DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	_			OMB NO	0.0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LETED
		345201	B. WING			(11/ [,]) 16/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	LIVINGCENTER - CHARI	OTTE		2	616 EAST 5TH STREET		
GOLDEN	LIVINGCENTER - CHARI	UTE		С	HARLOTTE, NC 28204		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 166 SS=D	RESOLVE GRIEVAN	O PROMPT EFFORTS TO CES ht to prompt efforts by the	F	166			12/14/16
	facility to resolve grie	vances the resident may with respect to the behavior					
	This REQUIREMENT is not met as evidenced by: Based on meal observations, a resident interview, staff interviews, review of resident grievances, and a test tray, the facility failed to promptly resolve grievances related to food quality for 1 of 8 sampled residents who filed grievances (Residents #1). The findings included: Resident #1 was admitted to the facility on 01/28/15. A quarterly minimum data set, dated 11/06/16 assessed Resident #1 with intact cognition, able to be understood/understand, clear speech, and required staff supervision and set up assistance meals.				Preparation on and/or execution of this plan of correction does not constitute admission or agreement by the provider 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 becaus it is required by the provisions of federa and state law. This plan of correction is submitted as the facility's credible allegations of compliance. 1)Social Worker completed a grievance for resident #1 in regard to food preferences and temperature on 12/7/10	r of f se II	
	Resident #1 expresses breakfast meal at 9:3 she requested another minutes still had not r Review of the grievar certified dietary mana Resident #1 and upda preferences. Resident #1 was inte PM and stated that sh for breakfast that look	ated the Resident's meal rviewed on 11/13/16 at 2:50 ne often received fried eggs ted like a fried egg, but did			 2)Each resident residing in the facility h the potential to be affected. 3) Social Service Director provided a "train the trainer" type of education to current managers on the facility policy, protocol and follow up to resolve grievances, to include the East and West Unit Managers and the DNS, Resident Council and Food Committee by 12/14/ Social Service will complete 100% audit grievances for current residents to ensure 	st 16. t of ure	
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed

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

12/12/2016

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/16/201 RM APPROVE IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		345201	B. WING		C 11/16/2016		
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - CHARI	LOTTE		2616 EAST 5TH STREET CHARLOTTE, NC 28204			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 166	not taste like one. Re fried eggs she receive edges were not crisp and at times tasted w expressed this conce dietary manager (CD not been resolved. An interview with the 4:10 PM revealed she #1 had previously exp the way her fried egg stated that she had s her concerns and det Resident received a f and stored on the trans Resident often express when she received a plated and served sp she expressed satisfa Resident #1's concer been an ongoing issue A follow up interview 11/14/16 at 10:30 AM fried eggs for breakfas not like. She stated the rubbery/soggy and di Resident #1 also exp cold grits for breakfas breakfast was received expressed that she she previously with admir concerns had not bee Resident #1 was obs PM in her room with the received barbeque ch	sident #1 stated that the ed were routinely soft, the y like fried eggs should be atery. She stated she had rn to the interim certified M), but that her concern had interim CDM on 11/13/16 at e was aware that Resident pressed that she did not like s were cooked. The CDM poken to Resident #1 about ermined that when the ried egg that was cooked y line before service, the ssed dissatisfaction, but fried egg that was cooked, ecifically for her, at times action. The CDM stated n with her fried eggs had te. with Resident #1 on I revealed that she received ast that morning that she did hat her fried eggs were often d not have crispy edges. ressed that she received at that morning and that her ed cold every morning. She hared these concerns histrative staff, but that her en resolved.	F 16	 6 that no other food related condidentified as unresolved. Any of grievances will be addressed appropriately by the responsible department to achieve resolutities. Social Services and DCE eductions will continue on grievance process for current employees. Education will continue on grievance process for current employees. Education will be of by 12/14/16. Leadership team to include the will review the grievances daily. Stand Up meeting. 4) A QI monitoring tool will be unweek x 4 weeks, then 3x a weaweeks then weekly x 4 weeks new grievances. Social Worker will report result monitoring to the QAPI commitmonthly, for 3 months, to ident trends that require further educt monitoring as well as revision is sustain substantial compliance. 	evutstanding le on. cation to cess. The rector of to educate ent completed e ED & DNS y in the tillized 5 x a ek x 4 to capture s of the QI ttee ify any cation or required to		

