PRINTED: 12/09/2013 FORM APPROVED OMB_NO. 0938-0391

AND PLAN OF CORRECTI	ON .	(X1) PROVIDER/SUPPLIER/C IA IDENTIFICATION NUMBE 3:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
\$		345008	B. WNG _		C 44/24/2042
GOLDEN LIVINGCE	NTER - DARTM			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE RD CHARLOTTE, NC 28207	11/21/2013
(X4) ID PREFIX (E TAG RE	ACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUL L SC IDENTIFYING INFORMATIC N)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
The resident schedule her interact vinside an about as are signiful. This REC by: Based o interview the choic residents The findirular Resident diagnoses and blinds Minimum assessed MDS indicating words and the second conducted she would per week, showers put an interview Nursing Assertion and American second conducted she would per week.	dent has the rest, and health ests, assessmith members do outside the pects of his officant to the rest the facility fee for bathing observed for mass included: #8 was admit with the assistant of the desident of the desid	ight to choose activities care consistent with his or ents, and plans of care of the community both facility; and make choices her life in the facility that esident. is not met as evidence: w and resident and starf elled to assess and hon or requency for 1 of 2 choices. (Resident #8) ted to the facility with led dementia, diabetes, tr#8's most recent (S) dated 11/14/13 cognitively intact. The (#8 was dependent for ence of one person. If an interview was triple the two showers he would like to have three controlled at 2:44 PM with the ence of the controlled at 2:44 PM with t	F 2	Preparation 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 statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. This plan of correction is submitted as the facility's credible allegation of compliance. F242 Residents # 8 was interviewed regarding her bath choices and time preference 12/04/13. The Shower Schedule and CNA care card were revised to reflect the changes. All residents upon admission will be interviewed about their choices as it relates to shower preference.	JAN - 6 2013 by: PARK

Any deficiency statement ending with an asterisk (*) denotes a deficiency v hich 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 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

Original Signature Date: 12-17-13

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI A IDENTIFICATION NUMBER	(X2) MUL A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
							; l
	, 3	345008	B. MNG			1000000000	21/2013
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
COLDEN	LIVINGCENTER - DARTM	Luzu		300 P	ROVIDENCE RD		
GOLDEN	LIVINGCENTER - DARTM	OUTH		CHA	RLOTTE, NC 28207		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORR .CTION		(X5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATIOI I)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
			•	1	T 0	ì	
F 242	Continued From page	11	F	242	The Shower Schedules and CNA care cards were revised		
		ain the shower schedul e is			to reflect any changes.		
		om number residents have.			Preferences to be reviewed by	2	
		nts want more than two			social services or designee	1	12/
		would have to ask. NA #3			upon admission, quarterly, or change of condition. The		10/221
		k anyone assessed how	Ĭ		nursing Staff was in-serviced	1	100/
	many showers the res	idents want per week.			regarding Residents Rights	1	1/3
	On 11/21/13 at 2:50 P				including making choices about his or her care.		1
	conducted with Nurse			i	about his of her care.		
		stated residents who want			The Director of		
		s per week would have :o	ŧ	1	Nursing/designee will	į	
	ask. She stated no on			i	randomly select 4 residents twice per week for 4 weeks, 4	la V	
		uld like when they were	r.	1.	residents per week for 4		
15		ated Resident #8 never old			weeks, 2 residents per week	K	
		than two showers per week.		i	for 4 weeks to focus on the bath preference and staff		
	mas and management	Tan the showers per wisek.	11 47		adherence to their choice.	i	
	On 1121/13 at 5:19 PM	d an interview was	į,	Ĭ.	The Director of		
	conducted with the Dir	ector of Nursing (DON)			Nursing/designee will report any negative findings to		
	The DON stated she d	d not think frequency of		1	Quality Assurance committee		
	showers was assessed		8		monthly for 6 months and	9,	
		reference for frequency of		\$0 10	quarterly thereafter.		2
	showers should be as		201	Ī			
F 312	483.25(a)(3) ADL CAR	E PROVIDED FOR	F	312			
SS=D	DEPENDENT RESIDE	NTS					
	A						
		le to carry out activities of	9	li li		Ü	
	maintain good putrition	necessary services to , grooming, and persor al				1	
	and oral hygiene.	, grooming, and person an		8			
	gione:					1	
						8	
	This REQUIREMENT	is not met as evidence I	1				
	by:			8		E	
		record review, and staff				10	
		ailed to provide nail care					
	for 1 of 3 sampled resi			(6)			
	activities of daily living	(ADL). (Resident # 96		10			1
				8			1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CL A IDENTIFICATION NUMBELL:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY • COMPLETED
	1 6				С
	•	345008	B. WNG _		11/21/2013
	ROVIDER OR SUPPLIER LIVINGCENTER - DARTN			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE RD CHARLOTTE, NC 28207	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUL . SC IDENTIFYING INFORMATIC 1)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 312	Continued From page	2	F 31	12	
	Findings included:		<u>(</u>	F312 Residents # 96 was provided finger nail care.	1
	Set (MDS) dated 08/2 assessed as having so and needed extensive most ADL including per Review of resident #9 dated 08/26/13 reveal anticipate resident needstaff to work with the resident of the revealed his finge quarter inch dark debrauts assessed in the revealed his finge quarter inch dark debrauts assessed in the revealed his finge quarter inch dark debrauts assessed in the revealed his finge quarter inch dark debrauts assessed in the revealed his finge quarter inch dark debrauts.	assistance of 2 persons for ersonal hygiene. 6's cognitive care planed interventions to eds and provide consistent esident. 2/13 at 8:15 AM and 12:58 nails on both hands had a is underneath the nail beds. ons on 11/21/13 at 11:13 aled his fingernails on both ye a quarter inch dark		All residents in the facility have the potential for being effected by the deficient practice. An audit of all resident nails was conducted and nail care provided as needed. The nursing staff was in-serviced regarding care of residents nails. Director of Nursing/designee will randomly select 4 residents twice per week for 4 weeks, 4 residents per week for 4 weeks, 2 residents per week for 4 weeks, 2 residents per week for 4 weeks to focus on nail care including cleaning. The Director of Nursing/designee will report	12/23/13
	An interview was cond #1 on 11/21/13 at 9:35 are done 2 and 3 time resident preference. A shaves and nails are of She said shaves and r just on shower days by An interview was cond 11/21/13 at 5:44 PM, responsibility for care of residents residing on the	ucted with Nurse Aide (NA) AM. She stated show ars a week depending on it the time of showers, ut, cleaned and trimme I. ails should not be done it as needed. ucted with NA #2 on She stated she had of Resident #96 and all ne short and long 100 r all, the only NA on the 100 hall evealed Resident #96 I ad Wednesdays and esidents nails and facia		any negative findings to Quality Assurance committee monthly for 6 months and quarterly thereafter.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI IA IDENTIFICATION NUMBE ₹:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ħ				С	
	345008	B. WING		11/21/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - DARTI			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE RD CHARLOTTE, NC 28207		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATIC N)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
hands before meals to clean and trim nails observed Resident #8 they had not been cleand needed to be cleand the NAs to monitor reroutine care and clean The DON observed Rand agreed they need be cleaned. F 323 483.25(h) FREE OF AHAZARD\$/SUPERVIOLEMENT of the facility must ensure new ironment remains as is possible; and ear adequate supervision prevent accidents. This REQUIREMENT by: Based on staff interviolement records and facility into supervise 2 of 3 sal with impaired cognition behavior. Resident #6 on the facility's side poback lobby. Resident #6 on the facility in the facility's side poback lobby. Resident #6 on the facility in the facility in the facility in the facility is side poback lobby. Resident #6 on the facility in the facility in the facility is side poback lobby. Resident #6 on the facility in the facility in the facility is side poback lobby.	She said she does hift and washes residen 's but had not always been able as needed. NA #2 B's fingernails and agre ad aned on his shower days aned. Director of Nursing (DO I) M revealed she expected sident's fingernails during them on a daily basis. esident #96's fingernails ded to ACCIDENT SION/DEVICES The that the resident as free of accident hazards ch resident receives and assistance devices to is not met as evidence the ews, review of medical estigations the facility finited mpled residents assessed and exhibiting wandering was unsupervised while bright and in the first floor floor was unsupervised	F 31	F323 Residents # 66 and #107 continue to wear Wanderguard bracelets and are monitored by staff. Upon admission, quarterly, or with a change of condition residents are assessed for the potential for Wandering the potential for being effected by the deficient practice. All residents in the facility were reviewed for the completeness and accuracy of their wandering assessment. A list was compiled of residents requiring a Wanderguard bracelet to assist in monitoring. The nursing Staff was in-serviced regarding Wandering and Elopement Policy. Exit door functions are checked daily by maintenance staff/designee.	12/23/3	
An interview with the on 11/21/13 at 6:03 P the NAs to monitor re routine care and clear. The DON observed R and agreed they need be cleaned. F 323 483.25(h) FREE OF A HAZARD\$/SUPERVI The facility must ensure environment remains as is possible; and ear adequate supervision prevent accidents. This REQUIREMENT by: Based on staff intervirecords and facility in to supervise 2 of 3 sar with impaired cognition behavior. Resident #6 on the facility's side points.	Director of Nursing (DO I) M revealed she expected sident's fingernails durir go them on a daily basis. esident #96's fingernails led to ACCIDENT SION/DEVICES The that the resident as free of accident hazards ch resident receives and assistance devices to is not met as evidence the ews, review of medical estigations the facility fulled mpled residents assessed and exhibiting wandering the was unsupervised while prich and in the first floor 107 was unsupervised	F 32	Residents # 66 and #107 continue to wear Wanderguard bracelets and are monitored by staff. Upon admission, quarterly, or with a change of condition residents are assessed for the potential for Wandering the potential for being effected by the deficient practice. All residents in the facility were reviewed for the completeness and accuracy of their wandering assessment. A list was compiled of residents requiring a Wanderguard bracelet to assist in monitoring. The nursing Staff was in-serviced regarding Wandering and Elopement Policy. Exit door functions are checked daily by	12/2	

