STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff and physician interviews the facility failed to notify the physician for a resident with a change in condition with increased confusion and pain for 1 of 4 sampled residents with a change in condition. (Resident #12) The findings included: Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the admission Minimum Data Set ((MDS) dated [DATE] indicated Resident #12 was moderately impaired in cognition for daily decision making and required extensive assistance by staff for activities of daily living. A review of admission physician's orders [REDACTED]. [MEDICATION NAME] 100 milligrams (mg) by mouth three times a day for infection and inflammation of spinal hardware. [MEDICATION NAME] 2 grams intravenously daily for infection and inflammation. [MEDICATION NAME] 125 mg by mouth twice daily for infection and inflammation. [MEDICATION NAME] 25 mg by mouth daily at bedtime for [MEDICAL CONDITION]. [MEDICATION NAME] 20 mg by mouth daily for depression. Oxygen 2 liters by nasal cannula as needed to keep oxygen saturation greater than 92 percent. A review of a Nurse Practitioner progress note dated [DATE] indicated Resident #12 was a new admission with post-operative pain and had a large back dressing with a wound vac. The notes also indicated Resident #12 was up all night with pain and anxiety and her past medical history included [MEDICAL CONDITION] and anxiety. The notes revealed the assessment and plan was to start [MEDICATION NAME] 50 mg by mouth every 6 hours as needed (PRN) for pain and [MEDICATION NAME] 0.5 mg by mouth every 12 hours PRN for anxiety. A review of physician's orders [REDACTED]. Start [MEDICATION NAME] 50 mg by mouth every 6 hours PRN pain. [MEDICATION NAME] 0.5 mg by mouth every 12 hours PRN anxiety. A review of physician's orders [REDACTED]. Give [MEDICATION NAME] PRN for anxiety Add [MEDICATION NAME] ,[DATE] mg (1) tablet by mouth every 6 hours PRN for pain A review of physician's orders [REDACTED]. A review of physician's orders [REDACTED]. Schedule an appointment with an Infectious Disease Specialist as soon as possible Consult psychiatric services for depression Discontinue [MEDICATION NAME] and begin Bactrim DS ,[DATE] mg daily indefinitely for prevention of infection A review of a Nurse Practitioner progress note dated [DATE] indicated she had a question about when to stop antibiotics and an Infectious Disease Physician office was called. The notes also indicated Resident #12 was also having some issues with depression and the assessment and plan was for Resident #12 to see the Infectious Disease Physician for follow up regarding antibiotic management and stop date. The notes also indicated to obtain a psychiatric consult. A review of physician's orders [REDACTED]. Change [MEDICATION NAME] 50 mg by mouth to twice a day as scheduled doses. Discontinue [MEDICATION NAME] PRN but keep [MEDICATION NAME] ,[DATE] by mouth every 6 hours PRN for pain. A review of a Nurse Practitioner progress note dated [DATE] indicated Resident #12 was complaining of pain on a nearly regular basis and she might not be cognitively able to ask for PRN medications as much as needed. The notes also indicated she spoke with an Infectious Disease Physician and Resident #12 was to take Bactrim DS (1) by mouth daily for her lifetime for prevention of infection. The notes revealed the assessment and plan was to continue [MEDICATION NAME] PRN for pain and to discontinue [MEDICATION NAME] PRN and give [MEDICATION NAME] 50 mg by mouth twice daily for pain. A review of a psychiatric progress note dated [DATE] indicated Resident #12 was seen for depression and was lying in bed and was irritable and uncooperative. The notes indicated Resident #12 had a history of [REDACTED]. The notes further indicated psychiatric services would give about 2 weeks and if behaviors continued would consider increasing [MEDICATION NAME] for mood disorder. A review of a Nurse Practitioner progress note dated [DATE] indicated staff reported Resident #12 had increased confusion. The assessment and plan indicated acute [MEDICAL CONDITION] and obtain a urinalysis and culture and sensitivity. A review of physician's orders [REDACTED]. A Review of a Medication Administration Record [REDACTED]. A review of nurse's notes for a change in condition dated [DATE] documented by Nurse #6 indicated a note for change of condition that Resident #12 was on the floor in her room at 2:00 AM and had increased confusion. The notes indicated Resident #12's vital signs were blood pressure ,[DATE]; pulse 76; respirations 18; temperature 98.1 Fahrenheit (F) and oxygen saturation was 97 percent with oxygen on at 2 liters per minute. A review of a facility document titled Verification of Investigation dated [DATE] at 2:45 AM documented by Nurse #6 indicated Resident #12 was noted on the floor of her room at 2:00 AM and it appeared that she was throwing herself on the floor due to increased confusion. The notes further indicated Resident #12 was verbally responsive with noted increased confusion, had impaired mental status and was unable to recount event and there was no bruising or injury noted. The notes revealed vital signs were blood pressure,[DATE]; pulse 76; respirations 18; temperature 98.1 F and oxygen saturation was 97 percent on 2 liters of oxygen. The notes indicated Resident #12 had a bed and chair alarm and a fall mat in place. A review of a facility document titled Post Fall Analysis/Plan dated [DATE] at 2:45 AM documented by Nurse #6 indicated possible cause and contributing factors and observations were Resident #12 had a change in mental status with increased confusion and impaired safety awareness and judgment. A review of nurse's notes dated [DATE] at 6:17 AM documented by Nurse #6 indicated Resident #12 was verbally responsive with noted confusion. The notes further indicated Resident #12 kept throwing herself out of bed last night but had no apparent injury and neurological checks were in place. During an interview on [DATE] at 7:02 AM with Nurse #6 she confirmed she provided care to Resident #12 during the 11:00 PM to 7:00 AM shift of [DATE]. She explained Resident #12 had back pain and cried out. She stated Resident #12 had some confusion when she was admitted to the facility but it had increased during the last ,[DATE] days before she went to the physician's office. She explained she thought Resident #12 had a urinary tract infection and that was the reason for her increased confusion but the results of a urinalysis and culture and sensitivity had not been received from the laboratory. She stated it was reported to her that during the night of [DATE] Resident #12 was screaming out about things that weren't there and was hallucinating and confirmed Resident #12 had not had hallucinations before but that night was different and she was very confused. She explained at 2:00 AM Resident #12 attempted to get out of bed and threw herself onto the floor. She further explained Resident #12 had not attempted to get out of bed before that night. She stated she could not remember if she called the on-call physician during the night. A review of nurse's notes dated [DATE] at 2:41 PM documented by Nurse #1 indicated Resident #12 was alert and responsive with confusion and was waiting for results of the urinalysis culture and sensitivity report. During an interview on [DATE] at 10:45 AM with Nurse #1 she explained she was assigned to care for Resident #12 on the 7:00 AM to 3:00 PM shift on [DATE]. She stated she worked part time so she did not know Resident #12 very well but she remembered Resident #12 was screaming at times but she was on scheduled pain medications. She stated she did not remember calling the Physician or Nurse Practitioner on [DATE] during her shift. A review of nurse's notes dated [DATE] at 6:18 PM documented by Nurse #7 indicated Resident #12 was alert and awake with confusion and continued to yell out after her fall and there were no signs or symptoms of new injury. A review of vital signs dated [DATE] at 10:00 PM indicated blood pressure ,[DATE]; pulse 78; respirations 17; temperature 98.1 degrees F and oxygen saturation was 97 percent. During a telephone interview on [DATE] at 8:59 AM with Nurse #7 she explained she was assigned to the care of Resident #12 during the 3:00 PM to 11:00 PM shift on [DATE] and remembered the resident was confused. She stated she was

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

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.

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F 0157 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) told in the shift report by Nurse #6 that Resident #12 had a fall during the night around 2:00 AM. She explained Resident #12 was at risk for falls because she was confused and she was strong enough to roll herself out of bed. She further explained there were mats on the floor next to her bed but she did not have side rails to stop her from rolling out of bed. She stated Resident #12 would state help me, help me and she seemed to be agitated. She further stated she explained to Resident #12 it was the 3:00 PM to11:00 PM shift but she didn't understand it and she had no clue of who or what was going on or where she was. She explained that was the only time she provided care to Resident #12. She stated during the shift Resident #12 screamed really loud and she went to her room and took a NA with her and they calmed her and later she went to sleep for a while. She described Resident #12's screaming was more like she was scared because she was not sure where she was and it was worse when she was alone in her room. She stated she did not remember if she checked vital signs or documented assessment information and confirmed she did not call the Physician or Nurse Practitioner. A review of nurse's notes dated [DATE] at 7:35 AM documented by Nurse #8 indicated Resident #12 was alert with periods of confusion after her fall. During a telephone interview on [DATE] at 5:30 PM with Nurse #8 she stated she was assigned to care for Resident #12 during the 11:00 PM to 7:00 AM shift. She explained she began her shift on [DATE] at 11:00 PM and finished her shift at 7:00 AM on [DATE]. She explained she did not routinely provide care to Resident #12 because she worked on different nursing units. She stated she did not call the Physician or Nurse Practitioner. A review of nurse's notes dated [DATE] at 8:59 AM documented by Nurse #9 indicated Resident #12 was in a lot of pain in her back. The notes further indicated Resident #12 was screaming out it hurts, my back and [MEDICATION NAME] was given due to resident screaming out in pain and she had a doctor's appointment at 10 AM. A review of nurse's notes dated [DATE] at 10:03 AM documented by Nurse #9 indicated Resident #12 was out for an appointment at 10 AM to an Infectious Disease Physician. The notes further indicated oxygen was on at 2 liters per minute by nasal cannula provided by non-emergent medics and Resident #12 was alert but appeared intermittently confused. During a telephone call on [DATE] at 8:59 AM with Nurse #9 she confirmed she was assigned to care for Resident #12 on the 7:00 AM to 3:00 PM shift on [DATE]. She explained when staff moved Resident #12 she cried out in pain and she confirmed she gave [MEDICATION NAME] to Resident #12 that morning because her orders for pain medication had been changed. She stated the pain medication was changed to scheduled medication times and since she had already received it earlier that morning at 6:00 AM she couldn't give it to her again until the next dose was scheduled to be given. She further stated Resident #12 did not have an order for [REDACTED].#12 had an appointment to see a Physician that morning. A review of an emergency medical transport report dated [DATE] at 10:46 AM indicated arrived to facility to transport Resident #12 to an Infectious Disease Physician appointment. The crew reported the facility reported Resident #12 was at her baseline mental status but the Infectious Disease Physician reported Resident #12 was not at her baseline mental status and he was concerned and wanted her to be transported to the hospital for evaluation. The report indicated Resident #12 could state her name but had severe tremors to her upper body and upper extremities. The assessment notes revealed at 10:50 AM Resident #12 was on oxygen at 6 liters per minute and at 10:56 AM her blood pressure was ,[DATE], pulse 100 and respirations 18. The report also indicated Resident #12 left the physician's office by medical transport at 11:04 AM and arrived at the hospital emergency room at 11:07 AM. A review of a laboratory report dated [DATE] for a urinalysis and culture and sensitivity indicated results of rare bacteria and moderate amounts of yeast. A handwritten note on the bottom of the results indicate Resident #12 was currently on Bactrim DS ,[DATE] mg daily by mouth and the Nurse Practitioner was notified on [DATE] at 10:50 AM. A review of nurse's notes dated [DATE] at 11:34 AM documented by the Director of Nursing (DON) indicated a nurse from the Infectious Disease Physician's office called and reported Resident #12 was sent to the hospital emergency room due to unresponsiveness. During a telephone interview on [DATE] at 1:14 PM the Infectious Disease Physician stated he had been told by one of his physician partners that Resident #12 had died in the hospital on [DATE] at 2:02 AM. He explained her admitting [DIAGNOSES REDACTED]. He further explained he had seen Resident #12 about a month ago during a previous hospital admission because she had infected hardware due to back surgery and she was alert at that time. He confirmed he saw Resident #12 when she came to his office on [DATE] and she was minimally awake but was not responsive and she was receiving oxygen but her saturation percentage was 88% and her blood pressure was low at ,[DATE], pulse 64, respirations 26 and her temperature was 97.6 F. He explained he talked to emergency medical transport and they said when they picked the resident up she was on oxygen at 2 liters per minute but they had to increase her oxygen because her oxygen saturation percentage was in the low to mid 80's and she was minimally responsive. He stated he took a quick look at Resident #12 and told emergency medical transport personnel to take her to the hospital emergency room . He explained after Resident #12 left the office he had his staff call the facility and they were told Resident #12 was a little confused when she left the facility. He stated he received no notes from the facility and had no indication of what had happened with Resident #12. He further stated the last time he saw Resident #12 about a month ago she was alert and awake. He confirmed his office was just down the street from the facility so Resident #12's transport would have only taken minutes. During an interview on [DATE] at 9:30 AM the facility Medical Director stated he only saw Resident #12 once on [DATE] but his Nurse Practitioner saw her routinely and kept him informed of Resident #12's condition. He explained Resident #12's biggest problem was infected hardware in her back but she also had a lot of medical conditions and was getting intravenous antibiotics and was followed by an Infectious Disease Specialist who managed the infected hardware in her back. He stated the Nurse Practitioner had questions about the antibiotics and did not want to make decisions about them on her own so she called the Infectious Disease Physician for his recommendations and he wanted to see Resident #12 at his office on [DATE]. He explained it was his expectation for nursing staff to assess residents who had a change in condition and call the physician. He stated a Physician or Nurse Practitioner was available by phone or pager 24 hours a day and there was no excuse for them not being notified. He stated he was not aware of Resident #12's increased confusion and pain and nursing staff should have called them regarding Resident #12's pain since pain medication had already been given on [DATE] and [MEDICATION NAME] was not indicated for pain. He further stated he couldn't speak to whether Resident #12's outcome would have been different but he expected staff should have called to discuss pain, medications and assessment of the resident because the chances of recovery were better the sooner he was notified. During an interview on [DATE] at 10:43 AM the Nurse Practitioner stated she was not aware of Resident #12's increased confusion and pain and she expected that nursing staff should have called her to explain Resident #12 had pain medication at 6:00 AM on [DATE] but was screaming in pain and she would have given orders for pain medication. She further stated pain medication could have been given since it had been about 3 hours since her last dose. She explained she was not aware of Resident #12's fall out of bed on [DATE] at 2:00 AM. She stated there was a communication book at the nurse's station where nursing staff documented concerns to the physician and she did not see any documentation about the fall. During an interview on [DATE] at 5:15 PM the Director of Nursing stated it was important for nursing staff to be timely in contacting the physician and responsible party and they should be proactive with a resident who had a change in condition. She further stated it was her expectation as soon as staff noticed a change in condition or were told of a change in condition they needed to act immediately. She also stated she expected nursing staff to assess residents for pain and if their pain was not relieved by medication or they did not have an order for [REDACTED].
F 0242 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure each resident has the right to have a choice over activities, their schedules and health care according to his or her interests, assessment, and plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record reviews, staff and resident interviews, the facility failed to honor a resident's choice of the time for getting up in the mornings (Resident #29) and failed to honor a resident's food preferences (Resident #105) for 2 of 5 sampled residents who were reviewed for choices. The findings included: 1) Resident #29 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #29 was cognitively intact, was capable of making her needs known and not having rejected care. Further review of the MDS revealed Resident #29 was coded as having the choice of her awake and sleep times as very important to her. The MDS indicated Resident #29 needed extensive physical assistance of 1 person for bed mobility and transfer. An interview was conducted on 04/27/15 at 4:06 PM with Resident #29. She stated she wanted to be out of her bed between 9:00 AM and 9:30 AM every day. She indicated the Nurse Aides (NAs) would not get her up most days until 11:00 AM and that when she pushed her call light and had asked them to get her up they would tell her they would as soon as they had time. An observation on 04/29/15 at 9:59 AM of Resident #29 revealed her room door to be opened. She was sitting up in her bed, watching everyone that passed in the hallway, and if an NA walked by her room she would call the NA by name and state I'm ready to get up. The NA responded back to Resident #29 I will be there in just a few minutes. An observation on 04/30/15 at 10:11 AM of