Facility ID: 952971

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _			C
		345201	B. WING			11/	16/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - CHARL	OTTE			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE	
F 166	was no visible steam lunch meal. A breakfast meal obset 11/15/16 at 7:50 AM. eggs were observed s submerged in a water monitoring was obser at 7:55 AM during the observed at the follow Oatmeal, 174 degrees Fried Eggs, 154 degrees Fried Eggs, 154 degrees On 11/15/16 at 8:03 A off the lowerator (plate plates were too hot to requested on 11/15/10 open cart with 18 meal arrived on the 200 un cart was transported to the 200 unit for meal of included a fried egg th the meal was plated. at 8:40 AM by the inte oatmeal was observe- steam. Butter, when a melt. The bacon was The interim CDM and breakfast meal and th that the oatmeal was was warm with a good was "more cool."	stating it was cold. There observed coming from her ervation occurred on Sausage links and fried stored on the tray line y liquid. Temperature ved conducted on 11/15/16 tray line with foods ving temperatures: s Fahrenheit ees Fahrenheit M, dietary staff #1 turned e warmer) stating that the touch. A test tray was 6 at 8:07 AM, placed on an al trays for residents, and it at 8:11 AM. The delivery to 3 different dining areas on delivery. The test tray nat was cooked just before The test tray was sampled erim CDM and surveyor. The d congealed with no visible added to the oatmeal did not cool/room temperature. surveyor both tasted the e interim CDM expressed medium warm, the fried egg d texture, and the bacon	F	166			
	supportive CDM on 1 st they were aware that	1/15/16 at 8:46 AM revealed					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/16/2016 M APPROVED O. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATI	E SURVEY PLETED	
		345201	B. WING			C 11/16/2016		
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
	LIVINGCENTER - CHARI	OTTE		261	6 EAST 5TH STREET			
GOLDEN		LOTTE		СН	ARLOTTE, NC 28204			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 166	that meal in their roor to take additional time meal delivery, but wa for multiple dining are same meal delivery of that she started in Se made aware from Foo residents had express temperatures and delinterim CDM stated th test tray monitoring to receiving cold foods, the dietary systems in with palatable foods. that the facility was in improvements in the having dietary staff as residents who were in that her plan was to in when she was the leas supportive role. The se that she had previous eggs/sausage links w tray line in a "buttered questioned dietary staff told this was done to residents with swallow CDM stated she was that storing the fried e watery solution could Resident #1 expresses with her fried eggs. Dietary staff #1 was in 9:00 AM and stated th cook and started emp Dietary staff #1 stated eggs and sausage link	m which caused nursing staff e to locate a resident for s not aware that meal trays eas was included on the art. The interim CDM stated optember 2016, and was od Committee meetings that sed concerns with food layed meal delivery. The nat she had not conducted o identify why residents were but that she had observed ntact to provide residents The supportive CDM stated of the process of making dining experience, to include ssist with meal delivery to ndependent with dining, but mplement new changes	F	166				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345201	B. WING _				C 16/2016
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - CHARL	.OTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204				
04015					•		(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE CO	
F 166	Continued From page dietary staff person.	2.4	F	166			
F 241 SS=E	11/15/16 at 4:36 PM. that she was aware of to cold foods and mor food temperatures in nursing units at the po- administrator stated th department had a def organization that wou plans for an improved implemented. 483.15(a) DIGNITY A INDIVIDUALITY The facility must prom manner and in an env enhances each reside full recognition of his of This REQUIREMENT by:	hat the facility and dietary inite opportunity for better Id be addressed when the I dining experience were ND RESPECT OF note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.	F2	241			12/14/16
	and medical record refeed 2 of 7 dependent provide a dignified dir #9 and #10) and ident (Resident #9) for 2 of observed during dinin The findings included	g. admitted to the facility on included Alzheimer's			Preparation on and/or execution of this plan of correction does not constitute admission or agreement by the provide 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 becau it is required by the provisions of federa and state law. This plan of correction is submitted as the facility's credible allegations of compliance. 1)DNS and Director of Clinical Education completed education with NA#1 and Na	er of of al	

