DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB I	NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		ATE SURVEY
		345008	B. WING				R-C
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		04/10/2017
					PROVIDENCE ROAD		
GOLDEN	LIVINGCENTER - DARTI	MOUTH		CHA	ARLOTTE, NC 28207		
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	FO	000			
{F 157} SS=D	Regulation (DHSR), I Certification Section I investigation at the fa Survey Agency to obt interviews to complet survey's exit date wa Event ID# NB8V12. 483.10(g)(14) NOTIF (INJURY/DECLINE/F (g)(14) Notification of (i) A facility must imm consult with the resid	acility. In order for the State tain all needed staff e the investigation the s extended to 04/10/17. Y OF CHANGES ROOM, ETC) Changes. Hediately inform the resident; ent's physician; and notify, her authority, the resident	{F 1!	57}			5/2/17
		ving the resident which as the potential for requiring n;					
	mental, or psychosoc deterioration in health	n, mental, or psychosocial reatening conditions or					
	a need to discontinue	erse consequences, or to					
	(D) A decision to tran resident from the faci §483.15(c)(1)(ii).	-					
	 DIRECTOR'S OR PROVIDED!	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE		TITLE		(X6) DATE
	cally Signed	SOLL LEN NEL NEGENTATIVE S SIGNATUR	~		III LL		04/26/2017
	ouny orgined						07/20/2017

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 05/01/2017 RM APPROVED IO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		345008	B. WING				R-C 4/10/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	LIVINGCENTER - DARTI	ЛОЦТН		3	00 PROVIDENCE ROAD		
COLDEN				0	CHARLOTTE, NC 28207		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 157}	 (14)(i) of this section, all pertinent informatic is available and provi physician. (iii) The facility must a resident and the resid when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the This REQUIREMENT by: Based on a physician practitioner interview, of the medical record the physician or nurse weight gain for Resid residents reviewed for The findings included Resident #82 was ad 12/13/16. Diagnoses calorie malnutrition, a 	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident representative(s). is not met as evidenced n interview, nurse staff interviews and review , the facility failed to notify e practitioner of a significant ent #82, for 1 of 4 sampled ir physician notification.	{F 1	157}		that dgain;	
		minimum data set dated dent #82 was assessed with			the residents weight gain and the Registered Dieticians recommendation		

Facility ID: 953418

STATEMENT C	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) D/	ATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		MPLETED		
						R-C		
		345008	B. WING			04/10/2017		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE			
	IVINGCENTER - DARTM			300 PROVIDENCE ROAD				
GOLDEN	IVINGCENTER - DARTIN	NOUTH		CHARLOTTE, NC 28207				
(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 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
{F 157}	Continued From page	e 2	(F 157	7}				
		nemory, intact long term		change the whole milk t	o 2% milk for			
	memory, moderately	impaired decision-making, ision and the physical		resident # 82.				
	assistance of a staff r			All residents have the p	otential to be			
	significant weight gain	n, but not on a physician		affected.				
	prescribed weight gai	in regimen.						
				All residents who trigge				
		he nurse practitioner (NP),		significant weight loss/g				
		ed Resident #82 with an ing/delusions, based on staff		in the weekly at risk me by the IDT team. The re				
		the resident's diagnoses of		weight changes were as				
	delusional disorder. T			Registered Dietician and				
	increase Seroquel (ar	-		interventions were put in				
	milligrams three times			resident⊡s responsible				
	reference to an asses	ssment regarding an		Medical Providers were	notified by the			
	increase in his weight	t.		DON/designee of the ch was completed on 4/26/				
	A nutrition data quarte	erly assessment by the		areas of non-complianc	e addressed			
		ager (CDM) dated 3/7/17		immediately.				
		82 with a current weight of						
		dy weight range of 149 - 184		An in-service training or				
		weight gain, intact skin,		Changes was complete				
	-	rge portions diet and a plan		the nursing staff by the				
	to continue to monitor	i weight and intake.		and/or designee. The N re-educated to notify the				
	A nutrition assessme	nt dated 3/16/17 by the		any changes in the resid				
		RD) revealed Resident #82		Staffs that were not ava				
		et with milk added at each		education were called a				
		otein and ate approximately		was completed via telep				
		D assessment indicated that		and/or designee.	-			
		nt weight was 188 pounds, a						
	22.1% significant rece			The Director of Nursing	-			
		is total food/fluid intake met		will audit 100% of chang	-			
		ds, but not estimated		conditions daily events				
		D's recommendation was to		notification in the clinica				
	-	nis food/fluid intake and		daily to ensure complian				
	-	since his skin was currently esident #82 was that the		non-compliance will be immediately. The Direct				
		ue to consume adequate		and/or designee will exp				

Facility ID: 953418

If continuation sheet Page 3 of 24

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED		
			A. DOILDING		R-C		
		345008	B. WING		04/10/2017		
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE			
				300 PROVIDENCE ROAD			
GOLDEN	LIVINGCENTER - DART	MOUTH		CHARLOTTE, NC 28207			
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETI		
{F 157}	Continued From page	• ²	(5.45	71			
{F 157}			{F 157		a far		
	amounts of food to m	neet his nutrient needs.		interventions and corrective actions non-compliance with notifications.			
	Review of the facility	's "Weekly Risk Management		will be completed 5 times a week for			
		and a "Weight Note" written		weeks, then weekly for 4 weeks, the			
		lical record by the Assistant		monthly for 6 months. Ongoing and			
		ADON), revealed Resident		expanded monitoring, interventions	s and		
		as discussed during WRM		additional corrective actions will be	;		
	meetings held on 3/3			implemented as needed.			
		rs to include the ADON and		The results of the Director of Nursi	•		
	-	s reweigh for accuracy and		and/or designee s audits will be re to the QAPI committee monthly me	-		
	to monitor his weight	weekiy.		for three months and then guarter	•		
	Review of Resident #	#82's care plan, revised on		thereafter until the QAPI committee			
		locumented Resident #82		determines compliance. Determine			
		ein energy intake and a body		will be recorded in the minutes of the			
		26.9% (obese) due to a		QAPI.			
		ight gain of 22.1% since					
	admission. The care	plan intervention included to					
	notify the physician c	of significant weight changes.		Education			
	Review of Resident #	#8's weight history revealed		F-157 483.10(g)(14) NOTIFY OF			
	the following weights			CHANGES			
	· 12/13/16, 154 poun	lds		(INJURY/DECLINE/ROOM,ETC) (g)(14)		
	· 1/11/17, 160 pound			Notification of Changes			
		83 pounds (16% gain)					
		88 pounds (18% gain)		A facility must immediately inform	7-		
	· 3/29/17, 193 pound	is (20% gain)		resident; consult with the resident			
	A telephone interview	w on 4/05/17 at 3:03 PM with		physician; and notify, consistent wi or her authority, the resident	11110		
		attended the facility's WRM		representative(s) when there is:			
		ne assessed Resident #82		" Accident involving the residen	t which		
	-	ght gain of 22.1% since		results in injury and has the potent			
		lity. The RD stated when she		requiring physician intervention			
		#82 on 3/16/17, she did not		" A significant change in the res			
		ons for changes to his plan of		physical, mental or psychosocial st			
		cause although he was eating		(that is, a deterioration in health, m	iental,		
	less than 100% of his			or psychosocial status in either			
	-	m the additional milk at each		life-threatening conditions or clinica	al		
	meai and his skin wa	as intact. The RD stated "I		complications);			