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F 0242 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Nurse #4 revealed she went into Resident #29's room, answered her call light, and the resident asked to be gotten out of bed. Nurse #4 was observed to leave Resident #29's room and informed NA #3 that Resident #29 had requested to be gotten out of bed. On 04/30/15 at 10:43 AM, NA #3 and NA #4 were observed assisting Resident #29 from her bed to the shower chair. An observation on 05/01/15 at 10:58 AM of Resident #29 revealed her room door to be opened. She was sitting up in her bed, and called out to Nurse #4 that she wanted to get out of bed. Nurse #4 was observed to advise NA #3 of Resident #29's request to be gotten out of bed. NA #3 reported to Nurse #4 that she would get Resident #29 up as soon as she had finished with another resident. An interview was conducted on 05/05/15 at 11:20 AM with NA #4. She indicated she assisted NA #3 with getting Resident #29 out of bed but was unaware that Resident #29 wanted to be out of bed in the mornings by 9:00 or 9:30 AM. She stated the NAs were expected to get the residents out of bed before first shift staff came in at 7:00 AM unless a resident had chosen to be gotten up later. An interview was conducted on 05/05/15 at 11:31 AM with NA #3. She stated she was unaware Resident #29 wanted to be out of bed by 9:00 AM or 9:30 AM every morning. NA #3 indicated Resident #29 usually requested to be gotten up after she finished her breakfast which was between 9:00 AM and 930 AM. She further indicated if a resident chooses a specific time to be gotten up the time would be specified on the NAs resident care guide. NA #3 verified that the resident's care guide did not specify the time the resident chose to get out of bed every morning. NA #3 stated she always tried to honor Resident #29's request to be gotten out of bed but there were times when she would be too busy. An interview was conducted on 05/07/15 at 12:25 PM with Nurse #4. He verified on the nurses care guide there was not a particular time listed for Resident #29 to be gotten up. He stated all the residents were supposed to be gotten up before every meal and Resident #29 had requested to be gotten up after her breakfast meal which would be around 9:00 AM to 9:30 AM. Nurse #4 further stated when Resident #29 called out and requested to be gotten up he would have informed the NAs and that it was his expectation for the NAs to have gotten Resident #29 out of bed. An interview was conducted on 05/07/15 at 4:31 PM with the Director of Nursing (DON). She revealed the time preferences that a resident wanted to get up in the mornings was supposed to be honored and that it was her expectation for the NAs to have gotten Resident #29 out of bed between 9:00 AM and 9:30 AM each morning. She stated her expectation was for the resident's preferences to honored according to their wishes. 2. Resident #105 was admitted to the facility 10/03/14. [DIAGNOSES REDACTED]. Review of the list of food dislikes per menu items for Resident #105 revealed the facility had approximately 726 foods documented that Resident #105 disliked to include cream of wheat, rice/broccoli casserole, and rice. Review of a dietary progress note dated 12/08/14 revealed the registered dietitian (RD) updated Resident #105's snack preferences that day. There was no documentation that Resident #105's meals preferences were also updated. Resident #105 was admitted to Hospice services on 12/12/14 with a physician's orders [REDACTED]. A quarterly Minimum (MDS) data set [DATE] assessed Resident #105's cognition as intact, indicated he was independent with eating and had a poor appetite. Review of the care plan, revised 03/09/15, revealed Resident #105 received a mechanical soft, consistent carbohydrate diet with fortified foods due to the [DIAGNOSES REDACTED]. Care plan interventions included comfort foods, food substitutes and snacks between meals, as requested. Resident #105 was observed on 04/29/15 at 12:49 PM feeding him self lunch. He received chopped chicken, peas/carrots, mashed potatoes, cake, coffee and lemonade. The tray card did not record any food preferences. Resident #105 stated during this observation that he did not receive applesauce with his meal. Resident #105 was observed on 05/01/15 at 8:56 AM feeding him self breakfast. He received French toast with syrup, scrambled eggs, oatmeal, sausage, orange juice, coffee, and whole milk. Resident #105 confirmed again that he did not receive applesauce and stated Yeah I would eat it (applesauce) if they would give it to me, but I don't always get it. Resident #105 was observed on 05/01/2015 at 1:17 PM in the 2nd floor dining room feeding him self lunch. He received a hamburger on a bun, cabbage, roasted red skinned potatoes, iced tea, coffee, whole milk, water, and banana cake. Applesauce was not provided with this meal. An interview with nurse aide (NA) #3 on 04/29/2015 at 11:36 AM revealed she was familiar with Resident #105 and that she had worked with him for a few months. NA #3 stated Resident #105 was able to make his needs known and often complained about the food. NA #3 stated an example was breakfast that morning (04/29/15), she stated Resident #105 did not like cream of wheat, but for some reason he continued to receive cream of wheat with his breakfast meals, as he did that morning. NA #3 stated that Resident #105 ate all of his breakfast except the cream of wheat and reminded her that he did not like cream of wheat. NA #3 stated she would offer to get him something else when this happened, but it happened a lot. Review of the breakfast tray card for Resident #105 revealed his breakfast meal should have included grits. A follow up interview with NA #3 on 05/04/2015 at 3:05 PM revealed Resident #105 did not receive applesauce for breakfast or lunch that day (05/04/15) and that applesauce had not been provided to him for breakfast or lunch for a while. NA #3 further stated that for lunch he received a hamburger on a bun, rice, broccoli, tea, and milk. NA #3 revealed that Resident #105 ate the hamburger but did not eat the rest of his food because he said he did not like it. Review of the list of food dislikes per menu item revealed rice and broccoli were listed as foods he disliked. During an interview with the director of food service (DFS) on 05/01/2015 at 5:51 PM, the DFS revealed that when Resident #105 was admitted the foods he disliked were entered into the computer in error and totaled approximately 50 pages of food items. The DFS stated this list had not been updated since Resident #105 was admitted to the facility in October 2014 and could explain why his tray card did not accurately reflect his food preferences and why he received foods he did not like and did not receive foods that he did like. The DFS also stated that because Resident #105 had so many disliked foods in the computer, his tray card did not print his food preferences. The DFS stated food preferences were obtained on admission and updated during quarterly care plan meetings, food committee meetings, resident council meetings, when the menu changed and when concerns were voiced by the resident/family. The DFS also stated that Resident #105 had voiced concerns to her about his food preferences. The DFS further stated that during a recent care plan meeting (she could not recall the date), family of Resident #105 requested he receive applesauce, for breakfast and lunch, because he liked it, but since his food preferences were not updated, applesauce did not print on his tray card, and dietary staff would not know to provide it. The DFS stated Resident #105 should have received his diet as ordered with his food preferences honored to include applesauce with the breakfast and lunch meals. During an interview on 05/05/2015 at 1:52 PM the RD reported that Resident #105 was to receive comfort foods as he requested per a 12/12/14 physician's orders [REDACTED]. After a review of Resident #105's weight history during the interview, the RD stated that his weight was currently stable. The RD further stated that when she assessed Resident #105 in December 2014 and spoke to him about his snack preferences, she knew he had a lot of foods he disliked, but that his meal preferences were not discussed. The RD stated that the goal for Resident #105 was to provide him with a diet as ordered by the physician and to honor his food preferences. During an interview on 05/05/2015 at 6:38 PM the director of nursing (DON) reported that she expected residents to receive their diet as ordered by the physician and according to their preferences. The DON further stated that she expected nursing staff to review the resident's tray card when they set up the meal to make sure the resident received all food items as per the tray card, if something was missing, the DON stated nursing staff should call the dietary department to have that food item provided to the resident.
F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, and facility documentation, the facility failed to provide a communication board to accommodate the needs of 1 of 1 sampled resident reviewed for accommodation of needs. (Resident #80) The findings included: Resident #80 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #80 had no short term or long term memory problems, was cognitively intact for daily decision making and required limited to extensive assistance with skills for activities of daily living. The MDS further revealed Resident #80 was occasionally incontinent of bladder and frequently incontinent of bowel and her preferred language was Spanish. Review of a care plan for Resident #80 dated 01/20/15 revealed she was non-English speaking and the resident was to use a communication board with pictures to communicate with staff. Review of the Care Card dated 5/1/15 located at the nursing station revealed Resident #80 was to have a communication board. During an observation on 04/29/15 at 12:50 PM Resident #80 was in her bed with the head of the bed in sitting position and staff was assisting her with setting up her lunch tray. Staff asked the resident if she needed any help with her lunch and the resident did not answer the staff and staff left the room after they opened her milk carton. Resident #80 drank her tea and staff returned to ask her if she needed any help with her tray but she did not answer the staff. There was no communication board used to communicate with this resident. During observation on 04/30/15 at 5:00 PM Resident #80 was in her wheelchair at a table in dining room and staff placed a dinner tray in front of resident and asked if the resident needed any help. Resident #80 did

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F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) not respond and staff began removing a lid from a cup of ice tea and cut up resident's meat. The staff member continued to talk to Resident #80, but she did not respond. There was no communication board to communicate with Resident #80. During observation on 04/30/15 at 8:34 AM Resident #80 was in her bed and staff knocked on her door and called Resident #80 by name and delivered the breakfast tray and placed the tray on the bedside table. At no time did the staff member use a communication board to communicate with the resident. During an observation on 05/01/15 at 09:40 AM Resident #80 was lying in the bed on top of her covers. There was no communication board visible in the room. During an interview on 05/01/15 at 12:35 PM with Nurse #3 she revealed Resident #80 was Spanish speaking and she was able to communicate with the resident using sentences that required short answers such as yes or no answers. Nurse #3 stated she was not aware the resident was to have a communication board in her room. The nurse looked at the nurses' station and was not able to locate a communication board for Resident #80. Nurse #3 stated she could communicate with Resident #80 using short open ended questions. Nurse #3 further explained there was another Spanish speaking resident with family on the hall that helped Resident #80 and staff communicate and Resident #80's son could be reached by phone and he would help to translate. During an interview on 05/01/15 at 12:45 PM with Nurse Aide #1 she revealed Resident #80 was Spanish speaking and could communicate using simple terms such as yes or no questions. She stated there was another Spanish speaking resident down the hall and the family would help translate for Resident #80 and staff. She stated she was not aware they were supposed to use a communication board to communicate with Resident #80. She stated the information about the resident's care was located on an information sheet called the Care Card and confirmed under special needs was written communication board for Resident #80. During an interview on 05/05/15 at 12:44 PM with Director of Rehabilitation Services she revealed Resident #80 was supposed to have a communication board with pictures. She stated the staff and the resident had been instructed on how to use the communication board and it was created by speech therapy and it was care planned and put on the Care Cards. She stated she expected staff to read the Care Card and do what the Care Card stated and the care plan and the Care Card are put in place so the staff will know how to take care of the residents. During an interview on 05/06/15 at 12:47 PM with the Director of Nursing she revealed her expectations were for staff to use a communication board for residents who were identified as requiring the use of a communication tool. She stated speech therapy would make a communication board for the residents and the need for the communication board would be placed on the care plan and on the Care Cards. She explained she expected her staff to read the care plan and the Care Cards and follow the plan of care for that resident.
F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet the interests and needs of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews the facility failed to provide activities for 2 of 4 sampled residents reviewed for activities. (Resident #82 and #76). The findings included: 1. Resident #82 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of a quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #82 was severely impaired in cognition for daily decision making. The most recent quarterly MDS dated [DATE] indicated a dash in each of the sections for cognition for Resident #82. A review of a facility document dated 06/06/14 which was an annual Recreation Services Assessment for Resident #82 indicated interests were bingo, walking, religious, programs, gospel music, gardening, magazines newspapers sitting on the porch shopping, bible study, church and visitors, which included activities with friends and family, in large or small groups. An observation on 04/29/15 revealed a large activity calendar posted on a bulletin board across from nurses station on the third floor which indicated activities for today as follows: 9:00 AM Morning news and 10:30 AM Bible knowledge. An observation on 04/29/15 at 9:17 AM revealed Resident #82 was in bed in her room with her eyes closed. A television was located in the corner in the living room on the third floor that was turned on and had a blue screen and there was no sound. There was no radio turned on in the room and there was no morning news. Resident #82 was observed in her room in bed with her eyes closed. An observation on 04/29/15 at 10:05 AM revealed an announcement was made that bible study would be at 10:30 AM on the second floor and staff were to assist residents but there was no announcement about activities on third floor. A television was turned on in the living room on the third floor with community service announcements scrolling continuously across the screen but no sound was turned on. An observation on 04/29/15 at 10:35 AM revealed Resident #82 was observed lying in bed in her room and there was no activity in the living room on the third floor. An observation on 04/30/15 at 8:07 AM revealed the activity calendar posted on a large bulletin board on third floor indicated the activities for the day would be 9:00 AM morning news and 10:00 AM movie matinee. An observation on 04/30/15 at 9:05 AM revealed a television in the living room on the third floor was turned on to a twenty four hour news channel and the sound was turned off. Resident #82 was observed in her room in bed. An observation on 04/30/15 at 10:04 AM revealed an announcement was made for a movie to be in the living room on the third floor and for staff to assist residents to attend. Resident #82 was observed in bed in her room. An observation on 04/30/15 at 10:13 AM revealed the Activity Director turned the movie on in the living room on the third floor. Resident #82 was still in her room in bed and no staff were observed to enter her room or ask if she wanted to see a movie. An observation on 04/30/15 at 11:10 AM revealed the movie was still on in the living room on the third floor and Resident #82 was still in bed in her room. An observation on 05/01/15 of the activity calendar on the third floor bulletin board indicated 10:00 AM trivia. An observation on 05/01/15 at 10:10 AM revealed there was no trivia activity on the third floor and Resident #82 was still in bed in her room. During an interview on 05/05/15 at 10:10 AM Nurse #12 she explained she had not observed Resident #82 in group activities and had not observed her in individual activities. She explained residents who lived on the third floor had dementia or [MEDICAL CONDITION] and staff could not transport the residents to other floors for activities because they were at risk for wandering or had behaviors in groups. She stated the television was turned on in the living room at times on the third floor but most residents did not realize the television was on and Resident #82 could not sit still to watch television. During an interview on 05/05/15 at 10:45 AM with a restorative aide she explained the third floor was the Alzheimer's unit and she had worked in the past as an activity assistant and provided activities specifically for them. She explained they used to provide activities such as memory magic and coloring books and puzzles for the residents on the 300 hall but those activities were no longer provided. During an interview on 05/06/2015 10:20 AM with the Activity Director she explained she began her position several months ago. She explained Resident #82 had an annual activity assessment completed 06/06/14 and she had indicated she liked bingo, walking, religious, programs, gospel music, gardening, magazines newspapers sitting on the porch shopping, bible study, church and visitors, which included activities with friends and family, in large or small groups. She explained she did not keep records when residents participated in activities. She explained Resident #82 could not leave the 300 hall because she displayed inappropriate behaviors when placed in large group settings. She explained most activities were held on the 2nd floor and she stated the same activity calendar was posted on each floor and there was no activity calendar that was created for residents who lived on the third floor. 2. Resident #76 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident# 76's significant change Minimum Data Set ((MDS) dated [DATE] revealed an assessment of severely impaired cognition. The MDS indicated Resident #76 usually understood others and usually was understood by others. The MDS listed Resident #76's activity preferences included listening to music, spending time outdoors, and participating in religious activities. Review of Resident #76's care plan dated 04/08/15 revealed a focus area in activity participation. Interventions included enjoyment listening to music, watching television, and one to one activities in small groups. Review of the facility's April 2015 activity calendar revealed the following schedule: Morning News at 9:00 AM each day Monday through Friday; Monday, 04/27/15: Nails at 10:00 AM, Plant a Seed at 2:30 PM and 3:30 Babe Ruth trivia; Tuesday, 04/28/15: crafty corner at 10:30 AM and a movie at 3:00 PM; Wednesday, 04/29/15: Bible knowledge at 10:30 AM and choose your meal at 2:30 PM; and Thursday, 04/30/15: movie at 10:00 AM and plant a seed at 2:30 PM. Observations revealed the following: · 04/27/15 at 9:03 AM: Resident #76 was seated in a wheelchair in the activity area with the television (TV) tuned to a twenty four hour news channel. · 04/27/15 at 9:50 AM: Resident #76 was seated in a wheelchair with his back away from the TV, which was tuned to a twenty four hour news channel. Resident #76 said hello when greeted. · 04/27/15 at 10:55 AM: Resident #76 was seated in the second floor activity room asleep in a wheelchair. The TV was tuned to a twenty four hour news channel. · 04/27/15 at 3:30 PM: Resident #76 was asleep in a low bed. · 04/28/15 at 10:48 AM: Resident #76 was seated in a wheelchair in the activity room. Resident #76 opened and closed his eyes. A western was on the TV. · 04/29/15 at 8:57 AM: Resident #76 was seated in a wheelchair holding an empty paper cup. The TV was on a twenty four hour news station. · 04/29/15 at 9:25 AM: Resident #76 replied hello, I am fine, seated in a wheelchair in the activity room. Resident #76 closed both eyes and placed his chin on his chest. The TV was on a twenty four hour news channel. · 04/29/15 at 9:58 AM: Resident #76 remained

