STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING _____ B. WING _____	C 03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews and record review the facility failed to notify the family when changes were made to a resident's medication	F 157	Preparation on and/or execution of this plan of correction does not constitute admission or agreement by the provider of	4/27/15

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

Electronically Signed | 04/23/2015

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F 157	Continued From page 1 regimen for 1 of 3 sampled residents (Resident #4). The findings included: Resident #4 was admitted to the facility on 12/02/14 with diagnoses that included dementia with behaviors, psychosis and others. The most recent Minimum Data Set (MDS) dated 12/09/14 specified the resident had severely impaired cognition and received antipsychotic medication. Review of Resident #4's medical record revealed that the facility's physician and psychiatrist practitioner were addressing Resident #4's behaviors with psychiatric medications. During the resident's stay, changes were made to the resident's psychiatric medications. The following changes were made to Resident #4's medications: - On 12/12/14 an order was written to increase Abilify (an antipsychotic medication) - On 01/09/15 an order was written to increase Depakote (a mood stabilizer) - On 01/30/15 an order was written to decrease Depakote (a mood stabilizer) Further review of the medical record revealed that there was no documentation that the family was notified of the medication changes. On 01/30/15 Nurse #1 made an entry documenting a medication change but failed to document that the family was notified of the change in medication. On 03/31/15 at 10:40 AM a family member of Resident #4 was interviewed and reported that	F 157	the truth of facts alleged or the conclusions set forth in the statment of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Resident #4 was discharged from the facility on 2/13/15. 2. Physician orders/progress notes will be reviewed Monday through Friday by interdisciplinary team members to assure resident's responsible party has been notified within 24 hours of any medication order changes. 3. Nurses will be educated by DNS or designee to notify resident's responsible party within 24 hours of any medication changes. DNS or designee will monitor interdisciplinary team findings regarding notification of resident's responsible party within 24 hours of any medication changes for one month then weekly for two months. 4. Findings of audits will be presented to the QAPI meetings by the DNS or designee monthly for 3 months then ongoing as needed to ensure compliance.	

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F 157	Continued From page 2 she was Resident #4's responsible party (RP). She stated that during the resident's stay in the facility she did not receive notification when medications were changed. On 03/31/15 at 11:15 AM the Unit Manager was interviewed and reported that it was the facility's practice to notify family members when changes were made to a resident's medications. He stated he would expect the nurse who received a new order to contact the family. On 03/31/15 at 12:15 PM the Director of Nursing (DON) was interviewed and stated that when a nurse received an order for a medication change that the nurse notify the family of the medication change. On 03/31/15 at 1:10 PM Nurse #1 was interviewed and reported that she was trained to notify family members when a change with the resident occurred such as a fall or injury but had not been trained to contact families when changes were made to medications. She explained that she did not notify Resident #4's family of medication changes.	F 157		
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514		4/27/15

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F 514	Continued From page 3 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to document on treatment administration records that treatments were administered to 1 of 3 residents reviewed for pressure ulcers. (Resident #1). The findings included: Resident #1 was admitted to the facility 07/08/14 with diagnoses which included adult failure to thrive, senile degeneration of the brain, and anorexia. A quarterly Minimum Data Set (MDS) dated 01/12/15 indicated Resident #1's cognition was severely impaired. The MDS specified Resident #1 required extensive staff assistance with activities of daily living and was incontinent of bowel and bladder. The MDS further specified the resident had 2 stage II pressure ulcers and was at risk for additional skin breakdown. A review of Resident #1's medical record was conducted. Treatment Administration Records (TAR) for the months of December 2013 and January 2014 contained physician orders for daily dressing changes on the 2 stage II pressure ulcers. Continued medical record review revealed dressing changes for 12 days of each month were not initialed as completed. An interview was conducted with Nurse #2 on 03/30/15 at 4:14 PM. Nurse #2 stated she was	F 514	Preparation on and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statment of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Resident #1 Treatment administration record (TAR) is reviewed daily by DNS or designee for documentation that treatments were administered for pressure ulcers. 2. Treatment administration records (TARs) will be reviewed Monday through Friday by interdisciplinary team members to assure documentation on treatment administration record that treatments for pressure ulcers were administered per physician's order. 3. Nurses will be educated by the DNS or designee on treatment administration record documentation to be completed per physician's orders. DNS or designee will monitor interdisciplinary team findings regarding	

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F 514	Continued From page 4 the nurse on Resident #1's hall. Nurse #2 stated usually the Treatment Nurse (TN) did treatments on all residents. When theTN was not available, the hall nurses were responsible for the treatments. Nurse #2 stated she was the nurse that did not initial the treatments for Resident #1. She added she did do the treatments she just did not initial them as completed. She explained she knew the instructions contained in the physician's order for the dressing changes and would have been told by the TN if the orders had been changed. An interview was conducted with the TN on 03/31/15 at 9:17 AM. The TN demonstrated how to pull up the TAR on the computer for a resident. The treatment order was observed written on the computer screen with a Y or N box by it. The TN explained the treatment order that should be followed appeared on the screen. The nurse responsible for the treatment could review the order before administering the treatment. The TN added after completing the treatment the nurse should check the Y box which noted the treatment had been done as ordered. The TN stated she does try to keep the nurses verbally informed when treatments were changed, but might miss a nurse from time to time. The TN stated the correct treatment order was always written on the TAR. The TN stated she frequently got pulled to act as a hall nurse to fill in for nurses that called out. She added on these days the hall nurses were responsible for completing the treatments on all the residents. An interview was conducted with the Director of Nursing (DON) on 03/31/15 at 12:48 PM. He stated he had concerns regarding nurses not documenting treatments that were done. The	F 514	documentation on treatment administration record for one month then weekly for two months. 4. Findings of audits will be presented to the QAPI meetings by the DNS or designee monthly for 3 months then ongoing as needed to ensure compliance.	

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F 514	Continued From page 5 DON added he was also concerned that if the nurse did not document in the TAR the treatment had been completed, the nurse did not read the order before doing the treatment. The DON stated he expected nurses documented what they did for residents.	F 514		