Facility ID: 953418

					OMB NO.	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE S COMPLE	
					R-0	C
		345008	B. WING		04/1	0/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - DART	MOUTH		300 PROVIDENCE ROAD		
				CHARLOTTE, NC 28207		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
{F 157}	Continued From page	e 4	{F 157	}		
. ,		cian of significant weight		A need to alter treatment sign	nificantly	
		nursing." She stated that		(that is, a need to discontinue an	-	
		to continue to monitor the		form of treatment due to adverse		
	resident's weight stat	US.		consequences, or to commence a	a new	
	An interview on 4/05/	17 at 3:30 PM with the		form of treatment); or A decision to transfer or disc	harge the	
		Irsing (IDON) revealed the		resident from the facility.	narge the	
		etings, she did not attend				
		eting, but that the ADON did				
		ted that she expected the				
		ician of any significant				
		ally or by documentation in nunication book. Review of				
		nunication book during the				
		ere was no documentation				
	regarding Resident #	82's change in weight status.				
	An interview on 4/05/	17 at 3:46 PM with the				
		ttended the 3/16/17 WRM				
		t #82's significant weight				
		I. The ADON stated that				
		the physician or NP of the weight status for Resident				
	#82 because the RD					
	expected that she wo					
	physician by writing a					
		, if there was a concern with				
	nutrition for a residen	IT.				
	A telephone interview	v with the physician for				
		ed on 4/5/17 at 4:15 PM. The				
		at he was not made aware of				
		n weight status for Resident				
		d not say whether or not his physician stated that if				
		ere advised, documentation				
	would be available in					
	communication book	and a corresponding				
	progress note would	be written by either the				

If continuation sheet Page 5 of 24

	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM): 05/01/201 1 APPROVEI 0. 0938-039
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE COMP	LETED
		345008	B. WING			-0 10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - DARTI	моитн		300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 157} {F 253} SS=D	that documentation w likely that neither he The physician stated he would expect notif gain could likely be d which would need to A telephone interview at 1:43 PM with the N that the NP was not a change in weight stat stated that typically th significant changes for note in the physician' due to multiple recen staff, Resident #82 m The NP stated that sl Resident #82 experise hallucinations, but sh not she ordered an a this. The NP further s antipsychotic, that co weight gain and she case an adjustment t needed. 483.10(i)(2) HOUSER SERVICES (i)(2) Housekeeping a necessary to maintai comfortable interior; This REQUIREMENT by: Based on observatio interviews and review facility failed to secur	The physician stated that if vas not available, then it was nor the NP, were advised. that for a 22% weight gain fication because the weight ue to swelling/edema/fluid be assessed. was conducted on 4/10/17 NP. The interview revealed advised of a significant tus for Resident #82. The NP he facility would advise of or a resident by leaving a 's communication book, but t changes in administration hay have been overlooked.	{F 15	7}	my the	5/2/17

Event ID: NB8V12

Facility ID: 953418

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUITIPI	LE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · /	IPLETED
						R-C
		345008	B. WING			4/10/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
				300 PROVIDENCE ROAD		
GOLDEN	LIVINGCENTER - DART	MOUTH		CHARLOTTE, NC 28207		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{F 253}	Continued From page	e 6	{F 253	3		
. ,		ntly (Resident #95), repair a	(, 200	admission that a deficiency exist	s or that	
		event it from scaring the floor		one was cited correctly. This Pla		
	· · ·	lentify and repair 4 broken		Correction is submitted to meet		
) for 2 of 7 sampled resident		requirements established by Stat	e and	
	rooms observed.			Federal law.		
	The findings included	ŀ		F-253		
				Resident # 95 bathroom grab-ba	r and	
	1a. Resident #95 was	s admitted to the facility on		bathroom door was repaired imm		
	1/18/17. Review of ar	n admission Minimum Data		The broken floor tile identified in	RM 317	
	Set (MDS) assessme	ent, dated 1/25/17, assessed		on the left side of bed-B was repa	aired	
		ear speech, understood,		immediately.		
		ognition, required limited				
		of one staff person with		All Residents of the facility have		
		se, unsteady, but able to assistance when moving		potential to be affected. The ma director and/or designee completed		
		ng position and moving		of all patient rooms on 4/27/17.		
		S also assessed Resident		grab-bars, doors and tile not in		
		admission and indicated that		compliance were repaired and/or	replaced	
	direct care staff believ	ved Resident #95 was		immediately.	•	
	capable of increased	independence in at least				
	some activities of dai	ly living.		The Executive Director and/or		
				Maintenance Director will provide		
		s Verification of Investigation		re-education to staff on the proce		
		dent #95 sustained a fall,		inputting housekeeping and mair		
	follow up to repair a lo	room on 3/30/17, with a		issues into the facility building en automated maintenance program		
		e of the fall, Resident #95		software when identified by staff		
	stated he fell because			the facility equipment and buildin		
	bathroom was loose a			properly maintained. The Mainte		
		-		Director was reeducated on 4/27	/17 by	
		7 at 12:25 PM with the		Wanda Whipple, RN (GLC-Lead	Clinical	
		r revealed that he did not		Support team) on maintaining a		
		ty rounds, because he had		preventive maintenance log and	a a l (h) 4 -	
		Ind daily. He stated that he		conducting house wide rounds w	eekly to	
		Assistant could not be in every day to identify needed		identify repairs as needed.		
		pected staff to report needed		Facility zone rounds were implen	nented for	
	repairs via the Buildir			department heads to assist in ma		

Facility ID: 953418

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/01/2017 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345008	B. WING				-C 10/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - DARTI	лоитн			0 PROVIDENCE ROAD		
	-			CI	HARLOTTE, NC 28207		I
(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) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
{F 253}	stated that he review twice daily, around 7: lunch time. He stated repairs by the end of via Building Engines. Resident #95 was inte PM and stated that the was unsecured to the bathroom last week a been loose for a while reported this to a staff the maintenance dep it, but the grab bar was stated he used the gr daily to transfer on/of grab bars to stabilize An observation of Re occurred on 4/4/17 at left grab bar, adjacen unsecured to the bath were loose from the w moved side to side w An interview on 4/4/1 (NA) #1 revealed Resi bars in his bathroom transfers on/off the co independence. NA #1 the left grab bar in his to the wall. An interview on 4/4/1	 Maintenance Director ed Building Engines at least 00 AM and again around that he completed all the day that were reported erviewed on 4/4/17 at 3:20 te grab bar in his bathroom e wall when he fell in the and that the grab bar had e. Resident #95 stated he f member and someone in artment was supposed to fix as still loose. Resident #95 ab bars in his bathroom f the commode and used the during his transfers. sident #95's bathroom a 3:20 PM and revealed the t to the commode, was proom wall, 1 of 2 screws wall and the grab bar easily hen touched. 7 at 3:30 PM with nurse aide sident #95 used the grab to stabilize himself during ommode to maintain his I stated she was not aware s bathroom was unsecured 7 at 3:35 PM with Nurse #1 5 used the bathroom sted assistance with	{F 25	53}	compliance. The facility zone rounds monitor facility and resident room s 5-times/week for 4 weeks, then 3-times/week for 4 weeks, then weekl 3 months. The Maintenance Director and/or designee will be responsible for compliance. The results of the monitoring will be reported to the QAPI committee mont meeting for three months, and then quarterly thereafter until the QAPI committee determines the ongoing or expanded need for additional monitori interventions and additional corrective actions needed to ensure compliance Determinations will be recorded in the minutes of the QAPI. Education F-253 483.10(i)(2) HOUSEKEEPING MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance service necessary to maintain a sanita orderly, and comfortable interior;&	y for r nly ng, &	
	revealed Resident #9 independently, reque	5 used the bathroom sted assistance with needed, but used the grab					