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	345008	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 0248 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) seated in a wheelchair in the activity area with his back to the TV and watched people in the hallway. · 04/29/15 at 10:18 AM: Resident #76 slept in the wheelchair in the activity area. · 04/29/15 at 10:29 AM: Resident #76 crossed and uncrossed both legs seated in the wheelchair which faced the hallway. Resident #76 replied hi when addressed. · 04/29/15 at 10:30 AM: An overhead pager announced an activity of puzzles on the second floor. The activity did not occur on the second floor. · 04/29/15 at 10:58 AM: Resident #76 consumed 100% of a liquid supplement and reported it tasted good. · 04/29/15 at 11:08 AM: Resident #76 held his head in both hands seated in a wheelchair in the activity area. The TV was on a twenty four hour news channel. · 04/29/15 at 11:21 AM: Resident #76 faced the trash can in his wheelchair in the activity area. · 04/29/15 at 11:43 AM: Nurse Aide (NA) #2 transported resident #76 to the dining room. · 04/29/15 at 12:26 PM: Resident #76 consumed the lunch meal seated alone at a table without conversation. · 04/29/15 at 12:52 PM: Resident #76 was seated in a wheelchair in the activity area. Resident #76 folded both arms across the chest, placed his chin on his chest and stated, I am fine. The TV was on a twenty four hour news channel. · 04/29/15 at 1:03 PM: Resident #76 self-propelled to the edge of the activity area and watched the hallway. · 04/29/15 at 1:39 PM: Resident #76 was asleep in a low bed in the room. · 04/30/15 at 8:15 AM: Resident #76 was in the dining room independently eating the breakfast meal. There was no one else seated at the table. Interview with NA #2 on 04/30/15 at 8:55 AM revealed Resident #76 ate every meal in the dining room. NA #2 reported Resident #76 spent waking hours in the activity room. NA #2 explained she did not know if Resident #76 enjoyed TV but Resident #76's usual routine was to go to the dining room for meals and remain in the activity room when awake. NA #2 did not know the type of activities Resident #76 enjoyed. Observation on 04/30/15 at 9:05 AM revealed NA #3 transported Resident #76 from the dining room to the activity area and positioned the wheelchair away from the TV. Interview with NA #3 on 04/30/15 at 9:07 AM revealed Resident #76 sat in the activity area during the day and ate meals in the dining room. NA #3 explained Resident #76 self-propelled on the unit. NA #3 did not know the type of activities Resident #76 enjoyed. Observation on 04/30/15 at 9:43 AM revealed Resident #76 seated in the activity area with both eyes closed. Resident #76 faced the hallway and the TV was on a twenty four hour news channel. Observation on 04/30/15 at 11:09 AM revealed Resident #76 asleep in the wheelchair in the activity area. Interview with Nurse #1 on 04/30/15 at 11:16 AM revealed Resident #76 remained in the activity area during the day. Nurse #1 reported she did not know if Resident #76 participated in activities. Nurse #1 explained she did not know Resident #76's preferences for activities. Telephone interview with Resident #76's family member on 04/30/15 at 1:07 PM revealed Resident #76 worked many hours as a truck driver and enjoyed doing minor mechanical and electrical repairs. Interview with the Activity Director (AD) on 05/04/15 at 2:07 PM revealed she recently began her position several months ago and could not provide information regarding Resident #76's activity involvement. The AD explained Resident #76 should receive one to one visits. The AD provided the April 2015 calendar for review. The AD reported room visits were scheduled on 04/14/15 at 10:00 AM and on 04/21/15 at 10:00 AM but did not know if Resident #76 received a visit. The AD explained an oversight occurred and Resident #76 should be invited to the movies shown at the facility. The AD reported Resident #76 could participate in an activity program which consisted of his activity preferences of movies, music and enjoyment of outdoors.
F 0253 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Provide housekeeping and maintenance services.** Based on observations, staff interviews and facility record review, the facility failed to keep walls, doors, baseboards and residents' furniture in good repair for 9 of 22 rooms (203A, 206A, 204A, 206B, 210A, 208B, 215B, 219B, 216B) observed on the 200 hall and 1 of 1 dining rooms on the 300 hall. The findings included: On 04/27/15 at 11:34 AM observation revealed the following environmental concerns: 1. 200 Hall a. On 04/27/15 at 11:34 AM observation of room 203A revealed the wall with scrapes and chipped paint noted on door entrance to room marked with a red marker that read, seasons. b. On 04/27/15 at 11:45 AM observation of room 206A revealed walls on both side of bathroom door with chipped paint and scuffs. Additionally, this room was noted with the wall on the right side of the door going out of the room with multiple scrapes and peeled paint. c. On 04/27/15 at 3:32 PM observation of room 204A noted walls in room on each side of bathroom doors with scrapes and chipped paint. d. On 04/27/15 at 4:18 PM observation of room 206B noted the door and walls at bathroom with multiple scrapes and peeled paint. e. On 04/28/15 at 8:13 AM observation of room 210A revealed walls with chipped paint, scrapes on walls on bedroom door and bathroom walls chipped with multiple scratches. f. On 04/28/15 at 9:04 AM observation of room 204A noted the walls scratched with chipped paint. g. On 04/28/15 at 10:25 AM observation of room 208B revealed area of baseboard peeled and chipped with a dirty wall above floor board. 2. 300 Hall On 04/27/15 at 12:00 PM observation in dining room noted cove molding missing on the floor on the 300 hall. 3. Furniture with broken handles: a. On 04/27/15 at 8:22 AM observed room #215B noted three drawers with bottom handles broken and no handles on tall wardrobe and four nightstand drawers with broken handles. b. On 04/27/15 at 8:09 AM observed room #219B noted a tall wardrobe in room with paint peeled on dresser. c. On 04/27/15 at 10:28 AM observed room #216B noted a wardrobe against wall with both handles broken. A review of the sanitation report dated 02/13/15 revealed a score of 86.5. Interview conducted with the maintenance director on 05/05/15 at 3:50 PM indicated work orders were checked daily and some repairs were still needed. An interview was conducted on 05/01/15 at 9:40 AM with the maintenance director and he explained that staff and residents report maintenance problems to him directly or it is entered in the system at the nursing station. The maintenance director explained he reviewed the repairs entered in the computer system daily and prioritized the work request and life safety issues first. He further stated, there was a definitive plan in place to replace furniture and cosmetics of the facility. He stated it was his expectation that residents were provided an environment that was safe and he expected to be notified of any needed repairs. An interview was conducted with administrator on 05/05/15 at 5:15 PM, he stated orders were made for furniture in December 2014, but the furniture was no longer on order and there was not a current order for furniture. During the interview, he stated the expectation was for maintenance to keep all equipment in functional condition at all times.
F 0272 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Conduct initial and periodic assessments of each resident's functional capacity.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews, the facility failed to comprehensively assess 5 of 37 sampled residents identifying how their condition affected each resident's function and quality of life (Residents #42, #90, #11, #99 and #2). The findings included: 1) Resident #42 was admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] coded Resident #42 as cognitively impaired (scoring a 0 out of 15 on the brief interview for mental status), requiring extensive physical assistance of 1 person for bed mobility, eating, dressing, and personal hygiene, and 2 persons assist with transfers and toileting, and was totally dependent on staff for bathing. Further review of the MDS coded her as needing assistance of staff to balance, being frequently incontinent of urine and receiving antipsychotic medications 7 out 7 days. Review of the Care Area Assessments (CAA) dated 07/14/14 revealed the following areas were not analyzed with the MDS information to determine the resident's strengths, weaknesses, and how her condition affected those areas: a) Nutrition CAA: triggered condition due to the use of a therapeutic diet. Further review of the CAA revealed there was no documentation/analysis of causes and contributing factors to determine the reason for the therapeutic diet and no documentation specific to Resident #42. The CAA did not indicate an analysis of the findings to support the consideration to proceed or not to proceed to the care plan. b) ADL CAA: revealed there was no documentation and/or analysis related to if any of her ADLs could improve or how they affected her function and quality of life. Interview with the MDS Coordinator on 05/05/15 at 5:11 PM revealed she completed all the MDSs and CAAs in the building. When completing a CAA, the MDS Coordinator stated she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. The MDS Coordinator explained she began the position approximately one month ago and verified the CAA did not contain documentation of analysis of findings specific to Resident #42 and/or the decision to proceed to care plan. She further reported a comprehensive assessment of Resident #42's nutrition and activities of daily living (ADLs) was not conducted and she could not provide a reason for the error on the MDS. 2) Resident #90 was admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. The most recent annual Minimum Data Set ((MDS) dated [DATE] coded Resident #90 as having no cognitive impairments, requiring total physical assistance of 2 persons for bed mobility, transfers, toileting, and bathing, and 1 person assist with dressing, eating, and personal hygiene. Further review of the MDS coded him as being non-ambulatory and receiving antidepressant, antianxiety, and hypnotic medications 7 out of 7 days. Review of the Care Area Assessments (CAA) dated 10/02/14 revealed the following areas were not analyzed with the MDS information to determine the resident's strengths, weaknesses, and how his condition affected these areas: a) Pressure Ulcer CAA: triggered condition due to the developing of 6 pressure ulcers as indicated as stage 2 and greater. Further review of the CAA revealed there was no documentation/analysis of causes and contributing factors to

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F 0272 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) determine reason for the increased number of pressure ulcers and no documentation specific to Resident #90. The CAA did not indicate an analysis of how his every day quality of life was impacted or affected. b) Positioning CAA: revealed there was no documentation and/or analysis related to turning and positioning could have improved the multiple pressure ulcers or any analysis of how his every day quality of life was impacted or affected. Interview with the MDS Coordinator on 05/05/15 at 5:11 PM revealed she completed all the MDSs and CAAs in the building. When completing a CAA, the MDS Coordinator stated she looked at all the information gathered, talked to the resident and staff and read the documentation in the medical record. The MDS Coordinator explained she began the position approximately one month ago and verified the CAA did not contain documentation of analysis of findings specific to Resident #90 and/or the decision to proceed to care plan. She further reported a comprehensive assessment of Resident #90's pressure ulcers and positioning was not conducted and she could not provide a reason for the error on the MDS. 3. Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #11's annual Minimum Data Set ((MDS) dated [DATE] revealed an assessment of severely impaired cognition with no behaviors. The MDS indicated Resident #11 required the extensive assistance of 2 persons with transfer. The MDS indicated Resident #11 had no falls since the prior assessment. Review of Resident #11's fall Care Area Assessment (CAA) dated 09/08/14 revealed the fall CAA triggered due to balance problems during transfer. Further review of the CAA revealed there was no documentation of causes and contributing factors with supporting documentation specific to Resident #11. The CAA did not indicate an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Observation on 04/29/15 at 10:10 AM revealed Nurse Aide (NA) #1 and Nurse #3 assisted Resident #11 from the bed with a mechanical lift to a wheelchair. Interview with NA #1 on 04/29/15 at 10:15 AM revealed Resident #11 used a scoop mattress, floor mat and low bed to prevent falls. NA #1 reported Resident #11 tried to get out of bed at times. Interview with the MDS Coordinator on 05/04/15 at 10:23 AM revealed the Fall CAA did not contain documentation of analysis of findings specific to Resident #11 and the decision to proceed to care plan. The MDS Coordinator explained she began the position approximately one month ago and could not provide a reason for the error in documentation of a fall on the MDS. The MDS Coordinator reported a comprehensive assessment of Resident #11's fall risk was not conducted. 4. Resident #99 was admitted to the facility 10/13/14. [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set ((MDS) dated [DATE] revealed that the sections on the Brief Interview for Mental Status (section C), the Staff Assessment for Mental Status (section C), Fall History on Admission/Entry or Reentry (section J) and Any Falls Since Admission/Entry or Reentry or Prior Assessment (section J), were not completed, but rather recorded dashes (-) or the sections were blank. Review of the Signature of Persons Completing the Assessment or Entry/Death Reporting revealed the facility's previous MDS Coordinator completed part of section A on 12/30/14 and the remainder of section A, sections C and J were completed by the facility's current MDS Coordinator on 02/06/15. During an interview on 05/04/2015 at 3:14 PM the MDS Coordinator revealed she assisted with completion of MDS assessments in January 2015, while the facility was in the process of hiring a MDS Coordinator, but could not explain why the MDS for Resident #99 did not assess his cognition or history of falls. The MDS Coordinator stated when she completed the MDS on 02/06/15 it was not within the 7 day assessment reference date window, so she did not assess the cognition for Resident #99 by completing a resident interview, but further stated she could have reviewed the medical record and interviewed staff to determine if there were any cognitive changes for Resident #99. Review of nurse's notes dated 01/10/15, 01/11/15, 01/14/15 and 01/15/15 during the interview revealed documentation that Resident #99 was alert, oriented, verbally responsive, stable and able to make his needs known. The MDS Coordinator stated this reflected that there was no evidence of acute changes in the mental status of Resident #99. The MDS Coordinator stated the cognition for Resident #99 could have been assessed by reviewing the medical record and by staff interviews. The MDS Coordinator also stated that section J should have been completed to assess the history of falls for Resident #99 by reviewing the medical record and the facility's incident log, but was not done. The MDS Coordinator reviewed the medical record and the facility's incident log at the time of the interview and stated Resident #99 did not have documentation of a fall since admission to the facility. During an interview on 05/05/2015 at 6:44 PM, the director of nursing (DON) stated she expected the MDS Coordinator to complete all sections of the MDS by assessing the resident, reviewing the medical record, care plan and incident reports and interviewing nursing staff to gather information necessary to assess whether or not a resident had fallen and to assess the resident's cognition. The DON confirmed that the previous MDS Coordinator no longer worked for the facility and was unavailable for interview. 5) Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] revealed the sections on the Hearing, Speech and Vision (Section B), Brief Interview for Mental Status revealed the sections on the Brief Interview for Mental and the Staff Assessment for Mental Status (section C), Functional Status (section G), Health Conditions, Pain Assessment (section J) and Falls Since Admission/Entry or Reentry or Prior Assessment (section J), Skin Condition (Section M) were not completed, but rather recorded dashes (-) or the sections were not assessed, or the sections were blank. During an interview on 05/05/15 at 09:15 AM with the MDS Coordinator she revealed she started full time 03/30/15 and she completed all the MDSs in the building. She explained the (-) information was unclear to what type of wound the resident had. She further explained (not assessed/no information) on the MDS reviewed the assessment were not completed during the 7-day look back period the assessment. She stated these sections of the MDS were completed late and per the resident assessment instrument (RAI) manual stated the information could not be completed. She stated she could not explain why the MDSs were not completed in a timely manner before she started to work at the facility. During an interview on 05/05/15 at 2:00 PM, the Director of Nursing (DON) stated she expected the MDS Coordinator to complete all sections of the MDS by assessing the resident, reviewing the medical record, care plan and incident reports and interviewing nursing staff to gather information necessary to complete the MDS in a timely matter. The DON confirmed that the previous MDS Coordinator no longer worked for the facility and was unavailable for interview.
F 0273 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when the resident enters the nursing home, in a timely manner.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews the facility failed to complete a comprehensive assessment within 14 days after admission to the facility for 1 of 37 sampled residents reviewed for comprehensive assessments. (Resident # 12). The findings included: Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the 14 day admission Minimum Data Set ((MDS) dated [DATE] indicated Resident #12 was moderately impaired in cognition for daily decision making and required extensive assistance by staff for activities of daily living. During an interview on 05/07/15 at 3:13 PM with the MDS Coordinator she confirmed she completed all the MDSs in the facility. She stated a comprehensive assessment was supposed to be completed within 14 days after a resident was admitted to the facility but stated Resident #12's comprehensive assessment was not completed within 14 days of admission. She confirmed Resident #12's comprehensive assessment was due to be done on 04/09/15 but it was not completed until 04/14/15. During an interview on 05/07/15 at 4:31 PM the Director of Nursing stated it was her expectation for a resident's MDS to be done in a timely manner. She explained the MDS Coordinator was new in her role and was still learning but should have completed the MDS as required.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews the facility failed to develop comprehensive care plans that included areas such as activities of daily living, behavioral symptoms, falls, positioning to promote wound healing and urinary incontinence for 4 of 37 sampled residents reviewed for care plans. (Resident # 12, #42, #90 and #80). The findings included: 1. Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the 14 day admission Minimum Data Set ((MDS) dated [DATE] indicated Resident #12 was moderately impaired in cognition for daily decision making and required extensive assistance by staff for activities of daily living (ADLs). A review of the Care Area Assessment Summary (CAAs) dated 04/14/15 indicated care areas triggered for ADL function, behavioral symptoms and falls and a check mark next to each of them revealed a care planning decision was indicated. A review of care plans for Resident #12 revealed there were no comprehensive care plans for ADLs, behavioral symptoms or falls. During an interview on 05/07/15 at