	7		WEDIONID OLIVIOLO				DINI BIND	0. 0938-0391
	OF DEFICIENC CORRECTION		(X1) PROVIDER/SUPPLIER/C LIA IDENTIFICATION NUMBER:	(X2) MULT		E CONSTRUCTION		SURVEY . LETED
	5		345008	B. WNG				21/2013
NAME OF P	ROVIDER OR S	SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	- 111	21/2010
		200.20 50						
GOLDEN	LIVINGCENT	TER - DARTA	NOUTH			000 PROVIDENCE RD		
					(CHARLOTTE, NC 28207		
(X4) ID		SUMMARY ST	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			MUST BE PRECEDED BY FU .L SC IDENTIFYING INFORMATI (N)	PREFI		(EACH CORRECTIVE ACTION & HOULD BE		COMPLETION DATE
mo			SO BENTI TING IN OKMATI M	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
				ļ				
E 200								
F 323	Continued	From page	4	F:	323	visitors not to allow residents	9	
	The finding	gs included				to tailgate them out of the		
						facility will be posted by the		-
	1. a. Resid	dent #66 wa	s admitted to the facilit /	l.		exit doors and elevators.		
			cluded Alzheimer's	1		Wanderguard bracelets are		
			and tobacco use.			checked every shift for		
	domonia,	poyeriosis	and tobacco use.			placement and function by the nursing staff.		
	Resident t	466'e care n	lan initiated 05/18/11			the natsing statt.		
			opement related to			The Director of		
	impaired	conition on	d post of the sure server			Nursing/designee will		
	with a goo	ognition and	d poor safety awarene: s			randomly select 4 residents		
	with a goa	or no incid	ence of elopement.			twice per week for 4 weeks, 4		
	interventio	ins included	placement on a secured			residents per week for 4 weeks, 2 residents per week		
	unit, daily	use of wand	der guard, to redirect th∋			for 4 weeks to focus		
			and to assist the Resident	Î.		Wanderguard documentation.	i	
	to/from sm	oke breaks				The Director of	1	
				l.		Nursing/designee will report	1	
	Resident #	#66 had a p	hysician's order dated	v: I		any negative findings to		
	02/21/13 f	or a wander	guard in place, requiring	1		Quality Assurance committee monthly for 6 months and		
	staff to mo	initor and ch	neck function/placemer t			quarterly thereafter.		
	each shift.	The facility	maintained documents tion			1		
			ninistration records of					
	routine mo	nitoring for	function and placemen; of				,	
	the wande							
		1						
	A quarterly	/ Minimum	Data Set (MDS) dated					
	07/1/13 as	sessed Res	sident #66 with impaire I				i	
			andering behavior and					
i	requirings	taff supervis	sion with ambulation of the					
ì	unit.						88	1
		- 1						
	A facility in	cident repo	rt and nurse's note dat id				!	
1			part that Resident #66 vas					
	noted by m	naintenance	staff unsupervised on the					
	side porch	in the resid	ent smoking area at				1.0	
	approximat	tely 11:30 A	M. Resident #66 state I he					
			arette. Resident #66 was		Y			1
			facility and back to the					1
-	Secure unit	by staff wat	h no injuries noted. He was					1
	noted by at	taff to was	a functioning words a vest					
ì	which com	an to wear	a functioning wander guard					1
	which sour	ided as ne	was assisted back to the					1

			VIEDICAID SERVICES					<u>OMB NO. 0</u>	938-0391
AND PLAN O	OF DEFICIENC F CORRECTION	IES V	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBELL:	945 2000,400 40		E CONSTRUCTION		(X3) DATE SU COMPLET	
			345008	B. WNG				С	
NAME OF F	ROVIDER OR S	SUPPLIER						11/21/	2013
	**					STREET ADDRESS, CITY, STATE, ZIP CO	DE		
GOLDEN	LIVINGCENT	ER - DARTM	иоитн		ı	00 PROVIDENCE RD			
					С	CHARLOTTE, NC 28207			
(X4) ID PREFIX TAG	(EA	H DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUL . SC IDENTIFYING INFORMATIO 1)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIA		(X5) OMPLETION DATE
F 323	secured u that maint doors and which wen re-educate Interview o revealed o on break v stating Re porch. Nur leave the s residents f did not see Resident # the elevato easily redi for his smo a staff mer	enance staff alarmed do e found fund ed on respor on 11/21/13 on 08/19/13 when Nurse sident #66 re secured unit for the 10:30 e him return f66 was in the or when any rected if he woke break. N mber should ak and bring	ent report documented checked all facility exit ors on the secured unit tioning. Staff were ding to door alarms. at 11:04 AM with Nurse #3 Resident #66's nurse wils #3 received a phone call she saw Resident #66 that morning with other AM smoke break, but she to the unit. Nurse #3 stated the habit of walking towards one left the unit, but he vas was told that it was not I me urse #3 further stated that take residents back to the	F	323				
	Interview of revealed state of Resident # frequently the windown redirected. Resident # for the .10:3 thereafter state of the side porch brought Reshe stated alarmed and revealed state of reve	in 11/21/13 and the was the following the was the following the was the took her was on breaker that Residunsupervise sident #66 be was wead was functi	at 11:17 AM with Nurse #7 -3 PM cart nurse assig red 19/13. She described used Resident who rds the elevator to look out but he was easily ated she observed unit on 08/19/13 with s aff break and then shortly break. Nurse #7 stated nurse #3 called her ar d ent #66 was found on the d. Nurse #7 stated she ack to the secured unit ring a wander guard that oning when he entered foor to the back porch and						

		TEDIONID OLIVICES					OMR M	0. 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IA IDENTIFICATION NUMBE R:	(X2) MUL A. BUILD		CONSTRUCTION			E SURVEY PLETED
				NO2-19-				С
		345008	B. WNG				11	/21/2013
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COD	ÞΕ		
GOLDEN	LIVINGCENTER - DARTA	OUTH		30	0 PROVIDENCE RD			
				CI	HARLOTTE, NC 28207			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	-	PROVIDER'S PLAN OF CO	RRECTION		(X5)
PREFIX TAG	REGULATORY OR I	MUST BE PRECEDED BY FUI L SC IDENTIFYING INFORMATIC N)	PREF	3700	(EACH CORRECTIVE ACTION	SHOULD B		COMPLETION
.,,,,		DENTI TING INFORMATICIN)	TAG		CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIA	ATE	DATE
			+	-				
F 323	Continued From page	6	F	323				
	also sounded at the fi	st floor elevator door and at		020				
	the elevator door on t	ne secured unit. The nurse	Î					
	stated each time the	alarm sounded she had to						
	enter a code to disarn	the alarm. Resident #6		1				1
	was assessed without	injury and placed on 1:1		-				
	observations. Nurse #	7 stated afterwards starf						
	was in-serviced to mo	nitor door alarms and to						
	make sure Resident #	66 was escorted to/fron		1				
	smoke breaks and ret	urned to the charge nurse	i					
	on the secure unit.	and to the charge har se		1				
	Resident #66 was obs	erved in his room on						
	11/21/13 at 12:07 PM	confused and seated ir a						
	chair at his bedside dr	essed and groomed wil 1 a						
	wander guard to his le	ft wrist. He was observed		i				
	to walk independently	towards the elevator to the						
	window at the far end	of the hall. The elevator		- 1				
	door alarm sounded a	nd the alarm to the stail well	1	1				
	also sounded. Staff re	sponded and entered a						
	code to disarm the ala	rm.						
	An interview on 11/21/	13 at 12:19 PM with the		1				
	Maintenance Assistan	(MA) revealed in August		-				
	2013 he was the facilit	y's maintenance director at		- 1				
	that time. On 08/19/13	around 11:30 AM he						
İ	walked outside to the	acility's side porch to take						
	his lunch break and sa	w Resident #66		Ì				
	unsupervised leaning	igainst the rail on the						1
	cinarette. The MA state	ated he was waiting for a		į				1
İ	attempted to loove the	d Resident #66 had ne ver		- 1				- 1
	attempted to leave the	bis and to be a Ti	1	-			!	
į	irritated if he did not ge	6 was taken back to the						
-	secured unit by staff.	o was taken back to the						
	secured unit doors loo	e stated that on the ling to the stairwells an 1					i	
	the elevator door was	larmed If a regident		1				
	wearing a functioning	yander guard approach 3d	1	31			1	
	the alarmed doors or the	e elevator door, the alarm						1
Î	would sound to alert st	aff and required a staff					i	1
		r unu roquirou a stati		24			- 1	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					O. 0938-0391
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBE 1:	1.00		INSTRUCTION		E SURVEY
			A BUILD	ING		COM	PLETED
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NAME OF C	DOLEDER OF THE	345008	B. WNG			11	/21/2013
NAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - DARTM	MOUTH		300 P	PROVIDENCE RD		
	- THE CENTER OF BARTIN	OTA		СНА	RLOTTE, NC 28207		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID				-
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FUI	PREF	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATIO V)	TAG	200	CROSS-REFERENCED TO THE APPROPRI		DATE
				- 1	DEFICIENCY)		İ
F 222							
F 323	Continued From page		F	323			4
	member to enter a coo	e to turn off the alarm. The	i				
	MA stated while he wa	s the maintenance dire :tor		1			
	he conducted daily ch	ecks of the wander guard					
	system. On 08/19/13,	after this incident occur ed					
	he checked all the ala	med exit doors and		i			
	elevators doors again	and found the wander		İ			
	guard system working			İ			
							1
	Interview with the inter	m Director of Nursing		İ			
	(DON) on 11/21/13 at	4:50 PM revealed residents		i			
	on the secure unit who	were assessed for risk of					
	wandering/elopement	should not be unsupervised		ļ			
	at any point. The interi	m DON stated she started					
	about two weeks prior	and had no further					
	information regarding t	he investigation from					
	previous management	to determine how				W	
Tel	Resident #66 was four	d unsupervised on the	į				1
	side porch. She stated	that the current week sine	¥.	1		1	
26	instructed staff to chec	k all the wander guard		1			
	bracelets for function,	placement and expiration					
1	The interim DON state	that each nurse was					
	responsible for checking	g placement and function		1		Ì	1
	of wander guards each	shift. The interim DON					
1	stated she was aware t	hat on 08/19/13					
	maintenance staff chec	ked all exit doors and the				ì	
	alarmed doors on the s	ecured unit and all alarins		1			1
1	were found functioning	The interim DON also				į	- 1
i	stated that on 08/20/13	all staff were re-educated				i	- 1
I	to monitor/respond to d	oor alarms.					1
	Documentation of this i	n-service was provided for				į	
	review.					1	
	Intention of 44/04/15	5 00 014	1				
	Interview on 11/21/13 a	t 5:09 PM with Central	1			i	
5	Supply Staff revealed the	at sne was already		1		i	
	outside on the side por	n supervising residents				1	
1	Resident #66	break on 08/19/13 when		7			
A.	Resident #66 was assist	ted to the side porch by		1		1	
j	the restorative aide. It s	tarted raining and all	1			!	
	residents were redirecte	d back into facility.	7	1		1	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/09/2013