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION		O. 0938-039 E SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · /	PLETED
					F	२- С
		345008	B. WING		04/10/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - DART	моитн		300 PROVIDENCE ROAD		
OOLDEN				CHARLOTTE, NC 28207		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
{F 253}	Continued From pag	e 8	{F 253	a		
[1 200]	10	stated she was not aware of	{ - 200	3		
	any needed repairs f					
	An interview occurre	d on 4/4/17 at 3:45 PM with				
		of Nursing (IDON) and				
		95 fell in his bathroom on				
		fall was discussed during the				
		Management meeting. The				
		follow up to the fall included				
	a plan to repair the lo	the request was discussed				
		d in the Building Engines.				
	-	documentation for review				
		he facility's Building Engines				
		air the grab bar for Resident				
		d that an attempt to repair				
	-	made until Monday, 4/3/17,				
		as unsuccessful. The IDON				
		the Maintenance Director to				
		d/audits to identify a need for				
		t needed repairs in Building Maintenance Director to				
		completed timely/effectively.				
	Follow up observatio	ns of Resident #95's room				
	-	view with the Maintenance				
		4/4/17 at 4:00 PM and				
		he observations revealed the				
		or Resident #95 was still in Aaintenance Director stated				
		at the grab bar Resident #95				
		because the repair was not				
		engines. On 4/4/17 at 4:15				
		e Director further stated that				
	the Maintenance Ass	sistant attempted to repair the				
	-	t #95 on 4/3/17 after receipt				
	-	or the repair during a morning				
		1/17. The Maintenance				
	LUirector stated the hi	ole in the wall was too large	1	I. Contraction of the second se		1

Facility ID: 953418

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345008	B. WING				-C 10/2017
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GOLDEN	LIVINGCENTER - DARTM	IOUTH			PROVIDENCE ROAD ARLOTTE, NC 28207		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 253}	 was unsuccessful and loose again. He also a of items to repair on T but the list did not inc #95's room. An interview with the occurred on 4/4/17 at revealed that he was 3/31/17 that the grab loose and needed to attempted to make th but the hole in the was screws, he attempted quick drying cement, after the repair to ensise secured to the wall be stated that he just loo realized the cement of anticipated it would, s and repair it again. 1b. Resident #95 was 1/18/17. Review of ar Set assessment, date Resident #95 with cle understands, and inta An interview on 4/4/1¹ Maintenance Director conduct routine facilit too much to do to rou and the Maintenance each resident's room repairs, but rather exprepairs via the Buildin reporting system). Th 	tial attempt to fill in the hole d now the grab bar was stated that he received a list Thursday, which he repaired, lude repairs to Resident Maintenance Assistant 4:20 PM. The interview notified on Friday morning, bar for Resident #95 was be repaired. He stated he e repair. Monday, 4/3/17, Il was too large for the to fill in the hole, using a but that he did not follow up ure the grab bar was efore it was used again. He ked at the grab bar and lid not fill in the hole as he so he would have to go back a admitted to the facility on a admission Minimum Data ed 1/25/17, assessed ar speech, understood,	{F 2	253}			

Facility ID: 953418

If continuation sheet Page 10 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED R-C	
		345008	B. WING				(-0 1/10/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - DARTM	NOUTH			300 PROVIDENCE ROAD CHARLOTTE, NC 28207			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
{F 253}	lunch time. He stated repairs by the end of via Building Engines. Resident #95 was inte PM and stated that the open/close easily bed the floor, but rather ge interview, the floor at bed, underneath the r with multiple deep ha to close the door reve floor when closed app required great force to An interview on 4/4/11 (NA) #1 revealed that room was difficult to of the floor when opened door had been like that know how long, but st repair. An interview on 4/4/11 revealed she was not repairs for Resident # An interview occurred the Interim Director of revealed she expected to conduct routine rou for repairs, staff to rep Building Engines (cor and for the Maintenar repairs were complete Follow up observation	00 AM and again around that he completed all the day that were reported erviewed on 4/4/17 at 3:20 re door to his room did not cause the door did not clear of stuck. During the the foot of Resident #95's room door, was observed If circular grooves. Attempts ealed the door scraped the proximately half way and o close it. 7 at 3:30 PM with nurse aide the door to Resident #95's close and created grooves in d/closed. NA #1 stated the at for a while, she did not he had not reported this for 7 at 3:35 PM with Nurse #1 aware of any needed t95's room. 4 on 4/4/17 at 3:45 PM with f Nursing (IDON) and d the Maintenance Director und/audits to identify a need port needed repairs in mputerized reporting system) nee Director to ensure ed timely/effectively.	{F 2	253				
	Follow up observatior							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	APPROVED	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED	
		345008	B. WING				R-C 4/10/2017	
NAME OF P	ROVIDER OR SUPPLIER	L	I		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	LIVINGCENTER - DARTM	IOUTH			300 PROVIDENCE ROAD CHARLOTTE, NC 28207			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
{F 253}	Director occurred on 4/4/17 at 4:15 PM. The room door for Reside repair. The Maintenan several rooms had do because the building not had an opportunit He also stated that he repair on Thursday, 3 but the list did not ince #95's room. 2. An observation occo of room 317. The floo B, across from the wit tiles were broken/jagg approximately 12 inch tiles. An interview on 4/4/11 Maintenance Director conduct routine facilit too much to do to rou and the Maintenance each resident's room repairs, but rather exprepairs via the Building reporting system). Th stated that he reviewed twice daily, around 7: lunch time. He stated repairs by the end of via Building Engines. An interview occurrect the Interim Director of expected the Maintenance round and the function of the function of the function of the function facilit too much to do to rou and the function of t	4/4/17 at 4:00 PM and he observations revealed the nt #95 was still in need of nee Director stated that bors that scraped the floor settled over time and he had y to address this issue yet. e received a list of items to i/30/17 which he repaired, lude repairs to Resident curred on 4/4/17 at 10:32 AM or next to the left side of bed ndow revealed 4 of the floor ged which left a space of hes x 6 inches void of floor 7 at 12:25 PM with the revealed that he did not y rounds, because he had nd daily. He stated that he Assistant could not be in every day to identify needed bected staff to report needed ag Engines (computerized e Maintenance Director ed Building Engines at least 00 AM and again around	{F 2	253	}			