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F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) 3:13 PM with the MDS Coordinator she confirmed when a resident was admitted she did a resident assessment first and when the admission MDS was completed the CAAs were completed to indicate triggered care areas. She explained the CAAs needed to be worked and each section reviewed to validate whether they were accurate or not. She stated some CAAs were generated from the MDS assessment and some needed to be added or manually checked with supporting documentation. She explained the comprehensive care plans for ADLs, behavioral symptoms and falls should have been completed for Resident #12 but were overlooked. During an interview on 05/07/15 at 4:31 PM with the Director of Nursing she stated it was her expectation that care plans should be specific to the resident and should be updated with changes or when there were new orders. She stated the MDS coordinator had told her that Resident #12 did not have a care plan for falls. She explained Resident #12 should have had comprehensive care plans in place for care areas that triggered from the CAAs. 2) Resident #42 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the initial nursing assessment dated [DATE] revealed Resident #42 was to receive assistance with her activities of daily living (ADLs) to include assistance with meals related to risk of weight loss. The admission Minimum Data Set ((MDS) dated [DATE] coded Resident #42 as cognitively impaired requiring extensive physical assistance of 1 person for bed mobility, eating, dressing, and personal hygiene, and 2 persons assist with transfers and toileting, and was totally dependent on staff for bathing. Further review of the MDS coded her with no difficulty in swallowing, receiving a therapeutic diet, and weighing 114 pounds being 4 feet 7 inches tall. Review of the Care Area Assessments (CAA) dated 07/14/14 revealed care plans would be developed for the areas of potential weight loss and assistance with ADLs. Review of Resident #42's care plan dated 04/14/15 with a focus of inadequate food intake due to dementia and significant weight loss had a goal for the resident to maintain body weight with the following interventions read in part to provide assistance with meals. Further review of Resident #42's care plan revealed no care plan was initiated and/or developed to address the resident's need for assistance with ADLs. Nurse Aide (NA) #2 was observed on 04/27/15 at 12:38 PM to go into Resident #42's room and ask her are you going to eat? and with no response from the resident NA #2 set up the resident's lunch tray with no attempts to assist her with eating. The food on Resident #42's lunch tray was observed to be un-touched. NA #3 was observed on 04/28/15 at 8:52 AM to go into Resident #42's room, set up her breakfast meal tray, and leave the room. Resident #42 was observed to eat her 1 piece of toast and the cream of wheat and eggs were observed to be un-touched. NA #3 was observed on 04/29/15 at 12:25 PM to set up Resident #42's lunch meal tray. Resident #42 was observed to roll her wheelchair back from the table and look at her plate while NA #3 asked the resident are you going to eat? and with no response from the resident NA #3 removed the lunch tray from the table with no attempts to feed her or assist her back to the table. The food on Resident #42's lunch tray was observed to be un-touched. NA #2 was interviewed on 04/30/15 at 10:13 AM, she stated she would set up Resident #42's meal tray and deliver the other meal trays to the resident rooms. She indicated Resident #42 would sometimes eat her food and then sometimes she would not eat. She further stated she was unaware Resident #42 needed assistance with eating and she had not reported to the nurse that Resident #42 was not eating her meals. NA #3 was interviewed on 04/30/15 at 10:36 AM, she stated Resident #42 would attempt to feed herself and that she was unaware the resident needed assistance with eating. NA #3 indicated Resident #42 was difficult to understand at times and when she rolled away from the table she assumed the resident was not going to eat because there were times when she had refused to eat. Interview with the MDS Coordinator on 05/05/15 at 5:11 PM revealed she was responsible for developing care plans based on the information she obtained from record review, other documentation, and interviews with direct care staff. She stated the care plans were incorporated into a computer system and she checked the intervention she wanted to use. The MDS Coordinator explained she began the position approximately one month ago and verified the care plan for Resident #42's weight and ADLs were not individualized with measurable goals and the interventions on the care plan were selected from the computer's list. 3) Resident #90 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the initial nursing assessment dated [DATE] revealed Resident #90 was admitted with multiple pressure ulcers and skin impairments. The most recent annual Minimum Data Set ((MDS) dated [DATE] coded Resident #90 as having no cognitive impairments, requiring total physical assistance of 2 persons for bed mobility, transfers, toileting, and bathing, and 1 person assist with dressing, eating, and personal hygiene. Further review of the MDS coded him as being non-ambulatory, having multiple pressure ulcers, receiving a therapeutic diet, and weighing 130 pounds being 6 feet tall. Review of the Care Area Assessments (CAA) dated 10/02/14 revealed care plans would be developed for the areas of skin integrity issues and assistance with positioning. Review of Resident #90's care plan dated 02/14/15 with a focus of multiple areas of pressure related skin impairments related to [MEDICAL CONDITION] and complex health status with a goal to demonstrate healing within the limits of the resident's health status with the following interventions: *conduct weekly skin assessment *nutritional and hydration support as ordered *provided a pressure reducing air mattress and pressure reducing wheelchair cushion *consult wound physician as needed *educate resident on importance of allowing wound care and re-enforcement of compliance Further review of Resident #90's care plan revealed no care plan was initiated and/or developed to address the resident's need for positioning to promote wound healing due to his inability to reposition in bed or wheelchair independently. The wound nurse was observed on 04/30/15 at 9:08 AM to remove the previous day's dressings from Resident #90's pressure ulcers, cleaned the pressure ulcers, and re-dressed the pressure ulcers according to the physician's orders [REDACTED]. The Wound Nurse was interviewed on 04/30/15 at 10:13 AM, he stated he had been in the position for approximately 3 weeks and he had noticed a large improvement in Resident #90's pressure ulcers. He further stated he was optimistic that the pressure ulcers would continue to heal but it would take time. Interview with the MDS Coordinator on 05/05/15 at 5:11 PM revealed she was responsible for developing care plans based on the information she obtained from record review, other documentation, and interviews with direct care staff. She stated the care plans were incorporated into a computer system and she checked the intervention she wanted to use. The MDS Coordinator explained she began the position approximately one month ago and verified the care plan for Resident #90's pressure ulcers and the need for positioning were not individualized with measurable goals and the interventions on the care plan were selected from the computer's list. 4. Resident #80 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #80 had no short term or long term memory problems, was cognitively intact for daily decision making and required limited to extensive assistance with skills for activities of daily living. The MDS further revealed Resident #80 was occasionally incontinent of bladder and frequently incontinent of bowel. The quarterly Minimum Data Set ((MDS) dated [DATE] revealed the MDS triggered the Care Area Assessment (CAA) dated 01/04/15 documented urinary incontinence to be addressed in care plan. A review of care plans revealed there was no care plan for urinary incontinence. During an interview on 05/05/15 at 9:00 AM with the MDS Coordinator, she revealed if a care area for a resident was triggered on the CAA and it was to be addressed in the care plan the care plan team would process the care plan. The new information would be added to the care plan and placed on the resident's care card for staff to be informed. She explained she was not aware this resident was triggered on the CAA for urinary incontinence, so she was not care planned for urinary incontinence. She further explained this resident just got missed for urinary incontinence on her care plan. She explained she started to work at the facility on 03/30/15 and this resident's CAA was completed on 01/04/15 and she was not here at that time. During an interview on 05/05/15 at 11:00 AM with the Director of Nursing (DON) she revealed the CAA were completed annually or when a resident had a change in condition. She further stated any areas triggered on the CAA were to be care planned if the MDS Coordinator determined the area triggered should be addressed in the resident's care plan. She continued to explain once the area was triggered it would be discussed at the care plan meeting for the resident and the team would discuss placing the triggered area on the care plan and at that time it would be added to the care plan. She stated she was not aware Resident #80 was triggered for urinary incontinence on the CAA and was not care planned. The DON confirmed the previous MDS Coordinator no longer worked for the facility and was unavailable for interview.
F 0309 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff and physician interviews the facility failed to assess a resident with a change in condition with increased pain and confusion for 1 of 4 sampled residents with a change in condition. (Resident #12) The findings included: A review of a facility procedure titled Condition Change of the Resident (Observing, Recording and Reporting) with an effective date of [DATE] indicated the procedure and purpose was to observe, record and report any condition change to the attending physician so proper treatment would be implemented. The procedure indicated in part to assess the resident's need for immediate care and compare the resident's current condition to his or her prior level of function. A

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	345008	A. BUILDING _____ B. WING _____	**05/07/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - DARTMOUTH	**300 PROVIDENCE ROAD CHARLOTTE, NC 28207**

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F 0309

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 7)