Event ID: TPDG11

Facility ID: 952971

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE S	. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	COMPL	
						;
		345201	B. WING		11/1	6/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
				2616 EAST 5TH STREET		
GOLDEN	LIVINGCENTER - CHAR	LOTTE		CHARLOTTE, NC 28204		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 241	Continued From page	e 5	F 24	41		
		data set assessment dated		on 11/15/16 regarding pos	sitionina durina	
		lan revised September 2016		dining experience and cor		
	-	had severely impaired		when referring to residents		
		eech, rarely understands,		resident #9.		
		ally altered/therapeutic diet				
		ensive assistance of 1 staff		2)All resident's have the p	otential to be	
	person with eating.			affected.		
	On 11/15/16 at 8:34 /	AM, nurse aide (NA) #1		3)DNS and Director of Clir	nical Education	
		a breakfast tray for Resident		and Social Services Dept.		
	-	e resident while standing to		in-service of current staff in		
	the left side of the res	sident's bed. The bed was in		positioning of resident - re	sident should	
	-	esident #9 looked up towards		be at eye level with care g		
		hyperextended and turned to		their head turned to one si		
		ed her food. A chair was not able in the resident's room.		another/hyperextended du experience and correct ve		
		ed during the observation		residents are not referred		
		all trays then feed the		but depended diners or as		
	feeders, she is a goo			in-service completed by 12 DCE will continue to in-ser	2/14/16.	
	During a follow up int	erview on 11/15/16 at 11:57		new employee regarding r		
		at she received training to sit		with dining to include posit		
		ents with meals. NA #1		resident in a comfortable a	_	
		here was no chair in the		manner for their condition,		
		sat down, and her bed height		level and how to refer to re		
		so that when I sit down, I		need assistance as depen		
	-	" NA #1 continued in the		assisted diners to keep re-	sident dignity	
		that she was trained that ired extensive/total staff		intact.		
		s the resident was referred		4)QI monitoring tool will be	e utilized 3x a	
	to as a "feeder."			week for 4 weeks, then 2x		
				weeks, then weekly for 4 w	veeks for 3	
		ducted on 11/15/16 at 1:45		months to ensure continue	-	
		lirector of education (CDE).		DNS will report results of t		
		she had been in this role		monitoring tool to QAPI co		
	-	nd that NAs were trained to		monthly x 3 Months to idea		
		sident at eye level and to dependent diners rather than		that require further educat monitoring.		
	feeders.			Executive Director will take		

Facility ID: 952971

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345201	B. WING				C 16/2016
NAME OF PI	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	LIVINGCENTER - CHARL	OTTE	2616 EAST 5TH STREET				
GOLDEN		OTTE		c	CHARLOTTE, NC 28204		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 241	Continued From page The administrator and were interviewed on 7 both stated that they of feed residents. The a had previously observe terminology "feeder" if dependent on staff fo that she corrected that heard it. The DON states she provided an inserve regarding dining/custor instructed to sit when of the documentation attended this training. 1b. Resident #10 was 1/15/10. Diagnoses in atherosclerosis and A A quarterly minimum 08/29/16 and a care prevealed Resident #1 cognition, no speech, highly impaired vision cognition, required ex staff person with eatin mechanically altered/ On 11/15/16 at 8:40 A delivered and set up a #10. NA #2 then fed t the left side of the resi waist height of NA #2	a director of nursing (DON) 11/15/16 at 4:36 PM and expected staff to sit down to dministrator stated that she ved/heard staff use the n reference to a resident r assistance with meals and at terminology when she ated that as a result of that, vice in September 2016 omer service and staff were feeding residents. Review provided revealed NA #1 s admitted to the facility on ncluded cerebral Jzheimer's disease. data set assessment dated olan revised August 2016 0 had severely impaired sometimes understands, n, severely impaired tensive assistance from 1 ng and received a		241		TE	DATE
		as she received her food. A					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/16/2 FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345201	B. WING		11/16/2016
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	LIVINGCENTER - CHARI	LOTTE		16 EAST 5TH STREET HARLOTTE, NC 28204	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	DATE
F 241	and stated that was to assisting residents w	e 7 ed on 11/15/16 at 11:30 AM rained to be seated while ith meals. NA #2 further d be at eye level when	F 241		
	have to look up and e because this would b An interview was con PM with the clinical d The CDE stated that	that the resident would not extend her head and also e more dignified. ducted on 11/15/16 at 1:45 irector of education (CDE). she had been in this role nd that NAs were trained to			
F 244 SS=E	sit down to feed a res The administrator and were interviewed on both stated that they feed residents. The E an inservice in Septe dining/customer servito to sit when feeding re documentation provid this training. 483.15(c)(6) LISTEN GRIEVANCE/RECOM When a resident or far must listen to the view grievances and recor	d director of nursing (DON) 11/15/16 at 4:36 PM and expected staff to sit down to DON stated that she provided mber 2016 regarding ice and staff were instructed esidents. Review of the ded revealed NA #2 attended ACT ON GROUP MMENDATION amily group exists, the facility ws and act upon the nmendations of residents	F 244		12/14/16
	operational decisions life in the facility. This REQUIREMENT by: Based on dining obs	ing proposed policy and affecting resident care and is not met as evidenced ervations, interviews with 2 #1 and #8), and a test tray,		Preparation on and/or execution of thi plan of correction does not constitute	S

