TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED C	
		345201	B. WING			
	ROVIDER OR SUPPLIER	0.0201		STREET ADDRESS, CITY, STATE, ZIP CODE		02/20/2017
	to vibert of tool 1 Eleft			2616 EAST 5TH STREET		
GOLDEN	LIVINGCENTER - 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 224 SS=D	() ()	BIT IGLECT/MISAPPROPRIATN	F 22	4		3/20/17
	abuse, corporal punis seclusion. This REQUIREMENT by: Based on observatio interviews the facility care to existing press healing as evidenced receiving daily wound Resident #3). The findings include:	ental, sexual, or physical shment, or involuntary ⁻ is not met as evidenced ns, record reviews, and staff neglected to provide wound oure ulcers to promote by 2 of 3 residents not d care. (Resident #1 and		Preparation of and/or executio Plan of Correction does not cor admission or agreement by the the truth of facts alleged or the conclusions set forth in the stat deficiencies. The Plan of Corre prepared and/or executed solel it is required by the provisions of and state law. This Plan of corr submitted as the facilities credit allegation of compliance.	nstitute provider of cement of ction is ly because of federal rection is	
	09/12/16 and had rea following a hospitaliza diagnosis which inclu disease, a previous a right lower leg, hyper anticoagulant therapy Minimum Data Set as time of readmission a	19/12/16 and had readmission on 01/15/17 bllowing a hospitalization. The resident had liagnosis which included: Peripheral Arterial lisease, a previous above the knee amputation of ight lower leg, hypertension, atrial fibrillation, inticoagulant therapy, and dementia. The <i>l</i> inimum Data Set assessment completed at me of readmission and dated 01/19/17 indicated hat the resident was severely cognitively		 Dressings were changed for Residents 3 on 2/20/2017 by the ADNS. Each Resident has the potential to be affected by the alleged deficient practice. One hundred percent of residents with wounds were audited by the DNS and wound care nurse for daily documentation on the treatment administration record 		
	impaired. Resident # assistance for bed mo toileting, and persona always incontinent of functions. Skin asses readmission and date the resident had deve	1 required extensive obility, transferring, dressing, al hygiene. The resident was bowel and bladder extension performed after ed 01/16/17 indicated that eloped an unstageable crum, and deep tissue injury		and that dressings were dated treatment was rendered. The DNS began education for a Licensed nurses, to include age Licensed Nurses on 2/23/2017, was comprehensive training on care to include - completing ski proper wound documentation o & MAR, review of orders and ca and the legal obligation of all nu	for the date all ency Education wound n audits, on the TAR are plans,	

03/07/2017

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.

Electronically Signed

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTR	RUCTION	(X3) D	NO. 0938-039 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	UILDING		C	OMPLETED
		345201	B. WING			C	
NAME OF PI	ROVIDER OR SUPPLIER	0.0201	STREET ADDRESS, CITY, STATE, ZIP CODE				02/20/2017
					T 5TH STREET		
GOLDEN	LIVINGCENTER - CHARL	OTTE		CHARLO	DTTE, 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 224	Continued From page	21	F 2	24			
	A record review was of wound care ordered b left heel, left foot, and be done daily. Docur Care MD on the form Specialist Evaluation the sacrum, left foot a etiology stated as pre Wound care for left he as follows: "Cleanse I apply betadine and w day shift." Wound ca on 01/16/17 was as fo foot with Normal Salir with Kerlix daily every order for the sacrum v 2/15/17 and was as fo wound with Normal S betadine gauze and of every shift." On 02/20/17 at 11 a.m incontinence care per #1. At that time it was on the sacral wound v coloring, was wet, and sacral area of Reside incontinence brief was the room of Resident condition of the woun that the date of 02/18 indicated that the dres	conducted and revealed by the Wound Care MD for I sacral pressure ulcers to mentation by the Wound titled Wound Care stated that the wounds on and left heel all had the issure. The Wound Care MD eel ordered on 01/16/17 was left heel with Normal Saline rap with Kerlix daily every re ordered for left lateral foot bollows: "Cleanse left lateral ne apply betadine and wrap v day shift." The wound care wound were updated on bollows: "Cleanse sacral aline apply moistened cover with dry dressing daily n. resident was observed as formed by nursing assistant s observed that the dressing was with brown and greyish d was loosened from the nt #1. The resident's s wet. Nurse #1 came into #1 and also observed the d dressing. Nurse #1 stated		follow are r their Nurs facilit dutie coun per ti perfo All lic round an of wour will b 3. Th audit with Clinic docu otheir defic a Un TARs dress week subs 4. Ra wour Desig veek Desig	w physician orders so that re- not subject to neglectful treat wounds. We #3 was asked to not return ty due to failure to complete is as directed by the DNS. And iseling of nurses has been or the company policy, as it related ormance of job duties. Censed nurses are being req d with the Treatment nurse at n-going education program re- nds and treatment thereof, all be completed by 3/20/2017. The DNS or Designee will com- ts daily for 2 weeks; For all re- wounds, charts reviewed dut cal Start Up, for appropriate imentation on TARS to ensur- residents are affected by all tient practice. The DNS will d it Manager and/or ADNS to re- s on the weekends, and valide sing changes are completed kends, to ensure continued tantial compliance. andom audits of all residents inds will be conducted by the gnee 3x weekly for 1 month, kly for 3 months by the DNS gnee to ensure continued pliance. Results of the audits weed during the QAPI meeting to determine if further action ressary.	ment of a to the assigned dditional onducted tes to uired to as part of elated to Il training duct skin residents ring wound re no leged lesignate review date on with DNS or then 1x or a will be ng by the	
	At 12.20 n m on 02/2	20/17 Nurse # 1 applied a					