If continuation sheet Page 12 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/01/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED R-C
		345008	B. WING		04/10/2017
	ROVIDER OR SUPPLIER	лоитн	300	REET ADDRESS, CITY, STATE, ZIP COL PROVIDENCE ROAD ARLOTTE, NC 28207	•
(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 CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
{F 253} F 323 SS=D	repairs were complete Follow up observation up interview with the occurred on 4/4/17 at PM. The observations (room 317) were still Maintenance Director that the floor tiles (roo repair because the re Building Engines. On Maintenance Director received a list of item 4/3/17 which included which he repaired. Th stated that he assum currently broken in th occurred, but when h room, he did not look needed. 483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI (d) Accidents. The facility must ensu (1) The resident envir from accident hazard (2) Each resident rec and assistance device (n) - Bed Rails. The fa appropriate alternativ bed rail. If a bed or s must ensure correct i	hee Director to ensure ed timely/effectively. hs of room 317 and a follow Maintenance Director : 4:00 PM and 4/4/17 at 4:15 is revealed the floor tiles in need of repair. The stated he was not aware om 317) were in need of opairs were not recorded in 4/4/17 at 4:15 PM, the further stated that he is to repair on Thursday, d floor tiles in room 317, he Maintenance Director also ed the tiles that were at room must have just e repaired the tiles in that to see if other repairs were -(3) FREE OF ACCIDENT SION/DEVICES ure that - ronment remains as free is as is possible; and eives adequate supervision es to prevent accidents. facility must attempt to use es prior to installing a side or ide rail is used, the facility	{F 253}		5/2/17

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/01/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		345008	B. WING				R-C / 10/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	800 PROVIDENCE ROAD		
GOLDEN	LIVINGCENTER - DARTN	NOUTH		0	CHARLOTTE, NC 28207		
			10		PROVIDER'S PLAN OF CORRECTION		(15)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	e 13	F	323			
	to the following eleme						
	to the following clothe						
	(1) Assess the resider from bed rails prior to	nt for risk of entrapment installation.					
	(2) Dovious the ricks of	and honofite of had rails with					
		and benefits of bed rails with nt representative and obtain					
	informed consent price						
	(3) Ensure that the be	ed's dimensions are					
		sident's size and weight.					
		is not met as evidenced					
	by:						
	-	ns, resident and staff			This Plan of Correction constitutes my		
		al record review, the facility			written allegation of compliance for the		
		b bar to the wall in the			deficiencies cited. However, submission		
	bathroom to prevent a				of this Plan of Correction is not an		
	intervention after a fal	ll for 1 of 3 sampled			admission that a deficiency exists or th	at	
	residents reviewed wi	-			one was cited correctly. This Plan of		
	(Resident #95)				Correction is submitted to meet		
					requirements established by State and		
	The findings included	:			Federal law.		
	Resident #95 was ad	mitted to the facility on			F-323		
	1/18/17. Diagnoses ir	ncluded Parkinson's disease,			Resident # 95 bathroom grab-bar was		
	chronic congestive he	eart failure and glaucoma,			repaired immediately.		
	among others.						
					All Residents of the facility have the		
		on Minimum Data Set			potential to be affected if a grab-bar is		
		lated 1/25/17, assessed			installed in their bathroom. The		
		ar speech, understood,			maintenance director and/or designee		
		ognition, required limited			completed an audit of resident rooms of	n	
		f one staff person with			4/27/2017. All grab-bars not in		
		e, unsteady, but able to			compliance were repaired and/or repla	ced	
		assistance when moving			immediately.		
		ng position and moving					
		also assessed Resident			The Executive Director and/or		
		idmission and indicated that			Maintenance Director will provide		
	direct care staff believ	ved Resident #95 was			reeducation to staff on the process of		

Facility ID: 953418

If continuation sheet Page 14 of 24

		MEDICAID SERVICES	0.00				O. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>′</i>		CONSTRUCTION	· /	E SURVEY IPLETED	
			1				R-C	
		345008	B. WING			04	04/10/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	LIVINGCENTER - DARTI	MOUTH		3	00 PROVIDENCE ROAD			
GOLDEN	EIVINGGENTER - DARTI			С	HARLOTTE, NC 28207			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 323	Continued From pag	e 14	F.	323				
1 020		independence in at least		525	inputting housekeeping and maintenand	6		
	some activities of dai	•			issues, (work orders and preventive			
		, <u>.</u>			maintenance tasks); into the facility			
	Review of Resident #	#95's care plan, revised			building engines automated maintenand	се		
		was at risk for falls related to			program software when identified by sta			
		v environment, weakness,			to keep the facility equipment and build	ing		
		arkinson's disease. Care plan			properly maintained.			
	0	rease/maintain his current tioning. Interventions			The Maintenance Director and/or			
		ensure adaptive equipment			designee will audit for life safety concer	ms		
	was secure.				5-times/week for 4 weeks, then			
					3-times/week for 4 weeks, then weekly	for		
	Review of the facility	's Verification of Investigation			3 months. The Executive Director will			
		at 04:43 AM and a nurse's			conduct audits for life safety concerns 3			
		t 06:37 AM, both written by			times a week for 4 weeks, then weekly	for		
		Resident #95 sustained a fall,			3 months. Identified repairs will be			
	follow up to repair a l	room on 3/30/17, with a			corrected at that time.			
		locumented that at the time			Facility zone rounds were implemented	for		
		#95 stated he fell because			department heads to assist in maintaini			
		athroom was loose and			compliance. The facility zone rounds w	-		
	unsteady.				monitor facility and resident room□s			
					5-times/week for 4 weeks, then			
		esident #95's bathroom			3-times/week for 4 weeks, then weekly	for		
		t 3:20 PM and revealed the			3 months. The Maintenance Director			
		nt to the commode, was hroom wall, 1 of 2 screws			and/or designee will be responsible for compliance.			
		wall and the grab bar easily						
	moved side to side w	•			The results of the monitoring will be			
					reported to the QAPI committee monthl	ly		
		terviewed on 4/4/17 at 3:20			meeting for three months, and then			
		he grab bar in his bathroom			quarterly thereafter until the QAPI			
		e wall when he fell in the			committee determines the ongoing or	-		
		and that the grab bar had			expanded need for additional monitorin	g,		
		e. Resident #95 stated he ff member and someone in			interventions and additional corrective actions needed to ensure compliance.			
	-	partment was supposed to fix			Determinations will be recorded in the			
		as still loose. Resident #95			minutes of the QAPI.			
		rab bars in his bathroom						