Event ID: TPDG11

Facility ID: 952971

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		ND HUMAN SERVICES				FOR	D: 12/16/20 MAPPROVE D. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345201	B. WING				C / 16/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - CHAR	LOTTE		2616 EAST 5TH STREET CHARLOTTE, NC 28204			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 244	Continued From page	e 8	F 2	244			
		esolve resident concerns with		•••	admission or agreement by the provid	er of	
		ed during 2 of 2 Resident			the truth of facts alleged or the		
		ittee meetings held in			conclusions set forth in the statement	of	
	September 2016 and	October 2016.			deficiencies. The plan of correction is		
					prepared and/or executed solely beca		
	The findings included	d:			it is required by the provisions of feder		
	1a Doviou of minuto	es from a Resident Council			and state law. This plan of correction i	S	
		8/16 revealed 11 of 12			submitted as the facility's credible allegations of compliance.		
	residents expressed				allegations of compliance.		
		ood was not satisfactory and			1)Residents #1 & #8 food preferences	;	
		essed they did not receive			were revisited by the RD on 12/9/16.		
	-	to eat. Resident #1 and			cards are accurate as of this date to		
	Resident #8 both atte	ended this meeting.			reflect the resident preferences.		
		om a Food Committee			2)Each resident residing in the facility	has	
	-	26/16 revealed that 12			the potential to be affected. Current		
		nd agreed that the food was			Resident were reviewed to ensure		
	often cold and receiv	ed late.			preferences were being honored and	that	
	A follow up interview	to the Resident			tray cards reflect their preferences.		
		ittee meeting was conducted			3)Service call performed to ensure the	ć	
		11/14/16 at 10:30 AM and			plate warmer was functioning correctly		
	revealed that she rec				Pellet warmer was repaired by an outs		
		ng that she did not like. She			vendor.		
	stated that her fried e						
		id not have crispy edges.			Executive Director or Designee will at		
		pressed that she received			the resident food committee for 3 mon		
	-	st that morning and that her ed cold every morning. She			to ensure grievances are documented that the appropriate actions are taken		
		hared these concerns			correct any documented grievances.		
		nistrative staff and during					
		od Committee meetings, but			Tray delivery system revised to improv	ve	
	that her concerns had	d not been resolved.			efficiency to ensure residents trays an timely.		
	A follow up interview						
		ittee meeting was conducted			Dietary Manager or Designee will prov		
		11/14/16 at 6:45 PM. During			education to current dietary staff befor	e	
	the interview, Reside	ent #8 stated that she had			12/14/16 regarding the use of plate		

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		ID HUMAN SERVICES			FOR	D: 12/16/2016
STATEMENT C	FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DAT	O. 0938-0391 E SURVEY IPLETED
		345201	B. WING		11	C / 16/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				2616 EAST 5TH STREET		
GOLDEN I	IVINGCENTER - CHARI	LOTTE		CHARLOTTE, NC 28204		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 244	Continued From page	- Q	F 24	4		
1 211		concerns with food quality	F 24	warmer and pelette system.		
	-	ot resolved. Resident #8		The Dietary Manager or desi	anee will	
		id not like the food, the food		review resident preferences		
	•	d did not look good. She		admission, and during the qu	•	
	stated that since she	expressed her concerns,		Plan review and with any foo	d related	
	someone came and t	alked to her, but the food		concerns/grievances.		
	was no better.					
				Random weekly Test Tray Au		
		interim CDM and the		conducted 2 times each wee	-	
		1/15/16 at 8:46 AM revealed		Social Service Director or As		
		ted in September 2016, and		Director of Nursing, Business		
		n Food Committee meetings		Manager, Unit Managers, Dir Clinical Education and the W		
		pressed concerns with food layed meal delivery. The		Supervisor to include the Ma		
	-	hat she had not conducted		Duty, to monitor the appeara		
		b identify why residents were		temperature, flavor and textu		
		but that she had observed		interviews will be conducted		
		ntact to provide residents		Test Tray audits to ensure re	•	
	with palatable foods.	The supportive CDM stated		satisfied with the temperature	e, flavor and	
	that the facility was in	the process of making		texture.		
	-	dining experience, to include				
		ssist with meal delivery to		4)Executive Director or Desig		
		ndependent with dining. She		utilize QI tool to ensure resid		
	-	t her plan was to implement		satisfaction is met and will re		
		he was the lead CDM and		to the QAPI committee mont	•	
	not in a supportive ro	IC.		months. Any trends identifie		
	An interview with the	social worker (SW) occurred		taken to the Resident Counc for discussion and action tak		
		PM and revealed that she		necessary to ensure continue		
	attended Resident Co			compliance.	~~	
		vances expressed by				
		ed the documentation to the				
		ent for follow up. The SW				
		lepartment resolved the				
		istrator would also follow up				
		n was resolved. The SW				
		Ild need to look at a system				
	of extending the follow	w up to ensure that the				