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C JA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 345008 B. WNG 11/21/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE RD **GOLDEN LIVINGCENTER - DARTMOUTH** CHARLOTTE, NC 28207 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FU L PREFIX PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR USC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 323 Continued From page 8 F 323 Central Supply Staff stated that the restorative aide took residents back into the facility through the side door leading to the porch and assisted residents back to the secured unit while she returned the smoke box to the front office by walking around the side of the facility and entering the facility through the front door. Central Supply Staff stated when she left the side porch there were no residents left on the porch. Interview with Restorative Aide on 11/21/13 a: 5:19 PM revealed she assisted residents to the side porch for the 10:30 AM smoke break on 08/19/13 including Resident #66. She stated 1 started raining and all the residents were assisted back inside the facility from the door leading to the side porch and taken back to their units. The Restorative Aide stated she assisted Residen: #66 back to the secured unit to the nurse. Sho stated she observed him with a wander guarc in place and the elevator door alarm sounded. b. Resident #66 was admitted to the facility 12/4/08. Diagnoses included Alzheimer's dementia, psychosis and tobacco use. Resident #66's care plan initiated 05/18/11 included his risk for elopement related to impaired cognition and poor safety awareness with a goal of no incidence of elopement. Interventions included placement on a secure unit, daily use of wander guard, to redirect from doors and to assist to/from smoke breaks. Resident #66 had a physician's order dated 02/21/13 for a wander guard, requiring staff to

monitor and check function/placement each sl ift. The facility maintained documentation on the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED C

345008 B. WNG 11/21/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE RD GOLDEN LIVINGCENTER - DARTMOUTH CHARLOTTE, NC 28207 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSO IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 323 Continued From page 9 F 323 medication administration records of routine monitoring for function and placement of the wander guard. A facility incident report dated 09/09/13 recorded in part that around 7:30 PM, Resident #66 was observed by the Staff Development Coordinato (SDC) standing in front of the therapy gym on the first floor unsupervised. Resident #66 was assisted back to the secured unit by the SDC. He was found with a wander guard on his left wrist which sounded at the elevator doors on the firs floor and on the secured unit and without injury Staff was re-educated to make sure all residents were assisted back to their units after a smoke break and a change to the door code was recommended. A quarterly MDS dated 09/30/13 assessed Resident #66 with impaired cognition, exhibiting wandering behavior and requiring limited staff assistance with ambulation off the unit. An interview with the SDC on 11/20/13 at 7:18 PM revealed she was leaving for the day around

An interview with the SDC on 11/20/13 at 7:18 PM revealed she was leaving for the day aroun 17:30 PM on 09/09/13 when she saw Resident #36 standing unsupervised in front of the therapy office on the first floor near the door leading to the side porch. The SDC stated she was unsure why Resident #66 was there alone, but she escorted him back to the secured unit, his wander guard was in place and the elevator door alarm sounded. The SDC entered a code to disarm the alarm. She described Resident #66 as a confused, independent with ambulation, with no previous attempts to leave the facility, but he did not like to miss a smoke break.

An interview with nurse aide #4 (NA #4) on

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		revealed on 09/09/13 st e	F 3	323			
	assisted regidents to	om the secure unit for the	İ				
	6:30 PM smake break	on the secure unit for the					
	go with her because h	but Resident #66 did not	i				
	#4 stated she sheers	e was eating his dinner. NA	İ		图		
	ooting dispass where the	Resident #66 in his ro m					
	whom she let when she	e left the secured unit ar d					
	described Besides 40	out 30 minutes later. N/ #4					
	described Resident #6	6 as a confused person		1			
	who wore a wander gu	ard and he did not like to					
	miss his smoke break.		İ				
	Intonious with the ad-	L				J	
	Interview with the adm	inistrator and interim					
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	Awi confirmed Residen	t #66 wore a wander guard	į			1	
	que to confusion/wand	ering behavior and that ne					
	should not be left unsu	pervised. The					1
	administrator and interi	m DON stated they wer a		1		1	
	this isside the administ	rative team at the time of	1				
	this incident and could	not explain why Residerit		1		e n	
	#66 was found unsupe	rvised on the first floor.				1	
		d that on 09/10/13 staff					- 1
	were re-educated on the	e facility's elopement					
	policy and to make sure	all residents were	1				
İ	assisted back to their u	nits after a smoke breal .					
		on the secured unit shot ld				i	1
	be returned to the char	ge nurse. The DON stated				i	
	the code to the elevator	doors was also changed.				- 1	
		-service was provided for				1	
	review.					į	
1	Interview with Nurse 42	on 11/21/13 at 10:10 A VI					
1	royaalad aba waa tha a	on 11/21/13 at 10:10 A VI				į	
ì	revealed she was the a	ssigned nurse for		1		1	
	Resident #66 on the 3-	11 PM shift on 09/09/13		ţ		1	
	Nurse #2 stated on 09/0	19/13 she administered				İ	
1	evening medications to	Resident #66 around 5: 00		1			
	PM and later that shift s	he observed him in his		1		1	
	room eating his dinner.	After eating he took his		1		i	
i	tray to the meal cart and	she entered a resident's		1		İ	-
	room to complete a dres	ssing change for about · 5		į		i	

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maintenance director stated he monitored the wander guard system weekly to ensure prope functioning. The maintenance director stated the 3rd floor was a secured unit and residents who		An interview	w was cond	ucted on 11/21/13 at 12:10		i		1	- 1
wander guard system weekly to ensure proper functioning. The maintenance director stated the 3rd floor was a secured unit and residents who		PM with the	e Maintenan	ce Director. The	10	1			Į.
wander guard system weekly to ensure proper functioning. The maintenance director stated the 3rd floor was a secured unit and residents who		maintenand	ce director s	tated he monitored the	1	-		1	
functioning. The maintenance director stated the 3rd floor was a secured unit and residents who	ā.	wander gua	ard system y	veekly to ensure prope					
3rd floor was a secured unit and residents who	i	functioning.	The mainte	nance director stated the	ji			8	
resided on that unit and wore a wander guard		3rd floor wa	as a secured	unit and residents who				i	
		resided on	that unit and	wore a wander quard	1			1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CI IA IDENTIFICATION NUMBE ?:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRI	UCTION		(X3) DATE SURVEY COMPLETED	
		345008	B. WNG				С	
NAME OF P	ROVIDER OR SUPPLIER	34000	B. WING	STDEET AD	DRESS, CITY, STATE, ZIP CODE		11/21/2013	
	LIVINGCENTER - DARTM			300 PROVI	DENCE RD	eg.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUI L SC IDENTIFYING INFORMATIC N)	ID PREFI TAG	S. D.	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE		
F 323	could not access the stairwells without staft the alarm. The Mainteresident exited the buguard, the wander gushould alarm to alert maintenance director maintenance logs dat revealed no malfunctisystem.	elevator or the doors to he entering a code to disarm nance Director stated if a iding wearing a wander and system on any exit coor staff. Interview with the and review of weekly ed 09/2013-11/2013 on of the wander guard	F	323				
÷ .	who were assessed for wandering/elopement at any point. The inter about two weeks prior survey, staff began characelets for function, The interim DON state	should not be unsupen ised im DON stated she star ed and the week of the ecking all the wander g lard placement and expiration. It is that each nurse was a placement and funct on						
	2. Resident #107 was Diagnoses included al Minimum Data Set dal Resident #107 with se independent with amb wandering behavior.	zheimer's dementia. ed 09/04/13 assessed verely impaired cogniticn,						
	observed seated in the	M Resident #107 was dining area on the 3rd a wanderguard to his ri jht						
	A care plan was initiate elopement related to the aimlessly throughout the							