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TATEMENT (S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE (CONSTRUCTION	(X3) DA	10. 0938-039
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G			MPLETED
		345008	B. WING			1	R-C
	ROVIDER OR SUPPLIER	340000			REET ADDRESS, CITY, STATE, ZIP CODE	0	4/10/2017
					0 PROVIDENCE ROAD		
GOLDEN	LIVINGCENTER - DARTI	MOUTH			HARLOTTE, NC 28207		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 323	Continued From page	e 15	F 32	2			
		ff the commode and used the	1.52		Education		
	grab bars to stabilize						
	0	C			F-323 483.25(d)(1)(2)(n)(1)-(3) FREE	OF	
		7 at 3:30 PM with nurse aide			ACCIDENT HAZARDS		
		sident #95 used the grab					
		to stabilize himself during ommode to maintain his			(d) the facility must ensure that (1) the resident environment remains free from		
		at she was not aware that it			accident hazards as is possible.		
	was not secured to th						
	An interview on 4/4/1	7 at 3:35 PM with Nurse #1					
	revealed Resident #9	95 used the bathroom					
	independently, reque						
		needed, but used the grab to stabilize during his					
		tated she was not aware of					
	any needed repairs for						
	An interview occurred	d on 4/4/17 at 3:45 PM with					
		of Nursing (IDON) and					
		95 fell in his bathroom on					
		the fall was discussed during Weekly Risk Management					
		stated that the follow up to					
		an to repair the loose grab					
		pathroom, the request was					
	-	nd recorded in the Building					
		ed repair system). The IDON tion for review dated 3/31/17					
		air the grab bar for Resident					
		Building Engines. The					
	IDON stated that an	attempt to repair the grab bar					
		londay, 4/3/17, but that the					
	-	sful. The IDON stated she					
		nance Director to conduct to identify a need for repairs					
	and to ensure repairs						
	timely/effectively.						

Facility ID: 953418

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/01/2017 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION IG	(X3) DATI COM	E SURVEY IPLETED
		345008	B. WING			₹-C I/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	
	LIVINGCENTER - DARTI			300 PROVIDENCE ROAD		
GOLDEN	LIVINGCENTER - DARTI	NOOTH		CHARLOTTE, NC 28207		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	Follow up observation and an interview with occurred on 4/4/17 at PM. The observations grab bar was still in m Maintenance Director that the grab bar was the repair was not ree On 4/4/17 at 4:15 PM further stated that the attempted to repair th receipt of a verbal ree morning staff meeting Maintenance Director wall was too large for to fill in the hole was grab bar was loose a An interview with the occurred on 4/4/17 at revealed that he was 3/31/17 that the grab loose and needed to attempted to make th but the hole in the was screws, he attempted quick drying cement, after the repair to ens secured to the wall bo stated that he just loo realized the cement of anticipated it would, s and repair it again. A telephone interview Nurse #2 revealed Re bathroom during a tra	ns of Resident #95's room the Maintenance Director t 4:00 PM and 4/4/17 at 4:15 s revealed the bathroom need of repair. The r stated he was not aware a in need of repair because corded in Building Engines. I, the Maintenance Director e Maintenance Assistant he grab bar on 4/3/17 after quest for the repair during a g on 3/31/17. The r stated that the hole in the t the screws, and the attempt unsuccessful and now the gain. Maintenance Assistant t 4:20 PM. The interview notified on Friday morning, bar for Resident #95 was be repaired. He stated he he repair on Monday, 4/3/17, all was too large for the d to fill in the hole, using a but that he did not follow up sure the grab bar was efore it was used again. He oked at the grab bar and did not fill in the hole as he so he would have to go back	F 3	23		

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		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 05/01/201 MAPPROVE D. 0938-039	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	COMF	E SURVEY PLETED	
		345008	B. WING				/10/2017	
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN I	IVINGCENTER - DARTI	MOUTH			PROVIDENCE ROAD			
				CH	IARLOTTE, NC 28207		1	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323	Continued From page		F 3	323				
	assessed him after the							
	•	o bar in his bathroom was l, but "shaky" when moved.						
	Nurse #2 stated she	assessed him without injury						
		the resident stated he felt rab bar was the reason for						
		ed she documented on the						
		follow up would be to repair						
	the loose grab bar. N aware that the grab b	urse #2 stated she was not						
	-	a 3/30/17, but confirmed that						
	the resident used the	grab bars in his bathroom to						
	transfer independent	ly.						
	A telephone interview	/ on 4/5/17 at 10:11 AM with						
		was the assigned NA for						
		e fell on the 11:00 PM - 7:00 and that she was also his						
		same shift on 3/31/17. NA #2						
	-	par in his bathroom was						
		on 3/30/17, but that she was it had been loose and that						
	-	e need for a repair. NA #2						
		Resident #95 used the grab						
		to transfer independently and continued to do so on						
	3/30/17 and 3/31/17.							
F 490			F 4	190			5/2/17	
SS=D	ADMINIS (RATION/R	RESIDENT WELL-BEING						
	483.70 Administration	n.						
	•	ninistered in a manner that						
	enables it to use its re efficiently to attain or	esources effectively and maintain the highest						
	•	mental, and psychosocial						
	well-being of each re							
	This REQUIREMENT	is not met as evidenced						
	~ .							

Facility ID: 953418

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 05/01/2017 ORM APPROVED 3 NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		STRUCTION		DATE SURVEY
		345008	B. WING _				R-C 04/10/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - DARTI	МОИТН			ROVIDENCE ROAD RLOTTE, NC 28207		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 490	Based on observatio interviews with the ph practitioner, staff inter and facility records, th failed to implement a to the physician or nu sampled residents (R significant change in utilize resources effect maintain repairs in bas (Resident #95 and ro resident rooms obser The findings included This tag is cross refer 1. F 157 Notification of physician interview, r staff interviews and ro the facility failed to no practitioner of a signi Resident #82, for 1 o reviewed for physicia During an interview of Interim Administrator Nursing (IDON), the I that it was not the fac notify the physician/n discussed during We (WRM) meetings, pan made to a resident's stated that the Regist WRM meeting held o recommendations for to the resident's signi IDON stated this was nurse practitioner we	ns, resident interviews, hysician and nurse rviews and review of medical he facility's administration system for communication urse practitioner when 1 of 4 tesident #82) experienced a weight status and failed to ctively to identify and athrooms and resident rooms om 317) for 2 of 7 sampled ved. I: rred to: of Changes: Based on a nurse practitioner interview, eview of the medical record, otify the physician or nurse ficant weight gain for f 4 sampled residents n notification. In 4/5/17 at 4:57 PM with the and the Interim Director of nterim Administrator stated cility's typical practice to urse practitioner of all items ekly Risk Management rticularly if no changes were plan of care. The IDON tered Dietitian attended the n 3/16/17 and had no r Resident #82 as it related ficant weight gain. The the reason the physician or	F	wr de of ad on Co Fe Fi All aff Th Nu suff ed Ec 20 Ar co cit Th Nu Op de ad Q/ an pe co Th	his Plan of Correction constitute itten allegation of compliance for ficiencies cited. However, subr this Plan of Correction is not ar mission that a deficiency exists ne was cited correctly. This Plan prection is submitted to meet quirements established by State ederal law. 490 I residents have the potential to fected. The Executive Director and Direct ursing received education on the opervision of resources for effect ficient administration. Corporate Operational support team providucation in their area of expertis ducation was completed on 4/26 017. The AD-HOC QAPI meeting was ompleted on 4/27/17 addressing fations. The Executive Director and Direct ursing, under the direction of Cli perational Support Team and/or esignee will validate the proper diministration of resources throug API process. The direction, mo ad support will take place throug erson and via conference call to ompliance.	or the mission of that of the or the or of the	