Facility ID: 952971

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE	ECONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		345201	B. WING				C 16/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - CHARL	OTTE			2616 EAST 5TH STREET CHARLOTTE, NC 28204		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
F 244	Continued From page	e 10	E:	244			
		ed and remained resolved.					
	An intension with the	activity director (AD)					
	An interview with the occurred on 11/15/16	at 4:30 PM and revealed					
		tment facilitated Resident y grievances that were					
		mented by the SW and					
		ate department for follow					
) stated that her department dietary concerns nor attend					
		etings. The AD stated that					
	-	o longer at the facility, but ble for minutes from the					
	Food Committee and	follow up to any dietary					
	concerns						
		administrator occurred on					
		The administrator stated f resident concerns related					
	to cold foods and mor	nitored for this by observing					
	food temperatures in nursing units at the po	the kitchen, but not on the					
		hat the facility and dietary					
		inite opportunity for better Id be addressed when the					
		dining experience were					
	implemented.						
	1b. Resident #1 was a	admitted to the facility on					
	01/28/15. A quarterly 11/06/16 assessed Re	minimum data set, dated					
		understood/understand,					
	clear speech, and rec	uired staff supervision and					
	set up assistance me	als.					
		rviewed on 11/13/16 at 2:50					
		ne often received fried eggs ked like a fried egg, but did					
		sident #1 stated that the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345201	B. WING _				C 16/2016	
NAME OF F	ROVIDER OR SUPPLIER		•	STI	REET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - CHARI	OTTE			16 EAST 5TH STREET IARLOTTE, 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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 244	fried eggs she receive edges were not crispy and at times tasted w expressed this conce dietary manager (CD) Council/Food Commi concern had not beer An interview with the 4:10 PM revealed she #1 had previously exp the way her fried egg stated that she had s her concerns and det Resident received a f and stored on the tray Resident often express when she received a plated and served sp she expressed satisfa Resident #1's concern been an ongoing issue A follow up interview 11/14/16 at 10:30 AM fried eggs for breakfan not like. She stated th rubbery/soggy and di Resident #1 also exp cold grits for breakfas breakfast was receive expressed that she sl previously with admir Resident #1 was obse PM in her room with H	ed were routinely soft, the y like fried eggs should be atery. She stated she had rn to the interim certified M) and during Resident ttee meetings, but that her n resolved. interim CDM on 11/13/16 at e was aware that Resident pressed that she did not like s were cooked. The CDM poken to Resident #1 about ermined that when the ried egg that was cooked y line before service, the ssed dissatisfaction, but fried egg that was cooked, ecifically for her, at times action. The CDM stated in with her fried eggs had te. with Resident #1 on revealed that she received st that morning that she did nat her fried eggs were often d not have crispy edges. ressed that she received at that morning and that her ed cold every morning. She hared these concerns histrative staff and during of Committee meetings, but d not been resolved.	F 2					