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/(LIA	- Commence (September 1987)		OMB	NO. 0938-0391
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBI R:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345008	D MANO			С
NAME OF	PROVIDER OR SUPPLIER	340008	B. WNG		1	1/21/2013
				STREET ADDRESS, CITY, STATE, ZIP COD	ÞΕ	
GOLDEN	LIVINGCENTER - DARTN	оитн		300 PROVIDENCE RD		
(X4) ID	SUMMARY OF			CHARLOTTE, NC 28207		
PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUI L SC IDENTIFYING INFORMATI(N)	ID PREFI TAG	1-1011 OOMMECHAE VCHON	SHOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	12				1
			F 3	323		1
	a wanderguard to aler	staff of any unsupervi: ed	1			1
	were implemented in	cility. Care plan measur is				
	incidence of elopemen	h the goal of having no t.				
	Review of physician or	rdoro with at a lar				
	04/15/13 indicated wa	nderguard placed on ric ht				
	leg for safety, check for	r placement and function				
	each shift. Review of M	dedication Administratic n				
	Record (MAR) dated 0	9/2013-11/2013 revealed		i		
	wanderguard checks w	ere performed each shift				
	as ordered.	p streamed adolf strik	-			
	Review of social service	es note dated 05/13/13				
	indicated Resident #10	7 was readmitted to the				
	facility and his family re	quested a room chang				
	on the sta moor secure	d unit. The social services		ľ		!
	note indicated Residen 2nd floor.	t #107 was moved to the				
	Review of incident reno	rt dated 10/05/13 at 12 28		-43	W. Maria	
	PM indicated Resident	#107 was found outside in				
1	the parking lot at the ba	ck of the building. Revi w			1	
-	of nurses notes indicate	d Resident #107 was		E		
Ì	returned to the 2nd floo	r hall where he resided				
	placed on 15 minute vis	ual checks, and				
	transferred to the 3rd flo	or secured unit. Record				
	review indicated no app	arent injury.				
1.	An interview was condu	cted on 11/20/13 at 11:16				
	AM with the restorative	nurse aide. The				
11	restorative aide stated s	he observed Resident		İ	1	l
1	#107 on 10/05/13 from t	he 3rd floor window			!	1
1 8	standing outside in the	ack parking lot	1		!	
	unattended. The restora	tive aide stated she told		E E		
2	ne 3rd floor nursing staf 2nd floor nursing staff.	f who called to notify the				
i		ted on 11/20/13 at 12:(\3				
	Interview was conduc	neu on 11/20/13 at 12:03		A contract of the contract of		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
		345008	B. WNG_		ł	С	
NAME OF P	ROVIDER OR SUPPLIER	343008	D. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE		11/21/2013	
GOLDEN	LIVINGCENTER - DART	лоитн		300 PROVIDENCE RD CHARLOTTE, NC 28207			
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	Resident # 107 seated the 2nd floor around Nurse #2 stated she was floor staff around 12:00 Resident # 107 was of unattended Nurse #2 the hall nurse aides was resident back to the unattended building near the smoothe wanderguard alar entered through the descorted back to the 2 minute checks and trasecured unit. Nurse # explanation of how Resident was concerned by the wanderguard system functioning. The Maintenance Director wandergaurd system functioning. The Maintenance floor. The Maintenance #107 exited the building was not a secould access the elevation.	arise #2 stated she saw If in the common tv area on It 30 AM on 10/05/13, was contacted by the 3rd It 30 PM and was notified that atside in the back parking lot stated that she and one of rent outside to bring the nit. Nurse #2 stated If back into the building fors on the side of the king patio. Nurse #2 state of m sounded as the resider to fors. Resident #107 was and floor, placed on 15 finsferred to the 3rd floor awas unable to provide an assident #107 exited the without staff knowledge. If the stated he monitored the weekly to ensure proper tenance Director. The stated he monitored the weekly to ensure proper tenance Director stated the cured unit and residents after to go down to the 1st the Director stated if Resident and wearing a wanderguard, the on any exit door should be review with the and review of weekly and 09/2013-11/2013	F3	323			
	Interview with the Inte (DON) on 11/21/13 at	rim Director of Nursing 5.15 PM stated she was y investigation that may					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C_IA IDENTIFICATION NUMBER:	The state of the state of the		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	5	345008	B. WNG			C	oc em a conservación con em	
NAME OF PE	ROVIDER OR SUPPLIER	0.000	1	CT	REET ADDRESS, CITY, STATE, ZIP CODE	11/2	1/2013	
	TO THE OWNER OF THE IN		- 1					
GOLDEN	LIVINGCENTER - DART	MOUTH	- 1		0 PROVIDENCE RD			
				CH	HARLOTTE, NC 28207			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENT	OY MUST BE PRECEDED BY FU .L LSC IDENTIFYING INFORMATI()N)	PREFIX	X	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION DATE	
1/10	THE OBSTORT ON	I SO IDEITH THE HE ORMATI MY	TAG	17	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(IE	0.110	
F 323	Continued From	1.5		6				
1 323	Continued From pag	11	F 3	323				
	have been conducte	d by previous managem ant						
		incident with Resident # 07.						
		ted cognitively impaired		10		+		
		ring behaviors should b						
	monitored to maintai	n a safe environment and to						
	ensure they did not e	exit the facility unattende 1.			X1222			
F 333			F	333	F333 Residents # 152 a blood	11		
1 10 100 100 100 100	SIGNIFICANT MED			500	sugar audit was reviewed an		~1	
00-8)				are within normal range.		121	
	The facility must one	ure that residents are free of		į			/ /23/	
	any significant medic	ore that residents are life of			Newly admitted residents		1001	
	arry significant medic	ation errors.		- 1	admission medication records	1	/ / 2	
					were reviewed with current physician orders for accuracy		113	
	This DECUMENT	is not met as evidence d		1	and any conflicting data.	1	,	
	by:	is not met as evidence d			and any contacting and	i		
	- 100 B 1 B 1 B 1 B 1 B 1 B 1 B 1 B 1 B 1	Landa alta di di di di di di di di di di di di di		į	All diabetic residents in the			
3	based on nospital re	cords, chart review and staff		-	facility have been reviewed			
	interviews the facility	ailed to give the correc			regarding their insulin			
	dose of insulin to 1 o	6 resident reviewed for		1	dosages Two nurses will review and sign. The nursing			
i	medication errors. (F	lesident #152)			Staff was in-serviced			
				38	regarding the process of			
i	The findings included	1			reviewing orders on	1		
	120 020W 50 WY00000A0D				admission for those residents			
		dmitted to the facility on			receiving Lantus Insulin.		1	
j	08/30/13 with diagno	ses which included diab ites.			The Director of	1		
1				i	Nursing/designee will			
		152's hospital discharge			randomly review all new	1		
i		0/13, listed under current			admission/readmission charts			
		ong others, Lantus (insu in)			of residents receiving Insulin for 4 residents twice per week			
	50 units subcutaneou	s twice per day.		Î	for 4 weeks, 4 residents per	1	1	
					week for 4 weeks, 2 residents		l	
		152's hospital medicatic n			per week for 4 weeks to	1	1	
ž.	reconciliation form da	ted 08/30/13 revealed an			review reconciliation hospital	a H	l	
		in 15 units injected twice a			physician orders with	4	l	
	day.	The control of the co			admission orders signed by 2 nurses. The Director of		1	
	2				Nursing/designee will report		l	
	Review of Resident #	152's August 2013		T	any negative findings to		1	
	Medication Administr			*	Quality Assurance committee	İ	1	
	revealed Lantus insul			- 1	monthly for 6 months and	1	I	
l l				ŀ	quarterly thereafter.	1		