facility document titled Pain Assessment and Management with an effective date of [DATE] indicated it is the policy to promptly assess resident pain levels and to provide relief of symptoms whenever feasible, using a resident-centered and interdisciplinary approach. The procedure further indicated in part residents will be assessed for pain utilizing standardized pain scales and evaluations as needed based on their exhibiting symptoms of pain or upon report of new onset of pain. A review of a facility document titled Pain Management Guideline with an effective date of [DATE] indicated a statement to provide guidance for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life, in concert with the resident's plan of care and goals for pain management. The guidelines indicated in part to recognize and report pain as the fifth vital sign, assess pain and evaluate response to pain management interventions using a pain management scale based on resident self-report or objective assessment for the cognitively impaired and intervening to treat pain before pain becomes severe. A review of a facility document titled Clinical Health Status of Change in Condition Guideline with an effective date of [DATE] indicated in part the process for identification of change of condition includes gathering objective data and documenting assessment findings, resident response and physician and family notification. Communication both written and verbal are an integral part of actions needed for change of condition. Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the admission Minimum (MDS) data set [DATE] indicated Resident #12 was moderately impaired in cognition for daily decision making and required extensive assistance by staff for activities of daily living. A review of admission physician's orders [REDACTED]. [MEDICATION NAME] 100 milligrams (mg) by mouth three times a day for infection and inflammation of spinal hardware. [MEDICATION NAME] 2 grams intravenously daily for infection and inflammation. [MEDICATION NAME] 125 mg by mouth
twice daily for infection and inflammation. [MEDICATION NAME] 25 mg by mouth daily at bedtime for [MEDICAL CONDITION].
[MEDICATION NAME] 20 mg by mouth daily for depression. Oxygen 2 liters by nasal cannula as needed to keep oxygen saturation greater than 92 percent. A review of nurse's notes dated [DATE] at 6:29 PM indicated Resident #12 was admitted to the facility and was alert and oriented to time, person and place and was able to voice concerns. The notes also indicated Resident was hard of hearing and her vital signs were blood pressure ,[DATE]; pulse 86; respirations 20 and oxygen saturation was 97 percent. The notes revealed Resident #12 had an approximate 14 inch incision to her back that was packed with a wet to dry dressing and 2 small incisions on her right side. A review of a Nurse Practitioner progress note dated [DATE] indicated Resident #12 was a new admission with post-operative pain and had a large back dressing with a wound vac. The notes also indicated Resident #12 was up all night with pain and anxiety and her past medical history included [MEDICAL CONDITION] and anxiety. The notes revealed the assessment and plan was to start [MEDICATION NAME] 50 mg by mouth every 6
hours as needed (PRN) for pain and [MEDICATION NAME] 0.5 mg by mouth every 12 hours PRN for anxiety. A review of physician's orders [REDACTED]. Start [MEDICATION NAME] 50 mg by mouth every 6 hours PRN pain. [MEDICATION NAME] 0.5 mg by
mouth every 12 hours PRN anxiety. A review of physician's orders [REDACTED]. Give [MEDICATION NAME] PRN for anxiety. Add
[MEDICATION NAME] ,[DATE] mg (1) tablet by mouth every 6 hours PRN for pain. A review of physician's orders [REDACTED]. A
review of physician's orders [REDACTED]. Schedule an appointment with an Infectious Disease Specialist as soon as possible. Consult psychiatric services for depression. Discontinue [MEDICATION NAME] and begin Bactrim DS ,[DATE] mg daily indefinitely for prevention of infection. A review of a Nurse Practitioner progress note dated [DATE] indicated she had a question about when to stop antibiotics and an Infectious Disease Physician office was called. The notes also indicated Resident #12 was also having some issues with depression and the assessment and plan was for Resident #12 to see the Infectious Disease Physician for follow up regarding antibiotic management and stop date. The notes also indicated to obtain a psychiatric consult. A review of physician's orders [REDACTED]. [MEDICATION NAME] 50 mg by mouth twice a day as scheduled doses. Discontinue [MEDICATION NAME] PRN but keep [MEDICATION NAME] ,[DATE] by mouth every 6 hours PRN for pain.
A review of a Nurse Practitioner progress note dated [DATE] indicated Resident #12 was complaining of pain on a nearly regular basis and she might not be cognitively able to ask for PRN medications as much as needed. The notes also indicated she spoke with an Infectious Disease Physician and Resident #12 was to take Bactrim DS (1) by mouth daily for her lifetime for prevention of infection. The notes revealed the assessment and plan was to continue [MEDICATION NAME] PRN for pain and to discontinue [MEDICATION NAME] PRN and give [MEDICATION NAME] 50 mg by mouth twice daily for pain. A review of a psychiatric progress note dated [DATE] indicated Resident #12 was seen for depression and was lying in bed and was irritable and uncooperative. The notes indicated Resident #12 had a history of [REDACTED]. The notes further indicated psychiatric services would give about 2 weeks and if behaviors continued would consider increasing [MEDICATION NAME] for mood disorder. A review of a Nurse Practitioner progress note dated [DATE] indicated staff reported Resident #12 had increased confusion. The assessment and plan indicated acute [MEDICAL CONDITION] and to obtain a urinalysis and culture and sensitivity. A review of a MAR indicated [REDACTED]. The notes revealed Resident #12's pain level was documented as 4 on a pain scale from 0 (no pain) to 10 worst pain but there was no documentation for reason for refusal. A review of nurse's notes for a change in condition dated [DATE] documented by Nurse #6 indicated a note for change of condition that Resident #12 was on the floor in her room at 2:00 AM and had increased confusion. The notes indicated Resident #12's vital signs were blood pressure ,[DATE]; pulse 76; respirations 18; temperature 98.1 Fahrenheit (F) and oxygen saturation was 97 percent with oxygen on at 2 liters per minute. A review of a facility document titled Neurological assessment dated [DATE] from 2:00 AM until 3:00 AM indicated Resident #12's vital signs were documented every 15 minutes. The notes revealed Resident #12's blood pressure ranged from ,[DATE] - ,[DATE], pulse ,[DATE] and respirations 18. A section labeled Consciousness indicated Resident #12 was disoriented and restless and a section labeled Response to Pain was blank. A review of a facility document titled Verification of Investigation dated [DATE] at 2:45 AM documented by Nurse #6 indicated Resident #12 was noted on the floor of her room at 2:00 AM and it appeared that she was throwing herself on the floor due to increased confusion. The notes further indicated Resident #12 was verbally responsive with increased confusion, had impaired mental status and was unable to recount event and there was no bruising or injury noted. The notes revealed vital signs were blood pressure ,[DATE]; pulse 76; respirations 18; temperature 98.1 F and oxygen saturation was 97 percent on 2 liters of oxygen. The notes indicated Resident #12 had a bed and chair alarm and a fall mat in place. A review of a facility document titled Post Fall Analysis/Plan dated [DATE] at 2:45 AM documented by Nurse #6 indicated possible cause and contributing factors and observations were Resident #12 had a change in mental status with increased confusion and impaired safety awareness and judgment. A review of a facility document titled Neurological assessment dated [DATE] from 3:00 AM until 4:00 AM indicated Resident #12's vital signs were documented every 30 minutes. The notes revealed Resident #12's blood pressure ranged from ,[DATE] - ,[DATE], pulse ,[DATE] and respirations 18. A section labeled Consciousness indicated Resident #12 was disoriented and restless and a section labeled Response to Pain was blank. A review of a facility document titled Neurological assessment dated [DATE] from 4:00 AM until 9:00 AM indicated Resident #12's vital signs were documented every 1 hour. The notes revealed Resident #12's blood pressure ranged from ,[DATE] - ,[DATE], pulse ,[DATE] and respirations ,[DATE]. A section labeled Consciousness indicated Resident #12 was disoriented and restless and a section labeled Response to Pain was blank. During an interview on [DATE] at 6:42 AM with Nurse Aide (NA) #8 she explained she provided care to Resident #12 on [DATE] during the 11:00 PM to 7:00 AM shift. She stated Resident #12 rolled off her bed around 2:00 AM onto the mat on the floor next to her bed and it took 3 staff to lift her back into bed. She further stated Resident #12 screamed in pain when they lifted her back to bed. She explained Resident #12 was up all night and when she made rounds she seemed confused and was very pale. She stated she got Nurse #6 and another NA to go with her into Resident #12's room because she was babbling to herself and that was different than any of the other nights when she had taken care of her. A review of nurse's notes dated [DATE] at 6:17 AM documented by Nurse #6 indicated Resident #12 was verbally responsive with noted confusion. The notes further indicated Resident #12 kept throwing herself out of bed last night but had no apparent injury and neurological checks were in place. A review of a MAR indicated [REDACTED]. During an interview on [DATE] at 7:02 AM with Nurse #6 she confirmed she provided care to Resident #12 during the 11:00 PM to 7:00 AM shift of [DATE]. She explained Resident #12 had back pain and would cry out. She stated Resident #12 had some confusion when she was admitted to the facility but it had increased during the last ,[DATE] days before she went to the physician's office. She explained she thought Resident #12 had a urinary tract infection and that was the reason for her increased confusion but the results of a urinalysis and culture had not been received from the laboratory. She stated it was reported to her that during the night of [DATE] Resident #12 was screaming out about things that weren't there and was hallucinating but she didn't see Resident #12 hallucinating or assess her for hallucinations. She confirmed Resident #12 had not had hallucinations before and that night was different and she was very confused. She explained at 2:00 AM Resident #12 attempted to get out of bed and threw herself onto the floor. She further explained Resident #12 had not attempted to get out of bed before that night. She stated Resident #12 could say if she was in pain but did not remember if she gave

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F 0309 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 8) Resident #12 pain medication but if she had she would have documented it on the MAR. She further stated she could not remember if she called the on-call physician during the night and she did not call the physician before she left work at the end of her shift. A review of a Medication Administration Record [REDACTED]. There was no documentation that the medication was effective or ineffective. A review of physician's orders [REDACTED]. A review of a facility document titled Neurological assessment dated [DATE] from 9:00 AM to 1:00 PM indicated Resident #12' s vital signs were documented every 2 hours. The notes revealed Resident #12's blood pressure ranged from ,[DATE] to ,[DATE], pulse ,[DATE] and respirations ,[DATE]. A section labeled Consciousness indicated Resident #12 was disoriented and restless and a section labeled Response to Pain was blank. A review of a MAR indicated [REDACTED]. A review of nurse's notes dated [DATE] at 2:41 PM documented by Nurse #1 indicated Resident #12 was alert and responsive with confusion and was waiting for results of the urinalysis culture and sensitivity report. During an interview on [DATE] at 10:45 AM with Nurse #1 she explained she was assigned to care for Resident #12 on the 7:00 AM to 3:00 PM shift on [DATE]. She stated she worked part time so she did not know Resident #12 very well but she remembered Resident #12 was screaming at times but she was on scheduled pain medications. She stated she did not remember calling the Physician or Nurse Practitioner on [DATE] during her shift. A review of a facility document titled Neurological assessment dated [DATE] at 4:00 PM indicated Resident #12's vital signs were blood pressure ,[DATE], pulse 66 and respiration 18. A section labeled Consciousness indicated Resident #12 was disoriented and restless and a section labeled Response to Pain was blank. A review of a MAR indicated [REDACTED]. A review of nurse's notes dated [DATE] at 6:18 PM documented by Nurse #7 indicated Resident #12 was alert and awake with confusion and continued to yell out after her fall and there were no signs or symptoms of new injury. During a telephone interview on [DATE] at 8:59 AM with Nurse #7 she explained she was assigned to the care of Resident #12 during the 3:00 PM to 11:00 PM shift on [DATE] and remembered the resident was confused. She stated she was told in the shift report by Nurse #6 that Resident #12 had a fall during the night around 2:00 AM. She explained Resident #12 was at risk for falls because she was confused and she was strong enough to roll herself out of bed. She further explained there were mats on the floor next to her bed but she did not have side rails to stop her from rolling out of bed. She stated Resident #12 would state help me, help me and she seemed to be agitated. She explained Resident #12 was confused and thought Nurse #7 was her daughter and had her days and nights mixed up. She stated she explained to Resident #12 it was the 3:00 PM to 11:00 PM shift but she didn't understand it and she had no clue of who or what was going on or where she was. She explained that was the only time she provided care to Resident #12. She stated during the shift Resident #12 screamed really loud and she went to her room and took a NA with her and they calmed her and later she went to sleep for a while. She described Resident #12's screaming was more like she was scared because she was not sure where she was and it was worse when she was alone in her room. She stated she did not remember if she checked vital signs or documented assessment information but she would have recorded that information in her notes if she had checked them. A review of a facility document titled Neurological assessment dated [DATE] at 8:00 PM indicated Resident #12's vital signs were blood pressure ,[DATE], pulse 76 and respiration 18. A section labeled Consciousness indicated Resident #12 was disoriented and restless and a section labeled Response to Pain was blank. A review of vital signs dated [DATE] at 10:00 PM indicated blood pressure ,[DATE]; pulse 78; respirations 17; temperature 98.1 degrees F and oxygen saturation was 97 percent. A review of a facility document titled Neurological assessment dated [DATE] at 11:00 PM indicated Resident #12's vital signs were blood pressure ,[DATE], pulse 67 and respiration 18. A section labeled Consciousness and a section labeled Response to Pain was blank. A review of a MAR indicated [REDACTED]. A review of a MAR indicated [REDACTED]. A review of nurse's notes dated [DATE] at 7:35 AM documented by Nurse #8 indicated Resident #12
was alert with periods of confusion after her fall. During a telephone interview on [DATE] at 5:30 PM with Nurse #8 she stated she was assigned to care for Resident #12 during the 11:00 PM to 7:00 AM shift on [DATE]. She explained she did not routinely provide care to Resident #12 because she worked on different nursing units. She stated she did not remember if she did an assessment or checked her vital signs but if she had she would have documented it in her nurse's notes. She stated she did not call the Physician or Nurse Practitioner. A review of nurse's notes dated [DATE] at 8:59 AM documented by Nurse #9 indicated Resident #12 was in a lot of pain in her back. The notes further indicated Resident #12 was screaming out it hurts, my back and [MEDICATION NAME] was given due to resident screaming out in pain and she had a doctor's appointment at 10 AM. A review of a MAR indicated [REDACTED]. A review of nurse's notes dated [DATE] at 10:03 AM documented
by Nurse #9 indicated Resident #12 was out for an appointment at 10 AM to an Infectious Disease Physician. The notes further indicated oxygen was on at 2 liters per minute by nasal cannula provided by non-emergent medics and Resident #12 was alert but appeared intermittently confused and there were no vital signs documented. During a telephone call on [DATE] at 8:59 AM with Nurse #9 she confirmed she was assigned to care for Resident #12 on the 7:00 AM to 3:00 PM shift on [DATE]. She explained when staff moved Resident #12 she cried out in pain and she confirmed she gave [MEDICATION NAME] to Resident #12 that morning because her orders for pain medication had been changed. She stated the pain medication was changed to scheduled medication times and she had already received it earlier that morning at 6:00 AM and she couldn't give it to her until the next dose was scheduled to be given. She further stated Resident #12 did not have an order for [REDACTED]. She stated she was not in Resident #12's room when emergency medical transport arrived but they came out and asked her to help transfer Resident #12 to a stretcher so she helped them. She confirmed Resident #12 received oxygen but did not remember how many liters per minute she received and described Resident #12 as intermittently confused because she knew her name and that it was morning but did not know where she was. A review of an emergency medical transport report dated [DATE] at 10:46 AM indicated the emergency medical transport staff arrived to facility to transport Resident #12 to an Infectious Disease Physician appointment. The crew reported the facility reported Resident #12 was at her baseline mental status but the Infectious Disease Physician reported Resident #12 was not at her baseline mental status and he was concerned and wanted her to be transported to the hospital for evaluation. The assessment notes revealed at 10:50 AM Resident #12 was on oxygen at 6 liters per minute and at 10:56 AM her blood pressure was ,[DATE], pulse 100 and respirations 18. The report also indicated Resident #12 left the physician's office by medical transport at 11:04 AM and arrived at the hospital emergency room at 11:07 AM. A review of a laboratory report dated [DATE] for a urinalysis and culture and sensitivity indicated results of rare bacteria and moderate amounts of yeast. A handwritten note on the bottom of the results indicate Resident #12 was currently on Bactrim DS ,[DATE] mg daily by mouth and the Nurse Practitioner was notified on [DATE] at 10:50 AM. A review of a hospital emergency department report dated [DATE] at 11:12 AM indicated Resident #12 was admitted with altered mental status [MEDICAL CONDITION] (a life threatening complication of infection). A review of nurse's notes dated [DATE] at 11:34 AM documented by the Director of Nursing (DON) indicated a nurse from the Infectious Disease Physician's office called and reported Resident #12 was sent to the hospital emergency room due to unresponsiveness. During a telephone call on [DATE] at 3:19 PM with a Medical Office Assistant at the Infectious Disease Physician's office she stated she remembered when Resident #12 came to the office on [DATE]. She explained Resident #12 was barely responsive, was not talking but was mumbling sounds and appeared to be in pain. She stated medics transported her to the office from the facility and she was brought immediately into an exam room when they got there and stated documentation in her chart indicated her vital signs were ,[DATE], pulse 64, respirations 26 and temperature was 97.6 degrees F. During an interview on [DATE] 11:40 AM with NA #9 she explained when Resident #12 first came to the facility she was independent but then she began to need more help. She stated during the past 2 days before she went out to the doctor's appointment on [DATE] they had to feed her and she needed total help. She explained Resident #12 complained of bad pain in her back and she reported it to the nurse. During an interview on [DATE] at 11:36 AM with a Physical Therapist she explained Resident #12 received physical and occupational therapy 5 days a week. She stated when Resident #12 was first admitted to the facility she was cooperative with therapy. She further stated Resident #12 had pain but she would get out of bed and go to the therapy gym for her therapy but she started deteriorating regarding her strength and transfers and would scream out when moved. She explained therapy staff talked to the nurse and Nurse Practitioner and she was started on pain medications routinely and Resident #12 was to have pain medication before her therapy sessions. She further explained on [DATE] they were told Resident #12 had an appointment so they did therapy while she was in bed but Resident #12 looked different that morning and she kept her eyes closed and was not talking and her mood was different and she reported it to the nurse. During an interview on [DATE] at 10:22 AM the Nurse Practitioner explained Resident #12 was a very complicated case because she had an infection from spinal surgery and was on intravenous antibiotics and had surgical wounds on her back. She stated Resident #12's hospital discharge records indicated she had [MEDICAL CONDITION] but she wondered if there was an underlying psychiatric [DIAGNOSES REDACTED]. She
explained when she talked to Resident #12 she could respond with yes or no answers but could not verbalize what was wrong. She further explained she had questions about the intravenous antibiotics because she could not tell from hospital records how long it they were to be continued so she called the Infectious Disease Physician. She stated when she called the office