Facility ID: 952971

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 12/16/2016 // APPROVED). 0938-0391
		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345201		B. WING				C 16/2016	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
		OTTE			2616 EAST 5TH STREET		
GOLDEN LIVINGCENTER - CHARLOTTE					CHARLOTTE, NC 28204		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 244	to eat her lunch meal was no visible steam lunch meal. A breakfast meal tray 11/15/16 at 7:50 AM. eggs were observed s submerged in a water monitoring was obser at 7:55 AM during the observed at the follow Oatmeal, 174 degrees Fried Eggs, 154 degree On 11/15/16 at 8:03 A off the lowerator (plate plates were too hot to requested on 11/15/10 open cart with 18 meal arrived on the 200 un cart was transported to the 200 unit for meal included a fried egg to the meal was plated. at 8:40 AM by the inter oatmeal was observe steam. Butter, when a melt. The bacon was The interim CDM and breakfast meal and the that the oatmeal was was warm with a good was "more cool."	 I tea. Resident #1 declined stating it was cold. There observed coming from her line observation occurred on Sausage links and fried stored on the tray line ry liquid. Temperature ved conducted on 11/15/16 e tray line with foods ving temperatures: s Fahrenheit ees Fahrenheit M, dietary staff #1 turned e warmer) stating that the o touch. A test tray was 6 at 8:07 AM, placed on an al trays for residents, and it at 8:11 AM. The delivery to 3 different dining areas on delivery. The test tray nat was cooked just before The test tray was sampled erim CDM and surveyor. The d congealed with no visible added to the oatmeal did not cool/room temperature. surveyor both tasted the ne interim CDM expressed medium warm, the fried egg d texture, and the bacon 	F	244			
	supportive CDM on 1						

Facility ID: 952971

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 12/16/2016 RM APPROVED IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION		TE SURVEY MPLETED C
		345201	B. WING			1	1/16/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN	LIVINGCENTER - CHARI	LOTTE			616 EAST 5TH STREET CHARLOTTE, NC 28204		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 244	normally ate a meal in that meal in their roor to take additional time meal delivery, but wa for multiple dining are same meal delivery of that she started in Se made aware from Foo residents had express temperatures and delinterim CDM stated th test tray monitoring to receiving cold foods, the dietary systems in with palatable foods. that the facility was in improvements in the having dietary staff as residents who were in that her plan was to in when she was the leas supportive role. The se that she had previous eggs/sausage links w tray line in a "buttered questioned dietary staff told this was done to residents with swallow CDM stated she was that storing the fried e watery solution could Resident #1 expresses with her fried eggs. Dietary staff #1 was in 9:00 AM and stated th cook and started emp Dietary staff #1 stated	n the dining room, may have m which caused nursing staff e to locate a resident for s not aware that meal trays eas was included on the art. The interim CDM stated optember 2016, and was od Committee meetings that sed concerns with food layed meal delivery. The nat she had not conducted o identify why residents were but that she had observed ntact to provide residents The supportive CDM stated of the process of making dining experience, to include ssist with meal delivery to ndependent with dining, but mplement new changes	F	244			

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	IPLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED C	
		345201	B. WING			/16/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - CHARL	OTTE		2616 EAST 5TH STREET CHARLOTTE, NC 28204		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 244 F 364 SS=E	dietary staff person. An interview with the 11/15/16 at 4:36 PM. that she was aware o to cold foods and mor food temperatures in nursing units at the po administrator stated th department had a def organization that wou plans for an improved implemented. 483.35(d)(1)-(2) NUT PALATABLE/PREFEF Each resident receive food prepared by met	administrator occurred on The administrator stated f resident concerns related hitored for this by observing the kitchen, but not on the bint of service. The hat the facility and dietary inite opportunity for better Id be addressed when the I dining experience were RITIVE VALUE/APPEAR, R TEMP es and the facility provides hods that conserve nutritive learance; and food that is	F 2			12/14/16
	by: Based on meal obse Council/Food Commit interviews (Residents review of resident grie facility failed to provid resident preference for The findings included	or temperature and taste. : s from a Resident Council /16 revealed 11 of 12		Preparation on and/or execution of plan of correction does not constitute admission or agreement by the prov the truth of facts alleged or the conclusions set forth in the statemen deficiencies. The plan of correction i prepared and/or executed solely be it is required by the provisions of fed and state law. This plan of correction submitted as the facility's credible allegations of compliance.	e der of t of s ause eral	