Facility ID: 953418

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/01/20 M APPROVE D. 0938-039
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
		345008	B. WING				(-C /10/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				30	00 PROVIDENCE ROAD		
GOLDEN	IVINGCENTER - DARTI	MOUTH		С	HARLOTTE, NC 28207		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 490	Continued From page	e 19	F4	490			
					address all identified areas in respect	to	
	This tag is cross refe	rred to:			the proper administration of resources	s for	
					the purpose of implementing appropri	ate	
	2. F253 Housekeepir				plans of action to correct identified		
		bservations, a resident			deficiencies.		
		iews and review of facility ailed to secure a loose grab			OADI maatinga will be askeduled for	ha	
		wall for a resident who used			QAPI meetings will be scheduled for 3rd Wednesday of each month at 11:		
		ndently (Resident #95),			a.m.	00	
		for to prevent it from scaring					
	-	95) and identify and repair 4			All plans of action initiated through Q	API	
	broken floor tiles (Ro	om 317) for 2 of 7 sampled			will be monitored, for the purpose of		
	resident rooms obser	rved.			updating, revising and/or amending a needed ensuring compliance and	S	
	During an interview of	on 4/5/17 at 4:57 PM with the			correction. Monitoring will continue for	or	
		and the Interim Director of			three months and then randomly		
	- · · ·	Interim Administrator stated			thereafter. All documentation of		
		of each department on			monitoring will be brought to QAPI for	-	
		nd discussed the status of			evaluation.		
	• •	ools to ensure monitoring pressed that he attributed the					
		e repair needs to a lack of			Education		
		ght/auditing and the need to					
		e repair services. The Interim			F 490 □ Facility Administrated Effectiv	ely	
		that there was no attempt to				-	
		r Resident #95 until Monday,			F490 ¿483.75 Administration A facility	/	
		t timely enough. The IDON			must be administered in a manner that		
	stated that the facility	-			enables it to use its resources effective	2	
		meetings and discussed			and efficiently to attain or maintain the		
		nd the need to repair the			highest practicable physical, mental, a		
		VRM meeting of 3/16/17. t an attempt to repair the			psychosocial well-being of each resid	ent.	
		de until Monday, 4/3/17 and					
	the facility's next follo						
		lemented would not have					
	-	, 4/7/17. The IDON stated					
	that if the Maintenand						
		ne facility may not have					
	identified that the gra	b bar was not repaired until,					

Facility ID: 953418

If continuation sheet Page 20 of 24

	-	ID HUMAN SERVICES				FORM	MAPPROVED
		MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
			A. BUILDI	NG_			R-C
		345008	B. WING				/10/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	LIVINGCENTER - DARTI			3	00 PROVIDENCE ROAD		
GOLDEN	LIVINGCENTER - DARTN	NOUTH		C	HARLOTTE, NC 28207		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIZ TAG		ATE	COMPLETION DATE	
					DEFICIENCY)		
F 490	10		F 4	490			
(=	Friday, 4/7/17 at the r	-					
{F 520}			{F 5	20}			5/2/17
SS=D	QUARTERLY/PLANS						
	(g) Quality assessme	nt and assurance.					
	(1) A facility must mai	intain a quality assessment					
	and assurance comm						
	minimum of:	0					
	(i) The director of nur	sing services;					
	(ii) The Medical Direc	tor or his/her designee;					
	(iii) At least three othe	er members of the facility's					
	staff, at least one of w						
		a board member or other					
	individual in a leaders	ship role; and					
	(g)(2) The quality ass	essment and assurance					
	committee must :						
	(i) Meet at loost quart	erly and as needed to					
	coordinate and evaluate						
		n respect to which quality					
	assessment and assu						
	necessary; and						
	(ii) Develon and imple	ement appropriate plans of					
		tified quality deficiencies;					
		mation. A State or the					
		quire disclosure of the nittee except in so far as					
		ated to the compliance of					
	such committee with	the requirements of this					
	section.						
1							

Facility ID: 953418

If continuation sheet Page 21 of 24

	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		ATE SURVEY
						R-C
		345008	B. WING		(04/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOLDEN I	IVINGCENTER - DARTM	лоцтн		300 PROVIDENCE ROAD		
				CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
{F 520}	{F 520} Continued From page 21		{F 52	0}		
	by: Based on observation physician/nurse praction interviews and review records, the facility's Assurance (QAA) con- implemented procedure interventions that the May 2016. This was fit was originally cited A Recertification/Complet subsequently recited Recertification/Complet Revisit/Complaint sur- the area of housekee services. The facility's implemented procedure interventions that the March 2017. This was was originally cited in Recertification/Complet subsequently recited Revisit/Complaint sur- the area of notification failure of the facility di- record show a pattern sustain an effective C Findings included:	and correct quality e used as a basis for is not met as evidenced ns, resident interviews, itioner interviews, staff of medical and facility Quality Assessment and nmittee failed to maintain ures and monitor these committee put into place in for 1 recited deficiency that pril 2016 on a laint survey and on the facility's current laint survey and a vey. The deficiency was in ping and maintenance s QAA also failed to maintain ures and monitor these committee put into place in s for 1 recited deficiency that February 2017 on a laint survey and on the facility's current vey. The deficiency was in n of changes. The continued uring 3 federal surveys of n of the facility's inability to quality Assurance Program.		 This Plan of Correction consuration allegation of complial deficiencies cited. However of this Plan of Correction is a admission that a deficiency one was cited correctly. Thi Correction is submitted to marequirements established by Federal law. F-520 All residents have the potential affected. The Executive Director and Nursing received education process by the Corporate CI Team, education was completed on 4/27/17 addrest citations. The QAPI committee will be at least, monthly and/or as maddress all identified areas i quality assessment and assis activities for the purpose of itematical and the purpose of itematical and the purpose of the purpose	nce for the submission not an exists or that s Plan of eet o State and tial to be Director of on the QAPI inical Support eted on was ssing 2567 gin meeting, needed, to n respect to urance mplement	
	This tag is cross refer	rred to:		appropriate plans of action to	o correct	

