructions.Upon request, additional documents were provided by the facility in lieu of a Policy / Procedure for glucometer disinfection:---A Glucometer Cleaning & Disinfection Observation described the purpose of the observation as: Bloodborne pathogens such as Hep B [hepatitis B], Hep C [hepatitis C], and HIV [human immunodeficiency virus] can be transmitted to other patients if glucometers are not cleaned & disinfected. Such transmission has occurred in the past in LTC [long term care] facilities that do not use a cleaning & disinfecting procedure. The requirements of the observation included, in part: - .The glucometer is cleaned and disinfected after each use. If the nurse is unsure whether the glucometer is clean, it should be cleaned and disinfected before use. -The glucometer is wiped down with the product specified for use by the manufacturer. Products approved for the [brand name] meter include: [4 brands of disinfectant wipes, including the facility's disinfectant] -Staff clean & disinfect surfaces that come into contact with the glucometer (e.g., overbed tables, med [medication] carts, etc.).-The glucometer remains wet for the time specified in the directions on the cleaning and disinfecting product.---Clinical Competency Validation Fingerstick Glucose Measurement included step #19 (of 23): Cleans and disinfects the blood glucose meter after use with EPA approved disinfectant, following manufacturer's instructions.A Healthcare Professional Operator's Manual & In-Service Guide (Dated 2023) from the manufacturer of the facility's glucometer included a section on Cleaning and Disinfecting your [brand name of the glucometer]. It noted the following information, in part: Cleaning and disinfecting the meter and lancing device is very important in the prevention of infectious disease. Cleaning is the removal of dust and dirt from the meter and lancing device surface so no dust or dirt gets inside. Cleaning also allows for subsequent disinfection to ensure germs and disease causing agents are destroyed on the meter and lancing device surface. The products listed as having been validated for disinfecting the facility's glucometer included the brand of disinfectant wipes available for use at the facility. The manufacturer instructions for the glucometer used at the facility indicated the cleaning and disinfection procedure required the following step:#4 (of 6). To disinfect the meter, clean the meter with one of the validated disinfecting wipes.Wipe all external areas of the meter including both front and back surfaces until visibly clean. Avoid wetting the meter test strip port. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use.The manufacturer's labeling of the brand of disinfectant wipes used at the facility was reviewed and read, in part: Kills HIV-1 [human immunodeficiency virus], HBV [hepatitis B virus], and HCV [hepatitis C virus] on precleaned environmental surfaces/objects previously soiled with blood/body fluids in health care settings or other settings in which there is an expected likelihood of soiling of inanimate surfaces/objects with blood/body fluids and in which the surfaces/objects likely to be soiled with blood/body fluids can be associated with the potential for transmission of HIV-1 (associated with AIDS), HBV, and HCV. The directions for use of the disinfectant wipes addressed the required contact time for disinfection. The