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	-	D 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 02/20/2017		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - CHARLOTTE					2616 EAST 5TH STREET			
GOLDEN LIVINGCENTER - CHARLOTTE					CHARLOTTE, NC 28204			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 224	clean dressing to the 1. The wound appear bled easily when clean time it was observed a dressing on the left for the foot and the heel. foot dressing was 02/ the date of 02/18/17 windicated that the dressing 02/18/17 and had not The dressing on the left the nurse at that time resident was being tra- out of the facility and observed at the appoint the left foot was dry ar- a brown colored dry or- diameter over the heel A telephone interview at 5:20 p.m. with Nurse week-end supervisor 02/18/17 and 02/19/11 that all of the wound the completed prior to lear shift. Nurse # 3 also so by the facility to docum- was to sign and initial the Treatment Admini- check mark and initial The date of 02/19/17 2. Resident #3 was are 02/20/17 and readmithed hospitalization with di Multiple Myeloma, art	sacral wound of Resident# red dark pink in color and nsed by Nurse #1. At that that the resident had a ot which covered most of The date written on the 18/17. Nurse # 1 stated that written on the dressing ssing had been changed on been changed on 02/19/17. eft foot was not removed by . Nurse #1 stated that the ansported to an appointment the wound would be intment. The dressing on nd intact. The dressing had ircle about one inch in el area.	F	22				

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If continuation sheet Page 3 of 10

	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMF	LETED
		345201	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	545201	<u> </u>	-	STREET ADDRESS, CITY, STATE, ZIP CODE	02/	20/2017
					2616 EAST 5TH STREET		
GOLDEN	LIVINGCENTER - CHARI	LOTTE		0	CHARLOTTE, NC 28204		
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224	indicated the resident assistance with bed m and personal hygiene cognitively. The reside bowel and bladder fur 01/24/17 indicated that 4 pressure ulcer on th A record review revea was updated on 02/19 ulcer. The wound can sacrum with Normal S and cover with dry dry A record review revea Administration Record Chart Codes at the bo TAR indicated that a for administered care. T 02/19/17 were blank for the sacral wound of On 02/20/17 at 5:00 p sacra area of Resider accompanied by Nurs loosened from the sa	sment dated 01/24/17 t required extensive nobility, transfers, dressing e and was severely impaired dent was incontinent of nctions. The MDS dated at Resident # 3 had a Stage he sacral area. aled that wound care order 5/17 for the sacral pressure re was as follows: "Cleanse Saline apply Dakin's solution essing daily every day shift." aled a Treatment d (TAR) for wound care. The ottom of the page on the check mark equaled he dates of 02/18/17 and on the TAR for Resident #3 care.	F	224			
	date 02/17/17 written wound was dark pink drainage. Nurse #4 s 02/17/17 indicated the changed on 02/17/17 on 02/18/17 and 02/1 A telephone interview	and had not been changed					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE SURVEY COMPLETED		
		345201	B. WING			C 02/20/2017		
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
GOLDEN LIVINGCENTER - CHARLOTTE				2	2616 EAST 5TH STREET			
GOLDEN				C	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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 224 F 314 SS=D	supervisor and treatm 02/19/17. It was state wound care had not b leaving at the end of st that the method of dow wound care was to ini Treatment Administrat appropriate date. The sacral wound care for 02/18/17 and 02/19/17 areas without the initia indicated wound care An interview was cond 02/20/17 at 5:30 p.m. the expectation that the make sure that treatment as ordered. A telephone interview was attempted, but the prior to the end of the 483.25(b)(1) TREATMENT/HEAL PREF (b) Skin Integrity - (1) Pressure ulcers. If comprehensive assess facility must ensure the (i) A resident receivess professional standard pressure ulcers and d ulcers unless the indiv	ent nurse on 02/18/17 and ed by Nurse #3 that all of the een completed prior to shift. Nurse #3 also stated cumentation of completed tial and check the tion Record (TAR) on the e areas of the TAR for the Resident #3 were blank for 7. Nurse #3 stated that als and check mark had not been done. ducted with the DON on The DON stated that it was he RN supervisor would hents would be administered with the Wound Care MD e MD did not return a call survey. MENT/SVCS TO ESSURE SORES Based on the issment of a resident, the hat.		314			3/20/17	