Event ID: NB8V12

Facility ID: 953418

If continuation sheet Page 22 of 24

						NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	ATE SURVEY OMPLETED
			A. BUILDING	2		R-C
		345008	B. WING			04/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		04/10/2017
				300 PROVIDENCE ROAD		
GOLDEN	LIVINGCENTER - DARTI	MOUTH		CHARLOTTE, NC 28207		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION DATE
{F 520}	Continued From page	e 22	{F 520)}		
		nurse practitioner interview,		QAPI will be held monthly	on the 3rd	
		eview of the medical record,		Wednesday at 11:00 AM.	,	
	the facility failed to no	otify the physician or nurse				
		ficant weight gain for		All plans of action initiated		
		f 4 sampled residents		will be monitored, for the p		
	reviewed for physicia	in notification.		updating, revising and/or a		
	During a Recortificati	on/Complaint survey of		ensuring compliance and Monitoring will continue for		
		ne facility was cited for failure		and then randomly therea		
		re power of attorney when a		documentation of monitori		
		cupational therapy utilizing a		brought to QAPI for evaluation	-	
	hand splint and a gua					
	-	rrent Revisit/Complaint		The Executive Director an		
		17, the facility was cited for		Nursing, under the direction	•	
		nysician/nurse practitioner of		Clinical Support Team and	-	
	significant change in	weight status.		will ensure the QAPI com addresses all identified an		
	1b. F 253 Housekeer	ping and Maintenance		quality assessment and as	•	
		observations, a resident		activities for the purpose of		
		iews and review of facility		appropriate plans of action		
	records, the facility fa	ailed to secure a loose grab		identified deficiencies. Th	e direction and	
		wall for a resident who used		monitoring of QAPI will tal		
		ndently (Resident #95),		in person and via conferen	nce call to	
		or to prevent it from scaring 95) and identify and repair 4		ensure compliance.		
		om 317) for 2 of 7 sampled				
	resident rooms obser	, ,				
				Education		
		on/Complaint survey of April				
	-	was cited for failure to		F-520 483.75(g)(1)-(iii)(2)		
		tiles, repairs holes in the		COMMITTEE-MEMBERS	/MEET	
		repair a leaking commode		QUARTERLY/PLANS		
		wall outlet covers. On the n/Complaint of February 16,		(g) Quality assessment ar	nd assurance	
		cited for failure to repair a		Facility must maintain a qu		
	-	faucets, over the bed table,		assessment and assurance	•	
		en floor tiles, door frames		consisting at a minimum c		
	and replace a missing	g drawer. On the subsequent		" DNS		
	Revisit/Complaint su	rvey of April 10, 2017, the		" Medical Director		

Facility ID: 953418

If continuation sheet Page 23 of 24

STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY COMPLETED R-C	
		345008	B. WING		04/10/201	7
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - DARTI	моитн		300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPL	(5) LETION ATE
{F 520}	floor tiles and a reside The Interim Administr Nursing (IDON) were 4:57 PM. The Interim was made aware of th the facility's February Recertification/Comp March 30, 2017. The he met with the head discussed the status to ensure monitoring he attributed the ongo needs to administrativ auditing. He also stat facility's typical practic physician/nurse pract during Weekly Risk M meetings, particularly a resident's plan of ca the Registered Dietitia 3/16/17 WRM meeting recommend a change	ailure to repair a grab bar, ent's room door. Tator and Interim Director of interviewed on 04/05/17 at Administrator stated that he he deficiencies cited during 2017 laint survey on Thursday, Interim Administrator stated of each department and of auditing/monitoring tools was ongoing. He stated that bing maintenance repair ve oversight due to a lack of ed that it was not the ce to notify the titioner of all items discussed	{F 520	At least three other members facilities staff, at lest one of who m the administrator, owner, a board to or other individual in a leadership in (g)(2) The quality assessment and assurance committee must: (ii) Develop and implement approp plans of action to correct identified deficiencies:	nust be member role; briate	

If continuation sheet Page 24 of 24

	-	ID HUMAN SERVICES				FOR	M APPROVED
		MEDICAID SERVICES					O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345008		B. WING			C 04/10/2017		
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				3	300 PROVIDENCE ROAD		
GOLDEN	LIVINGCENTER - DARTI	NOUTH		C	CHARLOTTE, NC 28207		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	Regulation (DHSR), I Certification Section I investigation at the fa Survey Agency to obt interviews to complet	cility. In order for the State					
F 157 SS=D	483.10(g)(14) NOTIF		F	157			5/2/17
	(g)(14) Notification of	Changes.					
	consult with the resid	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-					
	 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); 						
	a need to discontinue	erse consequences, or to					
	(D) A decision to tran resident from the faci §483.15(c)(1)(ii).						
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE
		SOLT ELECTED RESERVATIVE S SIGNATUR	~_		mee		
Electroni	cally Signed						04/26/2017

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.

			0.00			NO. 0938-039
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345008		· ,			(X3) DATE SURVEY COMPLETED	
			A. BUILDING	3		С
		B. WING		04/10/2017		
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		4/10/2017
GOLDEN LIVINGCENTER - DARTMOUTH				CHARLOTTE, NC 28207		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO DATE
F 157	Continued From page	e 1	F 15	7		
		ification under paragraph (g)				
		, the facility must ensure that				
		ion specified in §483.15(c)(2)				
	is available and provided upon request to the					
	physician.					
	(iii) The facility must also promptly notify the					
	resident and the resident representative, if any,					
	when there is-					
		n or roommate assignment				
	as specified in §483.	10(e)(6); or				
	(B) A change in resid	lent rights under Federal or				
		ons as specified in paragraph				
	(e)(10) of this section					
	(iv) The facility must	record and periodically				
		mailing and email) and				
		resident representative(s).				
		T is not met as evidenced				
	by:					
	Based on a physicia			This Plan of Correction consi written allegation of complian	•	
	practitioner interview, staff interviews and review of the medical record, the facility failed to notify			deficiencies cited. However,		
		e practitioner of a significant		of this Plan of Correction is no		
		lent #82, for 1 of 4 sampled		admission that a deficiency e		
		or physician notification.		one was cited correctly. This	Plan of	
				Correction is submitted to me		
	The findings included	1:		requirements established by	State and	
	Resident #82 was ad	Imitted to the facility on		Federal law.		
	Resident #82 was admitted to the facility on 12/13/16. Diagnoses included severe protein					
	calorie malnutrition, anorexia, and delusional			F-157		
		ers. His weight on admission				
	was 154 pounds.	-		Resident # 82 with significant		
				the resident's RP and MD wa		
		minimum data set dated		the residents weight gain and		
	3/3/17 revealed Resi	dent #82 was assessed with		Registered Dieticians recomm	nendation to	