STATEMENT		WIEDIOAID SERVICES				OMB N	O. 0938-0391
AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C_IA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION		E SURVEY PLETED
		345008	B. WNG_				C /21/2013
NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	11	121/2013
COLDEN			1		OVIDENCE RD		
GOLDEN	LIVINGCENTER - DARTA	оитн	1				
/Y4\1D	CUMMARYOT			CHAR	LOTTE, NC 28207		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU L	ID	.	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATIC N)	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
			1110		DEFICIENCY)	AIC	
							-
F 333	Continued From page	16	F 3	133			
		0 PM on 08/30/13. Furl ner	1	,55			
	review of the MAR rev	ealed Lantus insulin 5(1				
	units was administere	d to Resident #152 on					,
	08/31/13 at 6:30 AM.	The 9:00 PM 08/31/13 close	1	-			
	of Lantus 50 units was	not documented as giren.		į			
		grant and the second second					
	A nurse's note dated (8/31/13 at 9:40 PM	i	į			
	indicated Resident #1	52 had a blood sugar o 28		1			
	mg/dl. Resident #152	refused his Lantus insu in.					
			1				
	Review of MAR for Se	ptember 2013 indicated					
	Lantus insulin was not	given at 6:30 AM					
	on09/01/13. Further re	view of the MAR on					
	09/01/13 at 6:30 AM R	esident #152 had a blc od				J	
	sugar at of 58 mg/dl.		İ	-			
	A physician order date	d 09/01/13 at 12:15 PN to	İ				
- 1	discontinue Lantus (in	sulin) 50 units, decreas					1
	Lantus (insulin) to 15	nits subcutaneously tw ce					
	per day.	This subcutaneously twice					1
						1	
1	On 11/20/13 at 4:33 Pt	n interview was		1			i
	conducted with Nurse	44 who admitted Resident				ļ	
	#152 to the facility on (8/30/13. Nurse #4 stated				i	
	when the resident cam	e from the hospital he					
	reviewed the resident's	discharge summary read					- 1
ļ	Lantus 50 units was to	be administered twice . I				- 1	
	day. He stated that was	the only order for Lan us					1
	ne saw at the time of the	e resident's admission He		1		İ	1
ĺ	explained he called the	nurse practitioner on				1	
	08/30/13 and went ove	the medications that	İ	1			1
	Nurse #4 reported	ent's discharge summary.	Ė			1	1
1	Nurse #4 reported whe sugar was low on 09/0	/12 be sevieused the	ì				1
1	resident's chart and for	nd the 08/30/13 hospital					
	medication reconciliation	n sheet which containted		1		1	1
	an order for the residen	t to receive 15 units of		1		1	
ĺ	Lantus twice a day. Nur	se #4 stated he then	ŀ	į		İ	1
2	called stated he called t	he nurse practitioner to		Į.		į	
	72.10 04.104	ושוטט פומטוווטווטו ננ				J.	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					PRINTED: 12/09/2	013	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					FORM APPROV	ED.	
STATEMENT	OF DEFICIENCIES						OMB NO. 0938-03		
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI \ IDENTIFICATION NUMBER		TIPLE CONS	TRUCTION		(X3) DATE SURVEY		
		I SENTI TOXITON NOMBER	A. BUILD	ING			COMPLETED		
		1 !!	1			С			
		345008	B. WING						
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP COL		11/21/2013		
COLDEN	LIVINGOENZES SASS				VIDENCE RD)E			
GOLDEN	LIVINGCENTER - DART	гмоитн						- 1	
(X4) ID	CHANADA			CHARL	OTTE, NC 28207				
PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CO	RRECTION	(X5)		
TAG	REGULATORY OF	LSG IDENTIFYING INFORMATION	PREFI TAG		(EACH CORRECTIVE ACTION	SHOULD BE	E COMPLETIO	N	
		150 COOL 7000 085600	INO	l.	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIA	TE DATE		
					== (0.2.10 //		ļ.		
F 333	Continued From pag	19 17					į		
			F F	333					
	the social and this order	er and received an order fo						- 1	
	the resident to receive	ve Lantus 15 units twice a		1			į		
	day.		į.						
								- 1	
	An interview was cor	nducted on 11/21/13 at 4:4:!	į.					- 1	
	PM with the Nurse P	ractitioner (NP). The NP		ĺ					
	stated she was called	d regarding the admitting					İ		
	orders for Resident #	#152. She stated she did not	1						
	question the 50 units	of Lantus twice per day as							
	she sees residents in	this population with highe	1					1	
	doses of Lantus. She	stated with Resident #152's	1						
	diagnoses of severe	diabetes the order for Lant is							
	50 units did not alarn	n her. The NP further stated						- 1	
	the nurse should hav	e reviewed with her the	j				1		
	medications listed on	the hospital medication	į						
()	reconciliation form, a	s it is the legal document							
	that is signed by the	physician, instead of							
	reviewing with her the	e medications listed on the		1				- 1	
	resident's hospital dis	scharge summary.	1						
				i					
	An interview was con-	ducted on 11/21/13 at 5:10							
	PM with the Staff Dev	elopment Coordinator					-		
1	(SDC). The SDC state	ed that prior to the incident:	1						
	of Resident #152 rece	eiving the incorrect doses of	ì				i		
	Lantus Insulin on 08/3	30/13 and 08/31/13 it was							
	common practice for r	nurses who admitted						1	
	residents to this facilit	y to use the resident's	1						
	hospital discharge sur	mmary to review medicatio	ý						
1	orders. She further sta	ated nursing staff are		ì					
1.1	directed to always use	the resident's hospital		į					
11	medication reconciliati	ion with the medications							
1	isted on the resident's	s hospital discharge							
	summary for discrepar	ncies.	5	1			Ì		
Ì									
	On 11/21/13 at 5:17 P	M an interview was		İ					
	conducted with the Dir	ector of Nursing (DON).	1	1					
	The DON stated it was	s her expectation for staff to							
	and at both it is	The organism for stall to		1			1	1	

look at both the discharge summary and the medication reconciliation form to compare any

	OF DEFICIENCIES CORRECTION		(X1) PROVIDER/SUPPLIER/CLI \ (X2) MULTIF IDENTIFICATION NUMBER A. BUILDING			ONSTRUCTION		ATE SURVEY • DMPLETED
	5							С
			345008	B. WING				11/21/2013
J	IVINGCENTER		лоитн		300	EET ADDRESS, CITY, STATE, ZIP CODE PROVIDENCE RD ARLOTTE, NC 28207		7
(X4) ID PREFIX TAG	(EACH DE	FICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATIO!)	ID PREFI TAG		PROVIDER'S PLAN OF CÓRRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 222	0			_				l
F 333	Continued Fro			۲	333			2
	information the					0.		
	483.35(c) MEI ADVANCE/FC		ET RES NEEDS/PREP IN D	F	363			
	시시 10 프랑스 및 시 10 프랑스 (1987년 1987년 - 198		nutritional needs of e with the recommended					
	The same of the sa		ne Food and Nutrition		- 1	7262		
			esearch Council, Naticnal			F363 No specific residents were		
			be prepared in advance;			harmed by this action.		
	and be followed		be prepared in advance,	7.9				121
	and be followed	su.			8	The potential for harm to		123/
						residents needing is used includes wt loss, skin		19.2
	This REQUIR	EMENT	is not met as evidenced			breakdown, etc.		13
	7 SE 5 TO ST 1 TO ST 1	servation	s, staff interviews and			Cooks in-serviced on for the		
			the facility failed to serve			use of proper scoop sizes to		
			anical soft roast beef	9		ensure proper portions for all diets to include those		
			for 21 of 25 residents v ho			residents on mechanical soft		
			soft diet per physician':			diets. Tray line will be		
			86, 48, 17, 18, 47, 140			monitored 3 times per day time 3 weeks to assure that	1	
			6, 126, 11, 62, 107, 10, 46			the proper scoop sizes are		W
	and 146)					being used specifically those		E 20
						residents on a mechanical soft	10	8: 6:
	The findings in	ncluded:				diet. Then the audit will then be 6 times per week times 3		
			4 700 81	3		weeks.		
			unch meal tray line					
			t 12:09 PM. The lunch			Findings from the audits will be reported to Quality		Hi .
			ef, potatoes and Brussels		2	Assurance committee		
	sprouts. Furth	er review	of the menu revealed			monthly for 6 months and		
			an's order for a	1		quarterly thereafter.		
			ere to receive a ½ cup	10 10				
			oft roast beef. The tray al soft roast beef serve t	1				ă i
1			Lunch trays were observed					0.
			o 12:30 PM for Residents					
			r for a mechanical soft liet					
			14, 86, 48, 17, 18, and 17.					-