Facility ID: 952971

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345201	B. WING		02	C 2/ 20/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
GOLDEN	LIVINGCENTER - CHARL	LOTTE		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 314	Continued From page	9 5	F 3	14			
	necessary treatment a professional standard healing, prevent infect from developing. This REQUIREMENT by: Based on observatio interviews the facility existing Pressure UIc evidenced by 2 of 3 re wound care as ordere Resident #3). The findings include: 1. Resident #1 was a 9/12/16 and was reac hospitalization. The re included: Peripheral <i>A</i> above the knee ampu hypertension, atrial filt therapy, and dementi assessment complete and dated 1/19/17 inc severely cognitively in required extensive as transferring, dressing hygiene. The resider bowel and bladder fur performed on 1/16/17 had developed an unit	dmitted to the facility on Imitted 1/15/17 following esident had diagnosis which Arterial disease, a previous utation of right lower leg, prillation, anticoagulant a. The Minimum Data Set ed at time of readmission dicated the resident was		 Preparation of and/or execution of Plan of Correction does not constant admission or agreement by the protect of the truth of facts alleged or the conclusions set forth in the statement deficiencies. The Plan of Correction prepared and/or executed solely with it is required by the provisions of and state law. This Plan of Correct submitted as the facilities credible allegation of compliance. 1. Dressings were changed for Read 1 & 3 on 2/20/2017. 2. Each Resident has the potentiat affected by the alleged deficient proceed on the treatment administration read that dressings were dated for treatment was rendered. The DNS wound care nurse for daily document on the treatment administration read that dressings were dated for treatment was rendered. The DNS education for all Licensed nurses include agency Licensed Nurses 2/23/2017. Education was comport training on wound care to include completing skin audits, proper word documentation on the TAR & MA of orders and care plans, and the obligation of all nurses to follow present of the treatment of the treatment was rendered. 	itute rovider of nent of on is because federal ction is e esidents al to be oractice. s with and nentation ecord the date S began , to on ehensive - bund R, review legal		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION		E SURVEY PLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		C
		345201	B. WING			/20/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z		
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 (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 314	Continued From page	e 6	F 3	14		
	A record review was a wound care ordered f sacrum pressure ulce ordered on 1/16/17 a Normal Saline apply Kerlix daily every day for left lateral foot on lateral foot with norm wrap with Kerlix daily care order for sacrum as "cleanse sacral wo apply moistened beta dry dressing daily ever foot on 1/16/17 as "cl normal Saline apply to daily every day shift." sacrum wound updat sacral wound with no betadine gauze and o every day shift."	conducted and revealed for left heel, left foot, and ers. Wound care for left heel s "cleanse left heel with betadine and wrap with r shift". Wound care ordered 1/16/17 as "cleanse left al Saline apply betadine and every day shift." Wound n wound updated on 2/15/17 bund with normal saline adine gauze and cover with ery day shift." for left lateral eanse left lateral foot with betadine and wrap with Kerlix "Wound care order for ed on 2/15/17 as "cleanse rmal saline apply moistened cover with dry dressing daily . nursing assistant #1 was ence care was provided for observed that the dressing		 orders so that residents neglectful treatment of the part of ongoing education related to wound protocol be making rounds with the nurse. All education will 3/20/2017. 3. Physicians orders and reviewed by the DNS, dat for all residents with would care Plans updated as a Managers, DNS, ADNS Service Clinical Support conducted a 100% skin 2, 2017, as part of a QA The DNS will designate and/or ADNS to review weekends, and validate are completed on weeked continued substantial co Dressing Change Comp will be used by the Treat determine if additional tr on a continual basis. 	heir wounds. As in for nurses ol, all nurses will he treatment be completed by d Care Plans were aily for two weeks, unds. Orders and oppropriate. Unit and the Field for the company, sweep on Feb 1 & measure. a Unit Manager TARs on the dressing changes ends, to ensure ompliance. etency Checklist tment Nurse to	
	coloring, was wet and on sacral area of Res incontinence brief wa the condition of the w that the date written of Nurse #1 said that the dressing indicated that changed on 2/19/17. At 12:20 p.m. on 2/20 clean dressing to the	was with brown and greyish d loosened from the wound sident # 1. The resident's is wet. Nurse # 1 observed round dressing and stated on the dressing was 2/18/17. e date of 2/18/17 on the at the dressing had not been 0/17 Nurse #1 applied a sacral wound of Resident ared dark pink in color and		4. Random audits of all wounds will be conducted Designee 3x weekly for weekly for 3 months by Designee to ensure con compliance. Results of the reviewed during the QAI ED, to determine if furth necessary.	ed by the DNS or 1 month, then 1x the DNS or tinued he audits will be PI meeting by the	