Event ID: TPDG11

Facility ID: 952971

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CENTERS FOR MEDICARE & ME	HUMAN SERVICES			FORM	D: 12/16/2016 MAPPROVED D. 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		SURVEY PLETED
	345201	B. WING			/16/2016
NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN LIVINGCENTER - CHARLO	TTE		2616 EAST 5TH STREET CHARLOTTE, NC 28204		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
 6 of 6 residents express foods that they liked to a Resident #8 both attend Review of minutes from meeting held on 10/26/1 residents attended and often cold and received A follow up interview to Council/Food Committe with Resident #1 on 11/ revealed that she receive breakfast that morning t stated that her fried egg rubbery/soggy and did r Resident #1 also express cold grits for breakfast th breakfast was received expressed that she shar previously with administ Resident Council/Food that her concerns had n A follow up interview to Council/Food Committe with Resident #8 on 11/ the interview, Resident 5 previously expressed co during Resident Council meetings that were not 	d was not satisfactory and sed they did not receive eat. Resident #1 and led this meeting. a Food Committee 16 revealed that 12 agreed that the food was late. the Resident e meeting was conducted 14/16 at 10:30 AM and ved fried eggs for hat she did not like. She is were often not have crispy edges. sed that she received hat morning and that her cold every morning. She red these concerns trative staff and during Committee meetings, but ot been resolved. the Resident e meeting was conducted 14/16 at 6:45 PM. During #8 stated that she had oncerns with food quality I/Food Committee resolved. Resident #8 not like the food, the food did not look good. She pressed her concerns,	F 3	 64 1)Residents #1 & #8 food prefere were revisited by the RD on 12, cards are accurate as of this dareflect the resident preferences 2)Each resident residing in the the potential to be affected. Curresident were reviewed to ensight preferences were being honore tray cards reflect their preference 3)Service call performed to ensight warmer was functioning centray cards reflect their preference 3)Service call performed to ensight warmer was repaired by vendor. Dietary Manager or Designee weducation to current dietary stat 12/14/16 regarding the use of preview resident preferences up admission, and during the quare Plan review and with any food reconcerns/grievances. Random weekly Test Tray Audic conducted 2 times each week to Social Service Director or Assist Director of Nursing, Business Conducted 12 times each week to Supervisor to include the Mana Duty, to monitor the appearance temperature, flavor and texture interviews will be conducted allot the total service will be conducted allot to the total service and the total service will be conducted allot the total service will be conducted allot to the total service will be conducted allot total service will be conducted allot total service will be conducted allot total service will be conducted	 /9/16. Tray ate to facility has rrent ure ed and that ces. aure the orrectly. an outside will provide ff before blate ee will on terly Care related ts will be by the stant, Office ctor of ekend ger on e of food, Resident ong with the conduct of the stant of the stant	