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 9) she was told Resident #12 needed to have an appointment scheduled so that's why she went out to the office on [DATE]. During a telephone interview on [DATE] at 1:14 PM the Infectious Disease Physician stated it was reported to him by one of his physician partners that Resident #12 had died in the hospital on [DATE] at 2:02 AM. He stated her admitting [DIAGNOSES REDACTED]. He explained he had seen Resident #12 about a month ago during a previous hospital admission because she had infected hardware due to back surgery and she was alert at that time. He confirmed he saw Resident #12 when she came to his office on [DATE] and she was minimally awake but was not responsive and was receiving oxygen but her saturation percentage was 88% and her blood pressure was low at ,[DATE], pulse 64, respirations 26 and her temperature was 97.6 F. He explained he talked to emergency medical transport and they said when they picked the resident up she was on oxygen at 2 liters per minute but they had to increase her oxygen because her oxygen saturation percentage was in the low to mid 80's and she was minimally responsive. He stated he took a quick look at Resident #12 and told emergency medical transport personnel to take her to the hospital emergency room . He explained after Resident #12 left the office he had his staff call the facility and they were told Resident #12 was a little confused when she left the facility. He stated he received no notes from the facility and had no indication of what had happened with Resident #12. He stated the last time he saw Resident #12 about a month ago she was alert and awake. He confirmed his office was just down the street from the facility so Resident #12's transport would have only taken minutes. During an interview on [DATE] at 9:30 AM the facility Medical Director stated he only saw Resident #12 once on [DATE] but his Nurse Practitioner saw her routinely and kept him informed of Resident #12's condition. He explained Resident #12's biggest problem was infected hardware in her back but she also had a lot of medical conditions and was getting intravenous antibiotics through a PICC line and was followed by an Infectious Disease Specialist who managed the infected hardware in her back. He stated the Nurse Practitioner had questions about the antibiotics and did not want to make decisions about them on her own so she called the Infectious Disease Physician for his recommendations and he wanted to see Resident #12 at his office on [DATE]. He explained it was his expectation for nursing staff to assess residents who had a change in condition and call the physician. He stated a Physician or Nurse Practitioner was available by phone or pager 24 hours a day and there was no excuse for them not being notified. He further stated he was not aware of Resident #12's increased confusion and pain and nursing staff should have called them regarding Resident #12's pain since pain medication had already been given on [DATE] and [MEDICATION NAME] was not indicated for pain. He explained he couldn't speak to whether Resident #12's outcome would have been different but he expected staff should have called to discuss pain, medications and assessment of the resident because the chances of recovery were better the sooner he was notified. During a follow up interview on [DATE] at 10:43 AM the Nurse Practitioner stated the nurse should not have given [MEDICATION NAME] for pain to Resident #12 on [DATE]. She further stated she was not aware of Resident #12's increased confusion and pain and she expected nursing staff should have called her to explain Resident #12 had pain medication at 6:00 AM on [DATE] but was screaming in pain and she would have given orders for pain medication. She explained pain medication could have been given since it had been about 3 hours since her last dose. She stated she was not aware of Resident #12's fall out of bed on [DATE] at 2:00 AM. She explained there was a communication book at the nurse's station where nursing staff documented concerns to the physician and she did not see any documentation about the fall. She stated she was aware of the urinalysis and culture and sensitivity report dated [DATE] and the yeast colony count was too low for her to order medication to treat it and confirmed that did not cause Resident #12's [MEDICAL CONDITION]. During an interview on [DATE] at 5:15 PM the Director of Nursing stated it was important for nursing staff to be timely in contacting the physician and responsible party and they should be proactive with a resident who had a change in condition. She further stated it was her expectation as soon as staff noticed a change in condition or were told of a change in condition they needed to act immediately. She also stated she expected nursing staff to assess residents for pain and if their pain was not relieved by medication or they did not have an order for [REDACTED].#12 left the facility for her physician's appointment.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, the facility failed to provide timely incontinence care for 1 of 3 sampled residents observed for incontinence care (Resident #11). The findings included: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #11's quarterly Minimum Data set ((MDS) dated [DATE] revealed an assessment of severely impaired cognition. The MDS indicted Resident #11 required the extensive assistance of two persons with transfers and was always incontinent of urine and stool. Review of Resident #11's care plan revealed a goal of no complication from incontinency of urine such as skin breakdown and urinary tract infections [MEDICAL CONDITION] for the focus area of urine and stool incontinency. Interventions included frequent checks with incontinence care provided as needed and provision of briefs. Observation on 04/29/15 at 9:50 AM revealed Nurse Aide (NA) #1 gave Resident #11 a bed bath which included incontinence care and application of a disposable brief. A continuous observation on 04/29/15 from 10:12 AM to 1:58 PM revealed Resident #11 remained seated in the wheelchair on the seat cushion. Observation on 04/29/15 at 1:59 PM revealed NA #3, Nurse #3 and Nurse #4 transferred Resident #11 into the bed with a mechanical lift. Nurse #4 and NA #3 repositioned Resident #11 on the right side. NA #3, Nurse #3 and Nurse #4 exited the room and did not perform incontinence care. Interview with Nurse #4 on 04/29/15 at 2:05 PM revealed Resident #11's assigned NA, NA #1 would take care of Resident #11's incontinence needs. Interview with NA #1 on 04/29/15 at 2:26 PM revealed Resident #11 did not require any more incontinence care. NA #1 reported Resident #11 was in bed so she thought incontinence care had already occurred. During this interview, Nurse #4 approached and informed NA #1 Resident #11 required incontinence care. Further interview with NA #1 on 04/29/15 at 2:30 PM revealed Resident #11 did not receive incontinence care since the bed bath at 9:50 AM (4 hours and 40 minutes). NA #1 explained Resident #11 ' s usual routine was to be up in the wheelchair after dressing and incontinence care and transferred back to bed in the afternoon. NA #1 reported Resident #11 received incontinence care and repositioning twice during the eight hour shift and this was the normal routine. NA #1 explained it was not possible to check Resident #11 every 2 hours due to the needs of other residents on the assignment. Observation on 04/29/15 at 2:33 PM revealed NA #1 turned Resident #11 toward her and Nurse #3 washed her hands and donned gloves. Nurse #3 removed the wet brief which contained a soft formed bowel movement. NA #1 handed Nurse #3 disposable wipes. Nurse #3 wiped the bowel movement from back to front up to the labia using five wipes. When interrupted by the surveyor, Nurse #3 explained she attempted to keep the bowel movement from the urethral opening but wiped back to front in error. Nurse #3 reported she should have wiped front to back in order to prevent infection. Interview with the Director of Nursing (DON) on 04/30/15 at 10:53 AM revealed Resident #11 should receive incontinence care every 2 hours and as needed. The DON reported she expected staff to wipe front to back during incontinence care.
F 0314 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and wound physician interview, and record review, the facility failed to reposition, provide incontinence care and apply a [MEDICATION NAME] dressing for 1 of 3 sampled residents with pressure sores (Resident #11). The findings included: Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #11's quarterly Minimum Data Set ((MDS) dated [DATE] revealed an assessment of severely impaired cognition. The MDS indicted Resident #11 required the extensive assistance of two persons with transfers and was always incontinent of urine and stool. The MDS indicated one Stage 2 pressure sore since the prior assessment with an origin date of 11/25/14. Review of a nursing note dated 11/27/14 revealed a Stage 2 pressure sore on Resident #11's left buttock measured 0.5 centimeters by 1.0 cm. by 0.1 cm. and the wound physician received a referral. Review of a wound physician's note and nursing note dated 01/14/15 revealed Resident #11's Stage 2 pressure sore healed without complication. Review of Resident #11's quarterly MDS dated [DATE] revealed an assessment of severely impaired cognition. The MDS indicted Resident #11 required the extensive assistance of two persons with transfers and was always incontinent of urine and stool. The MDS indicated one healed Stage 2 pressure sore since the prior assessment and a risk for pressure sore development. Review of Resident #11's care plan revealed a risk for skin integrity impairment. Interventions included weekly skin assessments, pressure reducing mattress and cushion and repositioning. Review of Resident #11's weekly skin assessments from 02/27/15 to 04/10/15 revealed

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	345008	A. BUILDING _____ B. WING _____	05/07/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 0314 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 10) no skin integrity problems. Review of a nursing note written by the facility's wound nurse dated 04/13/15 revealed Resident #11 developed moisture excoriation on the left buttock described as a shear wound which measured 2.2 centimeters (cm.) by 0.5 cm. by 0.1 cm. The wound nurse documented the wound physician ordered barrier cream application every shift and as needed. Review of the wound physician's evaluation dated 04/13/15 revealed Resident #11 should receive barrier cream and be repositioned per the facility protocol. The wound physician described the shear wound as linear tear associated with moisture excoriation in the buttock crease. Review of the wound physician's progress note dated 04/20/15 revealed Resident #11 was out of the facility and did not receive a wound physician visit. Review of the wound physician's evaluation dated 04/27/15 revealed Resident #11's shear wound improved and measured 1.2 cm. by 0.4 cm with light serous exudate. The wound physician ordered a [MEDICATION NAME] dressing to be applied and changed every 3 days and as needed. Review of Resident #11's April 2015 Treatment Administration Record revealed documentation of [MEDICATION NAME] dressing application on 04/27/15 by the wound nurse. Observation on 04/29/15 at 9:50 AM revealed Nurse Aide (NA) #1 gave Resident #11 a bed bath which included incontinence care and application of a tab disposable brief. Resident #11's buttocks were red with one open area approximately 2 cm. by 2 cm. by 0.1 cm. on the left buttock. There was no dressing on the open area. NA #1 applied a barrier cream. Observation on 04/29/15 at 10:10 AM revealed NA #1 and Nurse #3 transferred Resident #11 from the bed with a mechanical lift to a wheelchair. Resident #11 sat upon a cushion. Interview with NA #1 on 04/29/15 at 10:15 AM revealed Resident #11 did not have a dressing over the open area and the wound nurse did the treatments later in the day. A continuous observation on 04/29/15 from 10:12 AM to 1:58 PM revealed Resident #11 remained seated in the wheelchair on the seat cushion. Resident #11 did not receive assistance with repositioning and did not receive incontinence care for 3 hours and 46 minutes. Observation on 04/29/15 at 1:59 PM revealed NA #3, Nurse #3 and Nurse #4 transferred Resident #11 into the bed with a mechanical lift. Nurse #4 and NA #3 repositioned Resident #11 on the right side. NA #3, Nurse #3 and Nurse #4 exited the room and did not perform incontinence care. Interview with Nurse #4 on 04/29/15 at 2:05 PM revealed Resident #11's assigned NA, NA #1 would take care of Resident #11's incontinence needs. Interview with NA #1 on 04/29/15 at 2:26 PM revealed Resident #11 did not require any more incontinence care. NA #1 reported Resident #11 was in bed so she thought incontinence care already occurred. During this interview, Nurse #4 approached and informed NA #1 Resident #11 required incontinence care. Further interview with NA #1 on 04/29/15 at 2:30 PM revealed Resident #11 did not receive incontinence care since the bed bath at 9:50 AM (4 hours and 40 minutes). NA #1 explained Resident #11 ' s usual routine was to be up in the wheelchair after dressing and incontinence care and transferred back to bed in the afternoon. NA #1 reported Resident #11 received incontinence care and repositioning twice during the eight hour shift and this was the normal routine. NA #1 explained it was not possible to check Resident #11 every 2 hours due to the needs of other residents on the assignment. Observation on 04/29/15 at 2:33 PM revealed NA #1 and Nurse #3 removed Resident #11's disposable tab brief. The open area remained uncovered. Nurse #3 reported barrier cream should be applied. Nurse #3 reported she was not aware of an order for [REDACTED]. Interview with the wound nurse on 04/29/15 at 2:58 PM revealed he applied the [MEDICATION NAME] dressing to the open area on Resident #11's left buttock on 04/27/15 and would not check the area until the next application scheduled for tomorrow (04/30/15). During the interview, the wound nurse observed the open area and reported the area unchanged since 04/27/15. The wound nurse reported the open area was due to pressure and wetness. The wound nurse reported the open area should have been covered with a [MEDICATION NAME] dressing. The wound nurse explained the floor nurses should apply the dressing if it came off. The wound nurse reported Resident #11 should receive assistance with repositioning and incontinence care every 2 hours. Interview with the Director of Nursing (DON) on 04/30/15 at 10:53 AM revealed Resident #11 should receive incontinence care and repositioning every 2 hours and as needed. The DON reported the facility's protocol included regular repositioning and incontinence care which would be at least every 2 hours. The DON reported she expected nursing staff to apply Resident #11's dressing as ordered. Interview with the wound physician on 05/04/15 at 3:57 PM revealed extended exposure to wetness and pressure caused the open area on Resident #11's buttock. The wound physician explained he documented the area as a shear wound but pressure also caused the area. The wound physician reported Resident #11 should be repositioned and provided incontinence care on a regular basis per the facility protocol. The wound physician reported the [MEDICATION NAME] dressing should be on the open area at all times as ordered.
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews and medical record review, the facility failed to implement fall interventions as care planned, replace a broken nightlight and operate a free standing fan safely to prevent an accident hazard. Resident #105 did not have a dycem in his wheel chair to prevent falls and Resident #11 did not have a floor mat in place for 2 of 8 sampled residents reviewed with a history of falls. A broken nightlight was not replaced (room 210) and a free standing fan was used in a resident's bathroom while wet towels hung covering the fan's motor (room 211) for 2 of 27 sampled resident rooms observed. The findings included: 1. Resident #105 was admitted to the facility 10/03/14 and readmitted on [DATE]. [DIAGNOSES REDACTED]. Review of the medical record and the Verification of Investigation report revealed that on 11/19/14, Resident #105 attempted a self transfer to his wheel chair and slid to the floor. He was wearing socks without shoes, He was uninjured. Recommendations after the fall included to keep the bed in the lowest position, call bell in reach, skid free socks while out of bed and place a dycem (slip resistant device to prevent sliding) to his wheel chair seat when up in the wheel chair. Further medical record review and the Verification of Investigation report, revealed that on 11/29/14, Resident #105 attempted a self transfer to the bed. He was found on the floor on the right side of bed, on his stomach face down, he was unable to recall the fall or his attempt to self transfer. He was transferred to the emergency department for further evaluation. Documentation of the fall did not include whether or not the dycem was in place at the time of the fall. Resident #105 returned to the facility on [DATE] after a R BKA due to severe PVD. A physician's orders [REDACTED].#105's wheel chair at all times when he used his wheel chair. The physician's orders [REDACTED]. Review of the nurse's note and the SBAR (situation, background, assessment, and request) change in condition report revealed that on 01/04/15, Resident #105 attempted an unassisted transfer from the wheel chair to the bed and fell . Stitches to his R BKA opened at one end and a small amount of blood was noted. The area was cleansed with normal saline and steri strips were applied. The documentation did not record whether or not a dycem was in place at the time of the fall. Review of the medication administration records (MAR) for November 2014 - March 2015 revealed there was no documentation that the nursing staff checked the placement of the dycem on the following dates/shifts: · The November 2014 MAR did not record the use of the dycem · 4 times in December 2014 (12/16/14, 7 AM - 3 PM shift; 12/24/14, 11 PM - 7 AM shift; 12/26/14, 11 PM - 7 AM shift; and 12/31/14, 7 AM - 3 PM shift) · 8 times in January 2015 (01/01/15, 7 AM - 3 PM shift; 01/02/15, 7 AM - 3 PM shift; 01/08/15, 11 PM - 7 AM shift; 01/09/15, 3 PM - 11 PM shift; 01/10/15, 7 AM - 3 PM shift; 01/11/15 11 PM - 7 AM shift; 01/15/15, 3 PM - 11 PM shift; and 01/20/15, 3 PM - 11 PM shift) · 7 times in February 2015 (02/04/15, 7 AM - 3 PM shift; 02/05/15, 11 PM - 7 AM shift; 02/06/15, 7 AM - 3 PM shift; 02/08/15, 7 AM - 3 PM shift; 02/15/15, 11 PM - 7 AM shift; 02/20/15, 7 AM - 3 PM shift; and 02/24/15 11 PM - 7 AM shift) · 1 time in March 2015 (03/04/15, 11 PM - 7 AM shift) Review of a quarterly Minimum (MDS) data set [DATE], assessed Resident #105 with intact cognition, requiring extensive staff assistance with bed mobility and transfers, unsteady balance, requiring staff assistance for surface to surface transfers between the bed and chair and one fall since re-admission. A care plan, revised 04/27/15, indicated Resident #105 was at risk for falls related to a history of falls and a R BKA, and required staff assistance with bed mobility and transfers. Interventions included dycem to wheel chair and footwear to prevent slipping. Review of the care guide (communication tool used by nurse aides) dated 05/01/15, documented Resident #105 required the assistance of one staff person for transfers, and should have a dycem to his wheel chair. Resident #105 was observed in his wheel chair on the following dates/times; a dycem was not visible in his wheel chair during these observations: · 04/29/15 at 11:18 AM, he self propelled in hallway · 04/29/15 at 11:49 AM, he was seated in front of the window in the 2nd floor dining area · 04/29/15 at 12:49 PM, he was seated at the dining room table and fed him self lunch in the 2nd floor dining area · 04/29/15 at 01:15 PM, he was in his room watching television · 05/01/15 at 08:56 AM, he fed him self breakfast in his room, propelled in his wheel chair independently in his room · 05/01/15 at 01:17 PM, he was seated at the dining room table, fed him self lunch in the 2nd floor dining area; self propelled out of the dining room on 05/01/15 at 01:20 PM toward his room During an interview on 04/29/2015 at 11:36 AM nurse aide (NA) #3 stated Resident #105 was able to propel independently in his wheel chair and often propelled from window to window in the 2nd floor dining room, looking out.