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:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345201	B. WING			C 02/20/2017		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - CHARLOTTE					2616 EAST 5TH STREET CHARLOTTE, NC 28204			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 314	bled easily when cleat time it was observed dressing on the left for the foot and the heel. dressing on the foot w stated that the date 2 dressing indicated that changed on 2/19/17. removed by the Nurse was getting the reside outside of the facility dressing was dry and brown dry circle about the heel area. A telephone interview at 5: 20 p.m. with Nur week-end supervisor. for wound care, also. she had not been able before the end of her 2/18/17 and 2/19/17. that the method used completion was to sig and to mark the TAR. without initials and the wound care not done 2. Resident #3 was an 2/20/14 and readmitte on 7/14/16 with diagn Myeloma, arthritis, hy dementia. The Minimi assessment dated 1/2 required extensive as transfers, dressing an	nsed by the Nurse. At that that the resident had a out which covered most of The date written on the vas 2/18/17. Nurse # 1 /18/17 written on the at the dressing had not been The dressing was not e at that time. The Nurse ent ready for an appointment to a Wound MD. The intact. The dressing had a t one inch in diameter over was conducted on 2/20/17 rse #3 who worked as Nurse # 3 was responsible It was stated by Nurse # 3 e to complete all treatments shift on the week-end of It was stated by Nurse # 3 to document wound care in and initial the dressing Nurse #3 stated that areas e check mark indicated	F	314				

Facility ID: 952971

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED	
		345201	B. WING			C 02/20/2017		
NAME OF P	ROVIDER OR SUPPLIER	I			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 PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 314	incontinent of bowel a Minimum Data Set as indicated that Resider ulcer on the sacral an	and bladder functions. The sessment dated 1/24/17 nt #3 had a stage 4 pressure ea.	F	314				
	for the sacral pressur 2/15/17. The care or with Normal saline ap cover with dry dressir A record review revea Administration Record The Chart Codes at the the TAR indicated tha administered. The da	dered as "cleanse sacrum oply Dakin's solution and ng daily every day shift." aled a Treatment d (TAR) for wound care. he bottom of the page on it a check mark equaled ates of 2/18/17 and 2/19/17						
	wound care. On 2/20/17 at 5:00 p. sacral area of Reside presence of Nurse #4 loosened from the wo greyish in color. It wa 2/17/17 had been writ wound color was dark drainage observed. date of 2/17/17 on the dressing had not been 2/19/17. A record review reveat for the sacral pressur 2/15/17. The care or with Normal saline ap	aled that wound care order						

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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 C		
		345201	B. WING			02/20/2017		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - CHARL	OTTE			16 EAST 5TH STREET HARLOTTE, NC 28204			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES II (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE REGULATORY OR LSC IDENTIFYING INFORMATION) TA			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 314	Continued From page	9 9	F	314				
	The Chart Codes at the TAR indicated that administered. The date administered. The date were blank on the TA wound care. A telephone interview at 5: 20 p.m. with Nur week-end supervisor. for wound care, also. she had not been able before the end of her 2/18/17 and 2/19/17. That the method used completion was to sig and to mark the TAR. without initials and the wound care not done. An interview was con 2/20/17 at 5:30 p.m. The expectation that the terms of the expectation that the terms of the terms of the expectation that the terms of the terms of the expectation that the terms of the terms of the expectation that the terms of terms	d (TAR) for wound care. he bottom of the page on t a check mark equaled ates of 2/18/17 and 2/19/17 R in the area of sacral was conducted on 2/20/17 res #3 who worked as Nurse # 3 was responsible It was stated by Nurse # 3 e to complete all treatments shift on the week-end of It was stated by Nurse # 3 to document wound care in and initial the dressing Nurse #3 stated that areas e check mark indicated						

If continuation sheet Page 10 of 10