Facility ID: 952971

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	12/16/2016 APPROVED 0938-0391
· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURV COMPLETE	
		345201	B. WING		C	6/2016
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - CHARL	OTTE		616 EAST 5TH STREET HARLOTTE, NC 28204		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 364	attended Resident Co documented any griev residents and provide responsible department stated that after the d grievance, the admini- to ensure the concern stated the facility wou of extending the follow grievance was resolve An interview with the 11/15/16 at 4:36 PM. that she was aware o to cold foods and more food temperatures in nursing units at the po- administrator stated the department had a definor organization that wou plans for an improved implemented.	M and revealed that she buncil meetings, vances expressed by d the documentation to the ent for follow up. The SW epartment resolved the strator would also follow up a was resolved. The SW Id need to look at a system w up to ensure that the ed and remained resolved. administrator occurred on The administrator stated f resident concerns related hitored for this by observing the kitchen, but not on the bint of service. The hat the facility and dietary inite opportunity for better Id be addressed when the I dining experience were	F 364	texture. 4)Executive Director or Designee will utilize QI tool to ensure resident satisfaction is met and will report resu to the QAPI committee monthly x 3 months. Any trends identified will be taken to the Resident Council commit for discussion and action taken as necessary to ensure continued compliance.		
	01/28/15. A quarterly 11/06/16 assessed Re cognition, able to be u clear speech, and rec set up assistance me	understood/understand, juired staff supervision and als.				
	Resident #1 expresse breakfast meal at 9:30 she requested anothe minutes still had not r Review of the grievan certified dietary mana	e dated 10/01/16, revealed ed that she received her D AM and her food was cold; er breakfast tray and after 45 eceived her breakfast. uce documented the interim ger (CDM) met with ated the Resident's meal				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345201	B. WING				C 16/2016	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>		
GOLDEN	LIVINGCENTER - CHARL	OTTE			2616 EAST 5TH STREET CHARLOTTE, NC 28204			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 364	PM and stated that sh for breakfast that look not taste like one. Re fried eggs she receive edges were not crispy and at times tasted w expressed this conce that her concern had An interview with the 4:10 PM revealed she #1 had previously exp the way her fried egg: stated that she had si her concerns and det Resident received a f and stored on the tray Resident often express when she received a plated and served spo she expressed satisfa Resident #1's concern been an ongoing issue A follow up interview 11/14/16 at 10:30 AM	rviewed on 11/13/16 at 2:50 ne often received fried eggs ted like a fried egg, but did sident #1 stated that the ed were routinely soft, the y like fried eggs should be atery. She stated she had rn to the interim CDM, but not been resolved. interim CDM on 11/13/16 at e was aware that Resident pressed that she did not like s were cooked. The CDM poken to Resident #1 about ermined that when the ried egg that was cooked y line before service, the seed dissatisfaction, but fried egg that was cooked, ecifically for her, at times action. The CDM stated in with her fried eggs had e. with Resident #1 on revealed that she received	F	364				
	not like. She stated th rubbery/soggy and di Resident #1 also expl cold grits for breakfas breakfast was receive expressed that she sh	istrative staff, but that her						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345201	B. WING			C 11/16/2016		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN I	IVINGCENTER - CHARL	OTTE			616 EAST 5TH STREET CHARLOTTE, NC 28204			
				Ŭ				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 364	PM in her room with h received barbeque ch cup, soup, water, and to eat her lunch meal was no visible steam lunch meal. A breakfast meal tray on 11/15/16 at 7:50 A eggs were observed a submerged in a water monitoring was obser at 7:55 AM during the observed at the follow Oatmeal, 174 degrees Fried Eggs, 154 degrees Fried Eggs, 154 degrees Fried Eggs, 154 degrees off the lowerator (plate plates were too hot to requested on 11/15/10 open cart with 18 mea arrived on the 200 un cart was transported to the 200 unit for meal of included a fried egg to the meal was plated. at 8:40 AM by the inter oatmeal was observer steam. Butter, when a melt. The bacon was The interim CDM and breakfast meal and the that the oatmeal was	erved on 11/14/16 at 12:58 her lunch meal. She nicken, potato salad, fruit I tea. Resident #1 declined stating it was cold. There observed coming from her line observation occurred M. Sausage links and fried stored on the tray line ry liquid. Temperature ved conducted on 11/15/16 tray line with foods ving temperatures: s Fahrenheit ees Fahrenheit es Fahrenheit teas Fahrenheit a tray staff #1 turned e warmer) stating that the to touch. A test tray was 6 at 8:07 AM, placed on an al trays for residents, and it at 8:11 AM. The delivery to 3 different dining areas on	F	364				
	-	a texture, and the bacon						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/16/2016 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345201	B. WING					C 16/2016
NAME OF PI	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
	LIVINGCENTER - CHARL	OTTE		:	2616 EAST 5TH STREET			
GOLDEN		OTTE			CHARLOTTE, NC 28204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 364	they were aware that normally ate a meal in that meal in their roor to take additional time meal delivery, but was for multiple dining are same meal delivery of meal delivery. The int started in September from Food Committee had expressed conce and delayed meal del stated that she had no monitoring to identify receiving cold foods, the dietary systems in with palatable foods. that the facility was in improvements in the of having dietary staff as residents who were in that her plan was to in when she was the leas supportive role. The se that she had previous eggs/sausage links w tray line in a "buttered questioned dietary staff told this was done to residents with swallow CDM stated she was that storing the fried e watery solution could Resident #1 expresses with her fried eggs.	interim CDM and the 1/15/16 at 8:46 AM revealed at times a resident who in the dining room, may have in which caused nursing staff is to locate a resident for is not aware that meal trays as was included on the art and could also delay erim CDM stated that she 2016, and was made aware is meetings that residents rns with food temperatures ivery. The interim CDM of conducted test tray why residents were but that she had observed that to provide residents The supportive CDM stated the process of making dining experience, to include asist with meal delivery to idependent with dining, but implement new changes d CDM and not in a supportive CDM also stated ly noticed that the fried ere stored on the breakfast a water solution", when she aff regarding this, she was provide soft/hot foods for ving difficulties. The interim unaware of this practice, but aggs/sausage links in a contribute to the concerns and regarding dissatisfaction	F	364		EFICIENCY)		
		nterviewed on 11/15/16 at						

Facility ID: 952971

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345201	B. WING				C 16/2016	
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - CHARLOTTE					616 EAST 5TH STREET CHARLOTTE, NC 28204			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 364	9:00 AM and stated th cook and started emp Dietary staff #1 stated eggs and sausage lin to keep them hot at th dietary staff person. An interview with the 11/15/16 at 4:36 PM. that she was aware o to cold foods and mon food temperatures in nursing units at the po administrator stated th department had a def organization that would	hat she was the morning loyment a few weeks prior. It that she stored the fried ks on the breakfast trayline he suggestion of another administrator occurred on The administrator stated f resident concerns related hitored for this by observing the kitchen, but not on the	F	364				

Facility ID: 952971

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