Facility ID: 953418

If continuation sheet Page 2 of 6

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION	(X3) DA	10. 0938-03 FE SURVEY
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			G		COMPLETED	
	345008					С
			B. WING	0	04/10/2017	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C		•		
			300 PROVIDENCE ROAD			
GOLDEN LIVINGCENTER - DARTMOUTH			CHARLOTTE, NC 28207			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
	1			DEFICIENCY		
F 157	Continued From pag	e 2	F 15	57		
	-	memory, intact long term		change the whole milk to 2% mi	ilk for	
	memory, moderately	impaired decision-making, vision and the physical		resident # 82.		
	assistance of a staff			All residents have the potential	to he	
		in, but not on a physician		affected.		
	prescribed weight gain, regimen.					
				All residents who triggered for a	l	
	A progress note, by t	the nurse practitioner (NP),		significant weight loss/gain were	e audited	
	dated 3/7/17, assess	sed Resident #82 with an		in the weekly at risk meeting on	4/20/2017	
		ting/delusions, based on staff		by the IDT team. The residents		
		the resident's diagnoses of		weight changes were assessed	•	
		The NP's plan was to		Registered Dietician and approp		
	increase Seroquel (antipsychotic) to 200			interventions were put into place		
	-	es daily. There was no		resident's responsible parties ar	nd Medical	
		ssment regarding an		Providers were notified by the		
	increase in his weigh	it.		DON/designee of the change.		
	A nutrition data quarterly assessment by the			was completed on 4/26/2017; w		
				areas of non-compliance addres	ssea	
		ager (CDM) dated 3/7/17 #82 with a current weight of		immediately.		
		9		An in convice training on Natifier	ation of	
		ody weight range of 149 - 184		An in-service training on Notifica		
		weight gain, intact skin,		Changes was completed on 4/2 the nursing staff by the Director		
	received a regular, large portions diet and a plan to continue to monitor weight and intake.			and/or designee. The Nursing s	-	
		of weight and make.		re-educated to notify the RP and		
	A nutrition assessme	ent dated 3/16/17 by the		any changes in the resident's co		
		RD) revealed Resident #82		Staffs that were not available for		
		et with milk added at each		education were called and the e	•	
		rotein and ate approximately		was completed via telephone by		
		RD assessment indicated that		and/or designee.		
	Resident #82's current weight was 188 pounds, a 22.1% significant recent weight gain since					
				The Director of Nursing and/or of	designee	
	-	nis total food/fluid intake met		will audit 100% of changes in re		
	estimated caloric nee	eds, but not estimated		conditions daily events that requ		
	protein needs. The F	RD's recommendation was to		notification in the clinical startup		
	have nursing record	his food/fluid intake and		daily to ensure compliance; all a		
	-	since his skin was currently		non-compliance will be correcte		
		Resident #82 was that the		immediately. The Director of Nu		
	resident would contir	nue to consume adequate		and/or designee will expand mo	nitorina	

Facility ID: 953418

If continuation sheet Page 3 of 6

			0.00			IO. 0938-03	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
			A. BUILDIN	G		0	
	345008		B. WING			C 04/10/2017	
	JAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0	4/10/2017	
NAME OF P	ROVIDER OR SUPPLIER						
GOLDEN	LIVINGCENTER - DART	моитн		300 PROVIDENCE ROAD CHARLOTTE, NC 28207			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 157	Continued From pag	le 3	F 1	57			
		neet his nutrient needs.		interventions and corrective action	ons for		
				non-compliance with notifications			
		's "Weekly Risk Management		will be completed 5 times a week			
		and a "Weight Note" written		weeks, then weekly for 4 weeks,			
		lical record by the Assistant		monthly for 6 months. Ongoing a			
		ADON), revealed Resident		expanded monitoring, interventio			
		as discussed during WRM		additional corrective actions will l	be		
		3/17 and 3/16/17 with rs to include the ADON and		implemented as needed. The results of the Director of Nur	eina		
		is reweigh for accuracy and		and/or designee's audits will be r	•		
	to monitor his weight			to the QAPI committee monthly r	-		
				for three months and then quarter	•		
	Review of Resident	#82's care plan, revised on		thereafter until the QAPI committ	•		
		locumented Resident #82		determines compliance. Determ			
	had inadequate prote	ein energy intake and a body		will be recorded in the minutes of	f the		
		26.9% (obese) due to a		QAPI.			
	-	ight gain of 22.1% since					
		plan intervention included to					
	notify the physician of significant weight changes. Review of Resident #8's weight history revealed			Education			
				F-157 483.10(g)(14) NOTIFY OF	:		
	the following weights			CHANGES			
	· 12/13/16, 154 pounds · 1/11/17, 160 pounds			(INJURY/DECLINE/ROOM,ETC)) (g)(14)		
				Notification of Changes			
	\cdot 2/8/17 (reweigh), 183 pounds (16% gain)						
		88 pounds (18% gain)		A facility must immediately inform			
	· 3/29/17, 193 pound	is (20% gain)		resident; consult with the residen			
		<i>w</i> on 4/05/17 at 3:03 PM with		physician; and notify, consistent or her authority, the resident	with his		
	-			representative(s) when there is:			
	the RD revealed she attended the facility's WRM meetings and that she assessed Resident #82 with a significant weight gain of 22.1% since			Accident involving the reside	ent which		
				results in injury and has the pote			
	admission to the facility. The RD stated when she			requiring physician intervention			
		#82 on 3/16/17, she did not		A significant change in the re	esidents		
	have recommendations for changes to his plan of			physical, mental or psychosocial			
		cause although he was eating		(that is, a deterioration in health,	mental,		
	less than 100% of hi			or psychosocial status in either			
	-	m the additional milk at each		life-threatening conditions or clin	ical		
	meal and his skin wa	as intact. The RD stated "I		complications);			

Facility ID: 953418

			0.00			0938-039
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED	
			C	;		
		345008	B. WING		04/10/2017	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN LIVINGCENTER - DARTMOUTH				300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 157	Continued From page	a 4	F 15	7		
1 157			F 15	A need to alter treatment sig	mificantly	
	don't notify the physician of significant weight changes, that's up to nursing." She stated that			(that is, a need to discontinue ar		
		to continue to monitor the		form of treatment due to adverse	-	
	resident's weight stat			consequences, or to commence	a new	
				form of treatment); or		
		17 at 3:30 PM with the ursing (IDON) revealed the		A decision to transfer or disc resident from the facility.	charge the	
		etings, she did not attend		resident nom the facility.		
	the 3/16/17 WRM meeting, but that the ADON did					
	attend. The IDON stated that she expected the					
		ician of any significant				
	weight changes verbally or by documentation in the physician's communication book. Review of					
		nunication book during the				
		ere was no documentation				
	regarding Resident #	82's change in weight status.				
	An interview on 4/05/	17 at 3:46 PM with the				
		ttended the 3/16/17 WRM				
		t #82's significant weight				
		I. The ADON stated that the physician or NP of the				
	nursing did not notify the physician or NP of the significant change in weight status for Resident					
	#82 because the RD					
	expected that she wo					
	physician by writing a					
	communication book, if there was a concern with nutrition for a resident. A telephone interview with the physician for					
		ed on 4/5/17 at 4:15 PM. The				
		at he was not made aware of				
		in weight status for Resident d not say whether or not his				
		e physician stated that if				
		vere advised, documentation				
	would be available in					
	communication book					
	progress note would	be written by either the				

Facility ID: 953418

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/01/2017 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY
345008		B. WING			C 04/10/2017		
NAME OF P	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOLDEN LIVINGCENTER - DARTMOUTH					300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	that documentation w likely that neither he n The physician stated he would expect notif gain could likely be do which would need to A telephone interview at 1:43 PM with the N that the NP was not a change in weight stat stated that typically th significant changes for note in the physician! due to multiple recent staff, Resident #82 m The NP stated that sh Resident #82 experies hallucinations, but sh not she ordered an an this. The NP further s antipsychotic, that co weight gain and she	The physician stated that if ras not available, then it was nor the NP, were advised. that for a 22% weight gain ication because the weight ue to swelling/edema/fluid be assessed. was conducted on 4/10/17 IP. The interview revealed idvised of a significant us for Resident #82. The NP ne facility would advise of or a resident by leaving a s communication book, but t changes in administration ay have been overlooked.	F	157			

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