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F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 11) During a follow up interview on 05/01/2015 at 01:55 PM, NA #3 stated she was assigned to care for Resident #105 for the past 2 months routinely, but had not placed a dycem in his wheel chair since caring for him and further stated that she had not seen it, nor did she know where the dycem was located. NA #3 referred to the care guide she used to know what care her assigned residents required and stated that she noticed that the care guide included the use of a dycem for Resident #105, but that she had not placed one in his wheel chair. During an interview on 05/01/15 at 02:05 PM nurse #4 stated he was a routine nurse for Resident #105 since January 2015 and he had not seen the dycem for Resident #105 in a while. Nurse #4 stated nurses were responsible to check the placement of the dycem daily for Resident #105, but could not recall whether or not the dycem was in place. Nurse #4 further stated he was aware that Resident #105 had a history of [REDACTED].#105 while in use to keep him from sliding out of his wheel chair. Nurse #4 stated that he did not check the placement daily for the dycem for Resident #105. Resident #105 was observed in his room in his wheel chair at the time of the interview without the dycem in place. Nurse #4 was unable to locate the dycem in the Resident's room. Resident #105 confirmed during the observation that staff did not routinely place the dycem in his wheel chair and that he had not had not seen it in a while. During an interview on 05/01/15 at 03:41 PM the rehab manager stated when nursing received a physician's orders [REDACTED]. The rehab manager further stated that since Resident #105 was discharged from therapy in November 2014, he was not on therapy case load at the time the physician's orders [REDACTED]. During an interview on 05/04/2015 at 04:03 PM with NA #2, the assigned NA when Resident #105 fell on [DATE], she revealed that Resident #105 required staff assistance with transfers. NA #2 stated that due to a history of falls, staff tried to keep the bed of Resident #105 in the lowest position. NA #2 stated that she did not recall placing a dycem in his wheel chair when she cared for him and could not recall if a dycem was in place at the time he fell on [DATE]. During an interview on 05/04/2015 at 4:09 PM nurse #10 stated Resident #105 required the assistance of one staff person with transfers due to his fall risk. Nurse #10 stated she remembered that Resident #105 fell twice in November 2014. Nurse #10 stated that after Resident #105 fell on [DATE], staff made sure he had shoes on and she placed a dycem to his wheel chair. Nurse #10 stated the use of the dycem was a recommendation she implemented at the time of the fall and it should have been recorded on the MAR for nurses to be reminded to check for placement. Nurse #10 further stated that if she did not record the dycem on the November 2014 MAR it may not have been in place routinely, because the nurses would not have known to check placement. Nurse #10 stated If it (dycem) was used, it would be documented on the MAR. Nurse #10 stated Resident #105 also fell on [DATE], but she could not recall if the dycem was in place at the time of this fall. Nurse #10 stated she worked with Resident #105 routinely, but did not always check for placement of the dycem to his wheel chair. During an interview on 05/05/2015 at 06:38 PM, the director of nursing stated that when fall interventions like an alarm or a dycem are added for a resident after a fall, the interventions should be recorded on the MAR for nurse monitoring, placed on the care plan and added to the care guide used by the nursing assistants for communication/implementation. During an interview on 05/06/2015 at 10:49 AM nurse #11 stated she was the nurse for Resident #105 when he fell on [DATE]. Nurse #11 stated Resident #105 was found on the floor after he attempted to self transfer and he was wearing shoes. Nurse #11 did not remember the use of a dycem at the time of this fall. Nurse #11 stated the stitches to his R BKA opened and a small amount of blood was noted, she cleansed the area with normal saline, applied steri strips and he was assisted to bed, which was placed in the lowest position. 2. Resident #11 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #11's quarterly Minimum Data set ((MDS) dated [DATE] revealed an assessment of severely impaired cognition. The MDS indicated Resident #11 required the extensive assistance of two persons with transfers. The MDS coded Resident #11 with one fall without injury since the prior assessment. Review of Resident #11's care plan revealed a risk for falls. Interventions listed were: use of a mechanical lift with two persons for transfers, medication review as needed, rehabilitation services as needed and bilateral fall mats at bedside. Review of Resident #11's nursing notes from 09/03/14 to 04/29/15 revealed there was no documentation of a fall. Observation on 04/26/15 at 4:30 PM revealed Resident #11 in bed with one floor mat next to the bed. There was no floor mat on the other side of the bed next to the window and no staff in the room. Observation on 04/29/15 at 8:50 AM revealed Resident #11 in bed with one floor mat next to the bed. There was no floor mat on the other side of the bed next to the window and no staff in the room. Interview with Nurse Aide (NA) #1 on 04/29/15 at 10:15 AM revealed Resident #11 used a scoop mattress, floor mat on one side and low bed to prevent falls. NA #1 reported Resident #11 tried to get out of bed at times. Interview with Nurse #3 on 04/29/15 at 10:30 AM revealed Resident #11 required fall prevention measures but had not fallen since she began employment approximately 5 months ago. Nurse #3 explained Resident #11 used a scoop mattress and floor mat. Nurse #3 was not able to provide a reason for the use of one mat on one side of the bed. Observation on 04/29/15 at 4:50 PM revealed Resident #11 in bed with one floor mat next to the bed. There was no floor mat on the other side of the bed next to the window and no staff in the room. Observation on 04/30/15 at 8:16 AM revealed Resident #11 in bed with one floor mat next to the bed. There was no floor mat on the other side of the bed next to the window and no staff in the room. Observation on 04/30/15 at 8:53 AM revealed Resident #11 in bed with one floor mat next to the bed. There was no floor mat on the other side of the bed next to the window and no staff in the room. Observation on 04/30/15 at 11:12 AM revealed Resident #11 in bed with one floor mat next to the bed. There was no floor mat on the other side of the bed next to the window and no staff in the room. Observation on 04/30/15 at 3:40 PM revealed Resident #11 in bed with one floor mat next to the bed. There was no floor mat on the other side of the bed next to the window and no staff in the room. Interview with NA #2 on 05/01/15 at 10:22 AM revealed Resident #11 required a floor mat on each side of the bed. NA #2 unsuccessfully searched Resident #11's for a second floor mat. Interview with Nurse #3 pm 05/01/15 at 10:42 AM revealed Resident #11 required a floor mat on each side of the bed. Nurse #3 reported a floor mat would be immediately obtained. Interview with the Director of Nursing (DON) on 05/01/15 at 11:48 AM revealed Resident #11 required a floor mat on each side of the bed when a staff member was not present. The DON reported staff should follow the care plan and place bilateral floor mats. A second interview with the DON on 05/04/15 at 10:48 AM revealed Resident #11 did not fall since the annual MDS and the quarterly MDS dated [DATE] was in error regarding the fall. 3. Review of Resident #28's quarterly Minimum Data Set ((MDS) dated [DATE] revealed an assessment of moderately impaired cognition with physical behavior directed toward others. Resident #28 resided in Room 210 Bed 1. Review of Resident #79's annual MDS dated [DATE] revealed an assessment of intact cognition. Resident #79 resided in Room 210 Bed 2. Observation on 05/05/15 at 10:55 AM revealed a broken 2 bulb night light inside the door to Room 210 on the left wall approximately 6 inches above the floorboard. One of the cylindrical bulbs was approximately 1 and ½ inch long with a jagged edge. The other cylindrical bulb was approximately 2 and ¼ inch long with a jagged edge. Interview with Nurse Aide (NA) #5 on 05/05/15 at 10:56 AM revealed she did not notice the broken night light. NA #5 explained she would immediately report the broken light to the nurse. Interview with Nurse #4 on 05/05/15 at 10:58 AM revealed he would report the broken bulb to the maintenance director. Nurse #4 reached down and pulled out the broken bulbs. Observation on 05/05/15 at 10:59 AM revealed the Maintenance Director examined the recessed area in the wall which contained the night light. The Maintenance Director announced the protective plate slipped down and exposed the bulbs. Interview with the Maintenance Director on 05/05/15 at 11:00 AM revealed the night lights come on automatically at night and staff and/or residents possibly bumped into the night light. The Maintenance Director explained the night light could break if something hit it without the protective covering. Interview with Resident #79 on 05/05/15 at 11:30 AM revealed he did not notice the broken light bulb. A second interview with the Maintenance Director on 05/05/15 at 3:39 PM revealed all resident room night lights were checked after the discovery today of the broken night light in Room 210. The Maintenance Director reported all resident room night lights were in good condition. Interview with NA #4 on 05/05/15 at 3:42 PM revealed she did not notice the broken night light bulb on 05/04/15. NA #4 reported both residents in Room 210 required assistance with mobility in their wheelchairs. 4) During an observation on 04/28/15 at 9:07 AM, a free standing fan was sitting in the bathroom floor of room 211 and covered with towels. Nurse Aide (NA) #4 was observed to be in and out of the bathroom 2 to 3 times and to be collecting soiled linens. Further observation revealed the fan was plugged in, turned on, and the towels were observed to cover the entire fan and the fans motor. During an observation on 04/28/15 at 9:36 AM, the fan was sitting in the bathroom floor with towels draped over the fan. Further observation revealed the front of the fan was blowing toward the wall and the motor of the fan was facing outward and was completely covered with towels. During an observation on 04/28/15 at 9:51 AM, the running fan remained sitting in the bathroom floor with towels draped over the entire fan and motor. During an observation on 04/28/15 at 10:22 AM, the fan was sitting in the bathroom floor, with the fans motor running and the towels covered the front of the fan and the fans motor. During an interview on 04/28/15 at 10:32 AM, NA #4 stated she had not placed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING _____ B. WING _____	05/07/2015

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GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 12) towels over the fan and was unaware of who or when the towels were placed on the fan. She confirmed she had been in and out of the bathroom several times but had not removed the towels from the fan. She stated it was not unusual for the towels to be draped over the fan and she had not thought anything about it. NA #4 further stated she would have considered the towels that covered the fan to be unsafe and a hazard. During an interview on 04/28/15 at 10:41 AM, Nurse #3 stated she would have expected NA #3 to have removed the towels from the fan. Nurse #3 further stated the NAs were expected to remove towels and/or linens from a residents room after they're used and considered it a hazard and unsafe for the fan to be covered with towels. During an interview on 04/28/15 at 10:37 AM, the Director of Nursing stated she would have expected the towels to have been removed from the fan. She further stated she expected the fans to be used for air circulation and to keep the resident's cool and not as a towel dryer. She indicated she was unaware the towels were being placed over the fan and that she considered it to be a safety hazard. During an interview on 04/29/15 at 10:21 AM, the Maintenance Director indicated he would have expected the towels to have been removed from the fan. He further indicated he was unaware that there were towels being placed over the fan. The Maintenance Director stated his expectation was for there to be nothing placed or hung on the fan because it certainly was a safety hazard.
F 0325 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to provide feeding assistance and address unintended significant weight loss for 1 of 5 residents reviewed for nutrition (Resident #42). The findings included: Resident #42 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The initial Nutritional Evaluation dated 06/27/14 completed by the Dietary Manager (DM) noted her usual meal intake was 50 % to 75 % and she received a therapeutic diet. This note stated her food preferences were obtained and review of this list revealed no dislikes. The Registered Dietician's (RD) nutritional evaluation dated 03/23/15 noted Resident #42 was on a therapeutic diet and her current intake ranged from 39 % to 47 %. The note included the recommendation to maintain her intake at greater than 50 % for all meals. The notes also included the need to monitor nutrition parameters with orders for nutritionally enhanced meals and follow up as needed. A review of the quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #42 was severely impaired in cognition for daily decision making. The MDS further indicated Resident #42 required extensive physical assistance of 1 person for bed mobility, eating, dressing, and personal hygiene, and 2 persons assist with transfers and toileting, and was totally dependent on staff for bathing. Further review of the MDS coded Resident #42 with no difficulty in chewing/swallowing, receiving a therapeutic diet, and weighing 114 pounds being 4 feet 7 inches tall. Per Resident #42's weight record, on 04/06/15 she weighed 111 pounds and on 05/05/15 she weighed 103.4 pounds (a one month 7.2 % significant weight loss). A care plan was developed on 04/14/15 with a focus of inadequate food/beverage intake related to dementia and significant weight loss. The goal was for the resident to maintain body weight through the next review. Interventions included to provide diet as ordered, encourage family to bring in favorite food items, provide assistance with meals, provide food substitutes, snacks between meals, supplement as ordered, monthly weights, and monitor meal consumption daily. Review of the documented intakes for Resident #42 from 04/01/15 through 05/06/15 revealed there was no documentation related to how the resident's intake was for 9 breakfasts, 14 lunches, and 7 dinners. In addition the intake reports noted Resident #42 ate less than 50 % of the meal for those days which were documented for 9 breakfasts, 12 lunches, and 13 dinners. Nurse Aide (NA) #2 was observed on 04/27/15 at 12:38 PM to go into Resident #42's room and ask her are you going to eat? and with no response from the resident NA #2 set up the resident's lunch tray with no attempts to assist her with eating. The lunch meal tray consisted of pork chop, lima beans, potatoes, and a glass of tea. The food on Resident #42's lunch tray was observed to be un-touched. NA #3 was observed on 04/28/15 at 8:52 AM to go into Resident #42's room, set up her breakfast meal tray, and leave the room. Resident #42 was observed to eat her 1 piece of toast and the cream of wheat and eggs were observed to be un-touched. Resident #42 was observed on 04/29/15 at 12:12 PM sitting in her wheelchair at a dining room table. NA #3 was observed on 04/29/15 at 12:25 PM to set up Resident #42's lunch meal tray which consisted of chicken, mashed potatoes, mixed vegetables, cake, and a 6 ounce glass of tea. Resident #42 was observed to roll her wheelchair back from the table and look at her plate while NA #3 asked the resident are you going to eat? and with no response from the resident NA #3 removed the lunch tray from the table with no attempts to feed her or assist her back to the table. The food on Resident #42's lunch tray was observed to be un-touched. NA #2 was interviewed on 04/30/15 at 10:13 AM, she stated she would set up Resident #42's meal tray and deliver the other meal trays to the resident rooms. She indicated Resident #42 would sometimes eat her food and then sometimes she would not eat. She further stated she was unaware Resident #42 needed assistance with eating and she had not reported to the nurse that Resident #42 was not eating her meals. NA #3 was interviewed on 04/30/15 at 10:36 AM, she stated Resident #42 would attempt to feed herself and that she was unaware the resident needed assistance with eating. NA #3 indicated Resident #42 was difficult to understand at times and when she rolled away from the table she assumed the resident was not going to eat because there were times when she had refused to eat. Nurse #4 was interviewed on 04/30/15 at 2:13 PM, he stated he was unaware Resident #42 had not been eating her meals or that she needed assistance with eating. He indicated he would have expected the NAs to have informed him of the resident's decrease and/or refusal of her meals. The Director of Nursing (DON) was interviewed on 05/05/15 at 4:31 PM. She stated she would have expected the NAs to assist Resident #42 with all of her meals and/or to have provided the resident with an alternate meal.
F 0353 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** Based on observations, records reviews and resident and staff interviews the facility failed to provide sufficient nursing staffing for two of three nursing units. The findings included: A review of staffing schedules dated January 1, 2015 through May 7, 2015 revealed when staff called in and could not work their assigned shift the staff members name was marked off the schedule and the name of the staff that covered the shift was written on the schedule. There were shifts where there was only 3 nurse aides scheduled for the 200 hall on the 7AM-3PM shift due to staff calling in. Observations of the daily staffing schedules posted from 04/26/15 through 05/07/15 on 100, 200 and 300 hall nursing units revealed a census of 80 residents and daily staff were scheduled for the 3 units as follows: Shift Hall Residents Nurses Nurse Aides Total 7AM-3PM 100 13 1-Nurse 2-Nurse Aides 3-staff 3PM-11PM 100 13 1-Nurse 2-Nurse Aides 3-staff 11PM-7AM 100 13 1-Nurse 1-Nurse Aide 2-staff 7AM-3PM 200 43 2-Nurses 4 Nurse Aides 6-staff 3PM-11PM 200 43 2-Nurses 3-Nurse Aides 5-staff 11PM-7AM 200 43 1-Nurse 3-Nurse Aides 4-staff 7AM-3PM 300 24 1-Nurse 2-Nurse Aides 3-staff 3PM-11PM 300 24 1-Nurse 2-Nurse Aides 3-staff 11PM-7AM 300 24 1-Nurse 2-Nurse Aides 3-staff Observation on 04/29/15 at 9:50 AM revealed Nurse Aide (NA) #1 gave Resident #11 a bed bath which included incontinence care and application of a disposable brief. A continuous observation on 04/29/15 from 10:12 AM to 1:58 PM revealed Resident #11 remained seated in the wheelchair on the seat cushion. Observation on 04/29/15 at 1:59 PM revealed NA #3, Nurse #3 and Nurse #4 transferred Resident #11 into the bed with a mechanical lift. Nurse #4 and NA #3 repositioned Resident #11 on the right side. NA #3, Nurse #3 and Nurse #4 exited the room and did not perform incontinence care. Interview with Nurse #4 on 04/29/15 at 2:05 PM revealed Resident #11's assigned NA, NA #1 would take care of Resident #11's incontinence needs. Interview with NA #1 on 04/29/15 at 2:26 PM revealed Resident #11 did not require any more incontinence care. NA #1 reported Resident #11 was in bed so she thought incontinence care had already occurred. During this interview, Nurse #4 approached and informed NA #1 Resident #11 required incontinence care. Further interview with NA #1 on 04/29/15 at 2:30 PM revealed Resident #11 did not receive incontinence care since the bed bath at 9:50 AM (4 hours and 40 minutes). NA #1 explained Resident #11 ' s usual routine was to be up in the wheelchair after dressing and incontinence care and transferred back to bed in the afternoon. NA #1 reported Resident #11 received incontinence care and repositioning twice during the eight hour shift and this was the normal routine. NA #1 explained it was not possible to check Resident #11 every 2 hours due to the needs of other residents on the assignment. During an interview on 05/06/15 at 8:40 AM with Nurse #4 he revealed the census on the 200 hall was 43 and there were 2 nurses and 4 NAs working 7AM-3PM. He explained it was hard on the Nurse Aides (NAs) to keep the residents repositioned every 2 hours and the NAs were only repositioning the residents 3 times a shift instead of 4 times per shift. He stated if a NA called in a