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE &		MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C .IA IDENTIFICATION NUMB! R:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
					С
NAME OF O	DOMEST 05 04	345008	B. WNG _		11/21/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	LIVINGCENTER - DARTA	оитн		300 PROVIDENCE RD	
				CHARLOTTE, NC 28207	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU L SC IDENTIFYING INFORMATI(N)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUNDED TO THE APPROPRIED TO T	ULD BE COMPLETION
F 000					The state of the s
F 363	Continued From page		F 3	363	1
	Interview with cook #1	on 11/20/13 at 12:32 FM			
	revealed she used the	menu and the utensil			
	guide located in a boo	k kept at the tray line to	i		
	determine which uten	sils to use for the meal			
	service. Cook #1 was	observed to review the	Ì		
	menu and then the ut	nsil guide and stated that			
	she should have serve	d 1/2 cup portion of			
	utonoil Cook #4 furth	beef using a gray hand ed			
	served residents and	er stated that she typically			
	1/3 cup parties of mar	ed a mechanical soft d et at, but the current menus			
	were new to her and s	t, but the current menu;			
	portion size for mecha	nical soft meat was			
	different. Cook #1 stat	ed she was currently			
	serving the last cart fo	r the 2nd floor and			
184	residents on the 1st ar	d 3rd floors had alread/			
	served.	anoug/			
	An interview with assis	stant dietary manager			
	(ADM) occurred on 11	20/13 at 12:34 PM. Thu			
	interview revealed that	she usually checked the	il .		
	serving utensils prior to	the start of the tray, but			
İ	she did not check that	day.			
İ	An interview with the d	etary manager/register ad	1		
	dietitian (DM/RD) occu	red on 11/20/13 at 12::17			
	PM. The DM/RD stated	that the portion sizes for			
i	foods served to resider	its with a physician's or ler	1		1 1
	for a mechanical soft d	let varied per meal. He			
	stated that cooks were	trained to refer to the			
j	colored utensil guide a	nd were responsible for	1		
1	making sure they serve	d foods in portions	1		
	according to the menu.	He also stated that			
1	residents who ate at lea	ast 50-75% of their meal	į		4
9	would meet their nutrition	onal needs, but those who		<u>1</u> 1	,
i i	ate less than 50% of th	eir meal and who also	*		
15	would not have their a	er than the menu required tritional needs met. The			
£ .	DM/RD stated that one	Resident on the 1st floor			
	Oldied that one	resident on the 18(110)t		ħ.	

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/C .IA	(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
AND PLAN OF		IDENTIFICATION NUMBER:	A. BUILDING			
	á				C	
		345008	B. WNG		11/21/2013	
NAME OF PE	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
		J	300	PROVIDENCE RD		
GOLDEN	IVINGCENTER - DART	MOUTH	СН	IARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FL LL LSC IDENTIFYING INFORMAT ON)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 363	Continued From page	20	F 363			
F 303	The contract of the contract o		, 555			
	(Resident #140) and	14 Residents on the 3rd 88, 52, 8, 39, 34, 76, 126,				
	11 62 107 10 48	and 146) with physician s				
	orders for mechanic	al soft diets had already been		F 371		
	served their lunch m	eal.		No residents were harmed by		
F 371			F 371	the deficient practice.	12/	
SS=D		SERVE - SANITARY		All Residents could potential	109	
00-0				be at risk secondary to no	123	
	The facility must -		- 5	warm water in dietary hand sink.	17	
	(1) Procure food fro	m sources approved or		our.	//	
l		ory by Federal, State or local		Hand sink water temperature	/	
	authorities; and			will be recorded twice a day		
		distribute and serve food	1	for 4 weeks, then checked and recorded daily on a		
	under sanitary cond	itions		monthly basis thereafter.		
1				Reduction of temperature will	1	
				be reported to the Dietary Service Manager,		
				maintenance, and Executive		
				Director. Staff in-serviced on		
1	This RECUIREMEN	T is not met as eviden æd		complete hand hygiene using		
	by:	1 is not met as evidenced		warm water prior to meal preparation. Twice daily water		
1		ions, staff interviews and		temperatures in the hand		
		ords, the facility failed to 1)		washing sink times one		
1		at the hand sink in the dietary	i	month then once daily temps for 2 weeks, then 3 times per		
	department and 2)	complete hand hygiene using		week until 1-22-14. Registered		
	warm water prior to	meal preparation for 2 of 2		Dietician or Dietary Service		
1	meal observations.	purchase and the first office of the second	**	Manager		
				Findings from the audits will		
120	The findings include	ed:	1	be reported by the Registered		
		ID: -i O is as a Hond		Dietician or Dietary Service		
	The facility's policy	Dining Services, Hand		Manager to the Quality Assurance committee		
		recorded in part the fo lowing on water and run until warm.	İ			
		osed forearms with warm	1	monthly for 6 months and		
		ighly with warm water.		then quarterly thereafter.	İ	
		ne before putting on		, January Control		
		before handling food, c ean				
1	equipment utensile	dishes or service wear."		İ		
	- COUIDINGILL GIGHOIS	21 4101100 01 0011100 1100 1	1	T C C C C C C C C C C C C C C C C C C C	£.	

	T.		
<u>.</u>			

DEPAR	TMENT OF HEALTH A	AND HUMAN SERVICES			PRINTED: 12/09/2013
CENTE	KS FOR MEDICARE 8	MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/. IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY
		I I I I I I I I I I I I I I I I I I I	A. BUILDING_		COMPLETED
		345008	B. WNG		С
NAME OF F	PROVIDER OR SUPPLIER				11/21/2013
			7.0	TREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	LIVINGCENTER - DART	моитн		00 PROVIDENCE RD	
WALID				CHARLOTTE, NC 28207	
(X4) ID PREFIX	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTI	ON 1 (75)
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BF COMPLETION
F 371	Continued From pag	e 21	F 371		
	An observation of		1		
	occurred on 10/19/13	ater from the hand sink			
	only was allowed to	3 at 10:50 AM. The hot wat∋r run for two minutes and	i		
	remained cold to tour	ch linutes and	P		
		511.			
	Interview with the ass	sistant dietary manager			
	(ADM) occurred on 1	0/18/13 at 10:52 AM. Durir g			
	the interview the ADN	I revealed that for the past			
	rew days the hot water	er at the hand sink had been			
	not at times and cold	at times. The ADM further			İ
	stated that it took a w	hile for the water to warm			
U	up. The ADM stated s	she had not reported this	1 1		
	concern. Further obse	ervations with the ADM at	1 1		
	10:55 AM revealed th	e prep sink with only cold	1		
	running water which r	emained cold to touch afte:			
	two minutes. Addition	ally the two staff bathroom;			
	were observed at 11:0	00 AM on the basement			
1	floor with only cold rur	nning water that remained			
	cold to touch after two	minutes. The ADM stated			
	sne was unaware that	the water at the prep sink			
1	was also cold.	oms on the basement floor			
	was also colu.		1		!
	Interview with the diet	ary manager/registered			
	dietitian (DM/RD) occu	urred on 11/18/13 at 11:05			
	AM and revealed he w	as just made aware that			
	the hand sink, prep sir	nk and the hand sinks in th			
1	staff bathrooms on the	basement floor did not	1		,
1	have hot water. He sta	ited he informed the			
1	maintenance director of	of the cold water and he			
1	was aware that the ma	intenance director was			
	addressing plumbing c	oncerns.	(4)		
l l			4		
100	A second observation	of the water at the hand			
	sink, prep sink and sta	ff bathrooms on the	1		1

after running for two minutes.

basement floor occurred on 11/18/13 at 4:12 PM and revealed the water remained cold to touch

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IA IDENTIFICATION NUMBE ?:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345008	B. WNG				С	
NAME OF P	PROVIDER OR SUPPLIER		1	20)		11/21/2013		
	LIVINGCENTER - DARTN			3	TREET ADDRESS, CITY, STATE, ZIP CODE OF PROVIDENCE RD CHARLOTTE, NC 28207			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUI L SC IDENTIFYING INFORMATIC N)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 371	Continued From page	22	F	371				
	11/18/13 at 4:15 PM a shift dietary staff were water at the hand sink bathrooms or given ar regarding hand hygier that she had not moni water at the hand sink bathrooms and she th now. An interview with a see #1) occurred on 11/18 revealed that she was sink about 30 minutes cold. DA #1 stated she was not hot, but she d was observed during the for the dinner meal whas observed during the for the dinner meal whas observed pouring individual cups with bath washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the had not regarding alternate har coming on shift. DA #2 work he had poured the made four pitchers of its stated he had not reported the made four pitchers of its stated he had not reported the made four pitchers of its stated he had not reported the made four pitchers of its stated he had not reported the made four pitchers of its stated he had not reported the made four pitchers of its stated he had not reported the made four pitchers of its stated he had not reported the made four pitchers of its stated he had not reported the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and the washed his hands at the minutes ago and t	y new instructions e. The ADM also stated ored the temperature of the prep sink or staff ought the water was ho cond shift dietary aide (DA 13 at 4:16 PM and hed her hands at the hand prior and the water was was unsure why the water d not report this. DA #1 he interview plating cake le wearing gloves. cond shift DA #2 occurred fl, during the interview he hands. DA #2 stated he hand sink about 30 ater was cooler than usual. of sure why the water v as received any instructions d hygiene options since stated since coming to ckened water/tea and emonade for residents. He ted the concern with water id sink.						
3	director on 11/18/13 at	4:30 PM. The interview red on 08/26/13. Since he				1		

STATEMENT	OF DEFICIENCIES	WILL DESCRIPTION OF THE PROPERTY OF THE PROPER				OWB MO	O. 0938-0391
AND PLAN C	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBE 1:			CONSTRUCTION		E SURVEY
		, and the state of	A. BUILD	ING_		COM	PLETED
			1			С	
NAME OF I	70014555	345008	B. WNG			11/21/2013	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - DARTM	IOUTH		30	00 PROVIDENCE RD		
103	- THE CENTRE OF BANKING	OTA		c	HARLOTTE, NC 28207		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	١.,			4
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FUIL	PREF	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATIO V)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
	,				DEFICIENCY)		
E 07.			i				
F 3/1	Continued From page		F	371			
	was hired he had iden	tified the inability to con rol	į.				
	water routed for reside	ent use at individual valves.		1			1
	He stated that some v	alves would not operate so		1			
	in order to make repai	rs he turned off water fc	ł.	1			
	the facility at night usir	ng the main valve. He					
	further stated that in o	rder to determine if the		1			
	replaced valves where	operational, he had to					
	assess this during the	day. The maintenance	1			W	
	director stated he was	unaware that this would					
E 7 E	affect hot water for the	dietary department. As a					
i	result he did not inform	the dietary staff that hot				1	
	water would be unavai	lable while he assessed					
	the valves. He stated t	hat as soon as the DM/ 3D		1			1
	informed him that hot y	vater was unavailable a:	1	- 1			
	the hand sink he turns	ed the hot water back or ,					
	the hot water was ched	ked and observed to be					
	warm, but knew it would	d take a while for the hot	1				I
	water to return. He sta	ted he was not sure what	1				
	caused the water to be	cold again, but he was in		i		1	
	the process of trying to	resolve this	İ	1	•		
	are process of trying to	resolve (ilis.		- 1		1	
	A follow-up interview w	th the DM/RD on 11/18/13		1		I	1
	at 4:35 PM revealed m	aintenance staff informs d	i	İ			1
	him earlier that morning	that the hot water was					
	back on. The DM/RD s	tated that he checked the					i i
27	water at the hand sink	himself after the lunch t ay		ĺ			
	line and the water was	hot. He further stated that					1
	he had not checked the	water at the hand sink or				1	
	the prep sink since lund	h and he was not awar ;	ä			1	
	that the water at these	sinks was cold again. The				1	
	DM/RD stated that diet	any staff was trained to		1		1	
	wash their hands using	hot water and soap and				1	
	he had also placed han	d sanitizer at the hand	3			į	
	sink for staff use.	a cantile of at the field	į				
F 412	483.55(b) ROUTINE/EN	MERGENCY DENTAL		40			
0 NO.45	SERVICES IN NFS	ILITOLINOT DENTAL	F4	12		!	
00-0	TOLO 114 141 0			1			
11	The nursing facility mus	t provide or obtain from		1		1	
525	3, 11100	F. F. T. Ido of obtain non	ì	1			
							(4)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE &	MI	DICAID SERVICES					OMB N	IO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION		(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDIN		PLE CONSTRUCTION		(X3) DAT	TE SURVEY .
	á		245008	O MANG					С
MANEOED	201100000000000000000000000000000000000	\perp	345008	B. WNG_	1			1	1/21/2013
NAME OF P	ROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - DART	MO	лтн			300 PROVIDENCE RD			
			<u> </u>			CHARLOTTE, NC 28207			
(X4) ID PREFIX TAG	(EACH DEFICIENT	CY M	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD E	BE	(X5) COMPLETION DATE
F 412	Continued From pag	-0.2		-	.,				
1 714	100 March 1			F 4	41.	2			E
	an outside resource,								
	§483.75(h) of this pa	irt, r	routine (to the extent						. *
	covered under the S	tate	plan); and emergency						8
	dental services to m								н
			sary, assist the resident in						1
	making appointment					<u>F412</u>			
			m the dentist's office; and			An appointment for a dental			
	must promptly refer					consult was made for Residents # 36 on 12/09/13			12/
	damaged dentures to	o a	dentist.			Resident #36 was seen by	90		721
						Beacon Dental Center, Dr			100
	This DEOLIDENEN					Conner.			1/13
		T is	s not met as evidenced	0		All social and middle and and			/
	by:		A Section of the sect			All residents with natural teeth have the potential for			10 11 11
	Based on record rev					being effected by the deficier	nt		1
	interviews the facility					practice.			
			ed residents reviewed for			1000 1000			b b
	dental concerns. (Re	esic	ent #36).			The resident received dental			ls a
	4					services and a plan for dental extractions was submitted for			
	The findings included	d:	4	1		payment to Medicaid. The	Š n		İ
	1					resident is being monitored	S.		
3	Resident #36 was ac	imt	ted to the facility on	9		for oral pain. The 24 Hour			
	12/09/11. A Signification	ant	Change Minimum Data	9		reported has been monitored			Ĭ.
	Set (MDS) dated 08/	19/	13 revealed Resident # 36			for residents with complaints of oral pain. The nursing Staf	c		[4]
			The MDS noted Resident			was in-serviced regarding	I)		
	#36 required limited	ass	stance of 1 person for	1		reporting oral pain.			
)	most activities of dail			77					i
j	personal hygiene.	he	MDS also noted Resident	0		The Director of			
		fac	cial pain or broken or			Nursing/designee will randomly 4 residents twice			
	loose fitting teeth.					per week for 4 weeks, 4			TO THE REAL PROPERTY.
						residents per week for 4			
	An interview was cor	ndu	cted with Resident #36 on			weeks, 2 residents per week			ii ii
	11/20/13 at 9:22 AM	. S	he said she had a top			for 4 weeks to focus on the			1
			dmitted to the facility.			dental concems. The Director of Nursing/designee			V.
			ropped the denture while			will report any negative			
			had been lost. Resident			findings to Quality Assurance			
			e denture had been lost			committee monthly for 6			
	and was seen by a d					months and quarterly thereafter.			a
9	recall the date of this	ар	pointment. She reveal d			tnereatter.			
			partial for missing teet 1						

STATEMENT	OF DEFINITION	1			OMB	NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AN IMPED		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345008	B. WNG _			C	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		11/21/2013	
			- 1	N N NO.	=		
GOLDEN	LIVINGCENTER - DARTH	MOUTH		300 PROVIDENCE RD			
, , , , , , , , , , , , , , , , , , ,	1			CHARLOTTE, NC 28207			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE	
			17/	DEFICIENCY)			
F 412	Continued From	25					
. 712	, and page		F 4	12			
	observed on her lowe	r arch. She reported she	1	17 0 17			
	nad not heard anymo	re about the partial and a					
	tollow-up scheduled o	lental appointment had not					
	been done. She said	she did not have mouth					
	pain but had some ch	ewing problems if meat was					
	not soft.						
(4)	Observation 44/00	440 40 000	Î				
	Resident #96 action to	/13 12:48 PM revealed	I				
	hall dining from Ch-	ner lunch meal in the 300	1				
	hall dining room. She	was observed with	1				
	brussel encute Desi	ng ground pot roast and		1			
	able to chou the crew	dent #36 stated she was					
	enroute because the	nd meat and eat the brus iel					
	her tray cord rougele	were soft. Observation of				1	
	diet with ground meat	she had a soft mechanic al					
	diet with ground meat	S.					
	An interview was cond	ducted with the MDS					
	Coordinator on 11/21/	13 at 4:40 PM. She stat∈d					
	Resident #36 came ba	ack from the hospital on					
ĺ	08/12/13 and a signific	cant change MDS was	1				
ĺ	completed. The MDS	Coordinator reported she					
!	had not coded Reside	nt #36 as having broken or					
ì	loose natural teeth. T						
	revealed she had not	noticed the resident had	ì				
12	broken teeth. She rev	realed the expectation					
i	would be if a resident	required dental services	į				
	staff should follow up	with residents and schedule	1				
	the dental appointmen	ts.					
	Record review of cons	ults revealed no dental	1				
1	consult sheets provide	d for Resident #36	3				
1	Review of Nurses prod	ress notes provided no					
1	documentation dental	services had been provided				4	
1	for Resident #36. The	re were no dental consults				N	
3	found in Resident #36	's entire chart.		ii N			
	70.000					1	
	An interview was cond	ucted on 11/21/13 at 4:58					
		rker. The Social Worker				9	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CL A IDENTIFICATION NUMBEI ::	(X2) MULTIPLE CONSTRUCTION A BUILDING		1	(X3) DA	TE SURVEY MPLETED
		345008	B. WNG			1	C 1/21/2013
	ROVIDER OR SUPPLIER LIVINGCENTER - DARTM			STREET ADDRESS 300 PROVIDENCE CHARLOTTE, N			172172013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FUL . SC IDENTIFYING INFORMATIO 1)	ID PREFI TAG	(EACH	ROVIDER'S PLAN OF CORRECTI H CORRECTIVE ACTION SHOUL -REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	facility since January, came to the facility he resident in the building procedural recomment outside dental offices. reported Resident #36 to be seen by the dent #36's medical record p sheets or dental inform. The Social worker reveloffice on 11/21/13 and Resident #36's last do n 11/21/12. The Social dental office told her the full upper denture and recommended during the Resident #36's remain removed before a dental appoin unit manager on the hawould schedule the deup transportation. The the facility had been with awhile so dental appoin been scheduled. The syear was a long time for had another scheduled her dental needs. An interview was conducted. An interview was conducted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted with a dental contracted contracted with a dental contracted con	had been provided to the 2012. When the dentise evaluated every Medical idea and made dental attions for residents to The Social Worker would have been eligible ist. She stated Resider the rovided no dental consult action in progress notes alled she called the deritist was informed that ental appointment occulared at Worker reported that he ey had been working on a partial bottom he visit of 11/21/12 but any the teeth would have to be all procedure could be set stated when a resident and the unit manager that appointment and set the Social Worker revealed thout a unit manager for the teeth working in the state of the stat	F	112			

		WEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C .IA IDENTIFICATION NUMBE R:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	5				С
		345008	B. WNG _		A G 500000 A 700000 - 50
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/21/2013
COLDEN	10/0000000			300 PROVIDENCE RD	
GOLDEN	LIVINGCENTER - DARTN	оитн		CHARLOTTE, NC 28207	
WALID	CUMMARYOT			CHARLOTTE, NC 28207	- A think the same of the same
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU L SC IDENTIFYING INFORMATI(IN)	PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 412	Continued From page	27			
			F 4	112	
	expected referrals to	e scheduled when ord red			
	and she had not been	aware Resident #36 had			×
E 444	not been seen by a de	ontist since 11/21/12.	83		
F 441	483.65 INFECTION C	ONTROL, PREVENT	F 4	141	
SS=D	SPREAD, LINENS				** **
					12/
	The facility must estal	olish and maintain an		F441	121
	Infection Control Prog	ram designed to provid a	8	Nurse # 1 was in-serviced	123/
	safe, sanitary and cor	nfortable environment and		regarding policy and procedure for cleaning the	1.7.2
	to help prevent the de	velopment and transmission		glucometer.	112
	of disease and infection	on.			, ,
				All residents in the facility	
	(a) Infection Control P	rogram		receiving glucometer checks	
	The facility must estab	lish an Infection Control	3	have the potential for being effected by the deficient	
0	Program under which	it -		practice.	
		ols, and prevents infect ons		practice.	
	in the facility;			The nursing Staff was in-	
		edures, such as isolation,	i	serviced regarding the	
	should be applied to a	n individual resident; a id	9.	cleaning procedure for	
	(3) Maintains a record	of incidents and corrective		glucometers.	
	actions related to infe	ctions	1	The Director of	1
	dolloris rolated to lillet	Citoris.		Nursing/designee will	
	(b) Preventing Spread	of Infaction		randomly select 3 nurses	
9	(1) When the Infection	Control Progress	2	twice per week for 4 weeks	, 3
9	(1) When the Infection determines that a residual	dent needs is als!		nurses per week for 4 week	s,
	provent the entered of	dent needs isolation to		and randomly each month thereafter to focus on	į.
		infection, the facility mi st	ï	thereafter to focus on	1
	(2) The facility must be	L. 1. 1	ž.		
!	communicable discar	ohibit employees with a	j	cleaning the glucometer	
1		e or infected skin lesior s		properly. The Director of	
		h residents or their food, if	E .	Nursing/designee will repo	ort
	direct contact will trans			any negative findings to Quality Assurance commi	ttee
	(3) The facility must re	quire staff to wash thei	11 52	monthly for 6 months and	
	nands after each direc	t resident contact for which		quarterly thereafter.	
	hand washing is indica	ated by accepted	0		
	professional practice.				
					î
1	(c) Linens				
Ĭ.	Personnel must handle	e, store, process and			÷

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	200 500 100	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
1		345008	B. WNG			С	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	05	11/21/2013	
	LIVINGCENTER - DARTM			300 PROVIDENCE RD CHARLOTTE, NC 28207	JE.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF TAG		N SHOULD BE	(X5) COMPLETION TE DATE	
F 441	Continued From page transport linens so as infection.	28 to prevent the spread of	F	441			
	by: Based on observation interviews the facility fa glucometer (used for b following a finger stick sampled residents observation. (Residents) The findings included: The facility policy titled Decontamination" with in part: "A wipe that is a tuberculocidal; effective broad spectrum of bact clean the monitor. The be cleaned and disinfer use on each resident which will be the same and disinference on each residents." Resident #3 was admitted included diabetes with a monitor the resident's but on 11/20/13 at 4:59 PM completing a finger sticle exited Resident #3's roce	"Blood Glucose Monitor revision date 08/2012 re ad an EPA registered as against HIV, HBV, and a eria will be utilized to blood glucose monitor w II ted with wipes following hen monitors are sharec ed 4/29/2003. Diagnose accuchecks ordered to bood glucose levels.					
	conducted with Nurse # observation. Nurse #1 s cleaned the glucometer of her shift with germicic	1 at the time of this tated she routinely at the beginning and en t					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DESICIENCIES

AND PLAN OF GORRECTION		I I IDENTIFICATION NUMBER		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345008	B. WNG		С	
	ROVIDER OR SUPPLIER LIVINGCENTER - DARTM	OUTH TEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE RD CHARLOTTE, NC 28207	11/21/2013	
PREFIX TAG	(EACH DEFICIENCY	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)		
SS=E	cart at the time of the supply of germicidal wordship of germicidal	w of Nurse #1's medicat on observation revealed a ipes on hand. PM an interview was all Development Control Nurse. The estated nurses were entrol practices and were ometers with germicidal the Infection Control Nurse are not appropriate to cometers for multiple RS/MEET a quality assessment and consisting of the director of sician designated by the ther members of the t and assurance st quarterly to identify which quality assessment to are necessary; and its appropriate plans of ed quality deficiencies. y may not require so found to the mittee with the	F 44	F 520 Residents # 66 and #107 continue to wear Wanderguard bracelets and are monitored by staff. All residents in the facility with a potential for	12/23/	
				the horsing statt.		

0747				- TOTAL OF TAXABLE		_		OME	3 NO. 0938-0391	
AND PLAN C	OF DEFICIENCIES OF CORRECTION	S	(X	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
				345008	B. WNG				C	
NAME OF F	ROVIDER OR SU	PPLIER				0	STREET ADDRESS, CITY, STATE, ZIP CODE		11/21/2013	
GOLDEN	LIVINGCENTE	R - DARTN	101	УТН	300 PROVIDENCE RD					
					CHARLOTTE, NC 28207					
(X4) ID PREFIX TAG	(EACH	DEFICIENCY	MI	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 520	Continued F	rom page	30			520	T			
				ne committee to identify	F	520				
1	and correct	mempis b	y u	re committee to identify			The Director of			
	and correct to	quality de	IICI	encies will not be used as			Nursing/designee will			
1	a basis for s	anctions.					randomly 4 residents twice per week for 4 weeks, 4			
							residents per week for 4			
	This DEOLU	DEMENT					weeks, 2 residents per week			
		REMENT	IS	not met as evidenced			for 4 weeks to focus			
	by:						Wanderguard documentation.			
	based on ra	cility doci	ım	ents, record review and			The Director of Nursing/designee will report			
	stail interviet	w the facil	ity	failed to effectively			any negative findings to		1	
	implement ar	na monito	rif	nterventions put into			Quality Assurance committee			
	place by the	Quality A	SS	essment and Assurance			monthly for 6 months and			
	committee to	r 2 of 3 re	Sic	dents reviewed for			quarterly thereafter.			
	wandering be	ehavior. (F	Re	sidents #66 and #107)						
	The findings	included:								
	Resident #66	admitted	Ito	the facility with			£			
	diagnoses wi	nich includ	dec	d Alzheimer's dementia						
	Resident #66	s most re	ce	ent Annual Minimum						
	Data Set (MD	S) dated	09	/20/13 revealed he had						
	moderate co	anitive ima	pal	rment. Resident #66						
	was also ass	essed with	hv	vandering behavior and						
	was independ	dent with	am	bulation	1					
	Resident #66	's care nla	an	dated 09/20/13 reveals d						
	he was at risk	s for elone	emi	ent due to impaired						
	cognition and	poor safe	etv	awareness						
1		,	1							
-	Review of fac	ility docur	ne	ntation revealed			•			
	Resident #66	was foun	d	outside the facility and in						
	an unauthoriz	ed area 0	18)	19/13 and 09/09/13.						
	Resident #66'	s wander	all	ard did not alarm or						
	alert staff he	vas out of	fth	e building or in an						
	unauthorized	area of th	e	ouilding			Į.			
	, ,	(1)								
		7 was adn	nitt	ed 03/21/2013.						
				imer's dementia.						
				09/04/13 assessed						
				elv impaired cognition						

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345008	B. WNG			C 11/21/2013	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - DARTIN		30	REET ADDRESS, CITY, STATE, ZIP CODE 0 PROVIDENCE RD HARLOTTE, NC 28207		11/21/2013	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
wandering behavior. A care plan was initial elopement related to aimlessly throughout a wanderguard to ale attempts to exit the fa were implemented will incidence of elopeme. Review of facility doc. Resident #107 was fo 10/05/13. Resident #1 wanderguard when he building. An interview with the 6:10 PM regarding the Assurance (QAA) comof wandering/elopeme been discussion in the The Administrator state not have been considerstated when residents should be two staff me all times. He stated he been put into place to phappening again. He s	ted 04/16/13 for risk of the resident wandering the facility; the resident had at staff of any unsupervise I cility. Care plan measures the the goal of having no not. Jumentation revealed und outside the building on 107 was wearing a at was found outside the was found outside the administrator on 11/21/13 at a goal of work on the area and the stated there had 10/09/13 QAA meeting, and these residents would be go outside to smoke there are go outside to smoke there are the go outside to smoke there are the QAA process as problem, to identify how, it	F 520				