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F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 13) nurse could be a NA for the shift that was short, but he had never seen it happen and the least amount of NAs he had worked with was 3. During an interview 05/06/15 at 8:45 AM with NA #3 she revealed in the last month there had been 3 NAs working instead of 4 NAs on the 200 hall from 7AM-3PM. She explained with 4 NAs it was hard to keep the residents repositioned every 2 hours or 4 times a shift. She stated with 4 NAs, 3 NAs would have 11 residents and 1 NA would have 10 residents. She explained the NA ' s only repositioned the residents 3 times a shift instead of 4 times a shift due to not having enough staff. She stated with 11 or more residents it was hard to keep up with the amount of work. During an interview on 05/06/ at 8:47 AM with NA #1 she revealed working with 4 NAs on the 200 hall was hard. She stated the residents were only getting repositioned 3 times a shift instead of 4 time per shift because of the work load. She revealed if there was just one more NA on the 7AM-3PM shift the NA ' s could keep the residents repositioned every 2 hours or 4 times a shift During an interview on 05/06/15 at 8:54 AM with Nurse #6 she revealed she worked on the 300 hall on the 7AM-3PM shift. She revealed there was 1 nurse and 2 NAs on the 300 hall from 7AM-3PM for 24 residents. She revealed it was hard with just 2 NAs especially in the morning because the residents needed help getting up and dressed, there were residents that needed to be fed and there were more behaviors issues in the morning. She stated it would make a big difference to have one more NA in the mornings. During an interview on 05/06/15 at 9:00 AM with NA #6 he revealed he worked 7AM-3PM on the 300 hall. He stated the census was down, but it was still hard on the NAs to get the residents up and dressed, fed breakfast and deal with the behaviors in the morning. He revealed another NA would make the work load better, and when the census went back up there would be a need to have an extra NA. During an interview on 05/06/15 at 9:15 AM the staffing coordinator explained she was responsible for the staffing of all nurses and NAs. She revealed she completed a monthly schedule for each month and had a list of staff to call when staff was unable to work. She explained the facility nurses and NAs worked 8 hours shifts and if staff was unable to work their shift, the staff member was to call in at least 2-3 hours before their shift was to start. She explained there had been a time when the numbers had fallen below the staffing ratio and would happen especially on holidays, but usually occurred at least one per month. She explained if she had a NA call in and she was not able to replace the NA she would come in and work as a NA. She explained there were no charge nurses on the units at night and the licensed nurse on the units would act as a charge nurse. During an interview on 05/06/15 at 11:49 AM with the Director of Nursing (DON) she revealed the facility was staffed according to the census. She explained on the 200 hall there was 2 nurses and 4 NA on first and second shift and 1 nurse and 2 NAs on third shift and on the 300 hall there was 1 nurse and 2 NAs for all three shifts. She stated if someone quit or turned in a notice she would notify the staffing coordinator. She explained staff would call her and the staffing coordinator if staff called in and they both would try and cover the call in. She explained she was concerned about staffing on the 200 hall on the 3PM-11PM shift and she explained there needed to be another NA working on the 200 hall on 3PM-11PM shift. She explained she wanted more NAs working on second and third shift. She states she can't fix something if she doesn't know it is broken. She stated there was no supervisor on and the nurse on the halls at nights was the charge nurse for that hall. She stated she expected her staff to reposition residents 4 times a shift and was not aware that the residents on the 200 hall were only being repositioned 3 times a shift due to there not being enough NAs. She stated she expects all 3 shift to reposition and change the residents every 2 hours or 4 times a shift and as needed.
F 0364 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Prepare food that is nutritional, appetizing, tasty, attractive, well-cooked, and at the right temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 6 of 10 resident complaints in resident council, 5 resident interviews (Residents #77, #109, #110, #50, and #22), 2 of 2 observations of the tray line meal service, a test tray, staff interviews, and review of facility records, the facility failed to provide residents with palatable foods based on resident preference for food temperature. The findings included: 1 a. Review of the minutes from the 04/01/15 resident council meeting revealed 6 of the 10 residents in attendance voiced concerns that their food always reached them cold. The director of food service (DFS) provided residents with a written response on this complaint on 04/02/15. Residents were informed that test trays would be conducted once weekly and that new meal delivery carts were ordered 02/16/15, received on 04/01/15, but not yet in use. The new carts required trays that fit which were ordered on [DATE], but had not yet arrived. The DFS provided documentation of test tray results dated 04/02/15 and 04/28/15 which identified milk was a little warm when served. There was no further documentation of test trays conducted. b. An admission nursing assessment dated [DATE] assessed Resident #77 as alert and oriented. The admission Minimum Data Set ((MDS) dated [DATE] did not assess the cognition of Resident #77. Resident #77 was interviewed on 04/27/15 at 10:13 AM and stated he had not received hot food in the facility in a long time, especially if he received his meal in his room. He stated all meals, breakfast, lunch and dinner were always cold. c. Review of the admission MDS dated [DATE] assessed the cognition of Resident #109 as moderately impaired. Resident #109 was interviewed on 04/27/15 at 05:05 PM and stated that the food was cold, breakfast was cold all the time, especially the eggs and supper was often cold. She stated she reported this concern to staff. d. Review of the admission MDS dated [DATE] assessed Resident #110's cognition as intact. The quarterly MDS dated [DATE] did not assess the cognition of Resident #110. Resident #110 was interviewed on 04/28/15 at 10:40 AM and stated that his food was always received cold; he stated his food was never hot. e. Review of the admission MDS dated [DATE] assessed Resident #50's cognition as intact. Resident #50 was interviewed on 04/28/15 at 11:57 AM and stated none of her meals were served hot, but that staff would reheat foods if asked. Resident #50 was observed on 04/28/15 at 12:49 PM to receive her lunch meal to include country potatoes and chicken. Resident #50 complained that her potatoes and chicken were cold. f. Review of the quarterly MDS dated [DATE] assessed the cognition of Resident #22 as moderately impaired. Resident #22 was observed on 04/28/15 at 12:50 PM with her lunch meal that included country potatoes and chicken. Resident #22 stated that the potatoes and chicken she received for lunch were not hot, that she usually received her meals cold and that coffee was seldom hot, usually lukewarm. She stated she reported this concern to staff. g. Review of the facility's policy Holding and Serving, not dated, revealed hot foods should be held at a continuous temperature of 135 degrees Fahrenheit or above on the serving line. Hot items like alternates that are not served continuously, should be covered and foods should not be plated and held on the steam table without direct heat. During kitchen observations of the tray line meal service, the following concerns were noted regarding food temperature and plating foods: · On 04/29/15 from 12:00 PM until 12:45 PM, the lunch meal tray line was observed in progress. On 04/29/15 at 12:32 PM, temperature monitoring revealed the country potatoes were 100 degrees Fahrenheit (F). The potatoes were observed stored on the steam table in a long stainless steel pan, two inches deep, which remained uncovered for the duration of the tray line service. · On 04/30/15 from 08:03 AM until 08:40 AM, the breakfast meal tray line was observed in progress. On 04/30/15 from 08:03 AM to 08:40 AM dietary staff #3 was observed to prepare 5 plates at one time for the duration of the tray line. Each plate remained uncovered on the steam table for 3 - 5 minutes until all 5 plates were completed and then covered. Dietary staff #3 was observed on 04/30/15 at 08:08 AM to prepare 2 plates which were left uncovered while he walked away from the tray line rinsed a serving utensil, washed his hands and donned gloves. · On 04/30/15 from 08:12 AM to 08:23 AM temperature monitoring of the breakfast tray line revealed the following foods had temperatures less than 135 degrees Fahrenheit (F): o Cream of wheat was 130 degrees F; stored in a half stainless steel pan, four inches deep and remained uncovered for the duration of the tray line. o Sausage patties were 118 degrees F; approximately 40 patties were stored in a half stainless steel pan, two inches deep and remained uncovered for the duration of the tray line. o Scrambled eggs were 130 degrees F; stored in a half stainless steel pan, two inches deep and remained uncovered for the duration of the tray line. During an interview on 04/30/2015 at 8:40 AM with dietary staff #3 he stated that hot foods should be kept on the tray line at least 145 degrees F. Dietary staff #3 stated he tried to conduct temperature monitoring prior to and at some point during the tray line service, usually every 45 minutes, unless he got busy and was unable to complete a second check. Dietary staff #3 stated he could not explain why the country potatoes served at lunch on 04/29/15 did not hold temperature during the tray line service. Dietary staff #3 further stated that he conducted temperature monitoring for the main menu items that morning (04/30/15) prior to the start of the tray line to include the eggs, but that he did not conduct temperature monitoring of the sausage patties because the breakfast meats were alternates available to residents upon request. Dietary staff #3 further stated that he routinely conducted temperature monitoring prior to the start of the tray line for main menu items, but not always for alternate menu items. During an interview on 04/30/2015 at 8:51 AM, the director of food service (DFS) stated that in order to provide residents with palatable foods, hot foods were to be held on the tray line at a temperature of at least 135 degrees. The DFS stated

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F 0364 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 14) that temperature monitoring was conducted prior to the start of the tray line, hot foods were not placed on the tray line more than 15 minutes before the start of the tray line. The DFS stated that foods were held on the tray line for up to 1 hour and after 45 minutes a second temperature check was conducted. The DFS further stated that as a result of observations of hot foods not being held at least 135 degrees F on the tray line, dietary staff could place foods on the tray line in smaller batches and keep foods covered during the tray line. On 05/01/15 a lunch meal test tray for a regular diet was requested at 12:35 PM and arrived on the 2nd floor at 12:56 PM in an enclosed stainless steel cart. The lunch meal was plated and and the plate was enclosed in an insulated dome lid and bottom. The meal included ham, cabbage, potatoes and coffee. The DFS was present and tasted the lunch meal on 05/01/15 at 01:25 PM along with the surveyor. The DFS and surveyor agreed that the coffee was hot, ham and potatoes were warm and the cabbage was lukewarm. During a follow up interview on 05/07/2015 at 02:32 PM, the DFS stated she started as the DFS in November 2014 and began monitoring the tray line temperatures Monday - Friday taken at the beginning of the tray line meal service, with no concerns identified. The DFS stated that she did not monitor the tray line temperatures she expected the cooks to take about 45 minutes after the tray line began. The DFS stated residents, including those with frequent food concerns or who often requested alternate meal selections, were invited to attend monthly food committee meetings, which she also attended, to discuss food concerns. Minutes were kept, which she reviewed, but she was unable to locate the minutes from the last 3 monthly meetings (February - April 2015). She further stated that a food committee meeting was not held in January 2015. The DFS stated that Resident #109 voiced concerns to her about 2 weeks ago regarding cold eggs at breakfast. Additonally, she statd that residents commented during the April 2015 resident council meeting that they received lunch meals that were cold. The DFS stated she provided a written response to the April 2015 resident council meeting that she would watch food temperatures on the tray line and conduct weekly test trays. The DFS stated that she had not conducted weekly test trays, as indicated in her reponse to resident council, but rather conducted them every once in a while. The DFS stated she conducted a test tray on 04/02/15 after the resident council meeting and again on 04/28/15 after concerns were identified during the survey. The DFS stated that she had recently provided Resident #109 with a hot breakfast twice after Resident #109 complained again of receiving cold breakfast foods. The DFS also stated that in April 2015 she identified that a couple of the food carts were missing doors and submitted a request to the maintenance director for repairs. Additionally, she asked the maintenance director to look at the steam table on 04/30/15 as a result of tray line observations during the survey of foods not holding temperature. During an interview on 05/07/2015 at 4:42 PM the maintenance director stated that he replaced missing doors to a food cart in March 2015 and was asked by the DFS to check the steam table on 04/30/15. He found that the 2 middle bays of the steam table were 15 - 20 degrees less than the other 3 bays. The maintenance director stated that the temperature gauges could be bad, but since the heating elements were still working he did not make any repairs, but rather asked the DFS to continue to monitor the food temperatures.
F 0367 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that special or therapeutic diets are ordered by the attending doctor.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and medical record review the facility failed to provide Resident #105 a nutritionally enhanced diet as ordered by the physician for 1 of 4 sampled residents reviewed for therapeutic diets. Findings included: Resident #105 was admitted to the facility 10/03/14 and readmitted on [DATE] after a surgical procedure. [DIAGNOSES REDACTED]. A quarterly Minimum (MDS) data set [DATE] assessed Resident #105's cognition as intact, indicated he was independent with eating and had a poor appetite. A physician's orders [REDACTED].#105 to receive a nutritionally enhanced (NE), mechanical soft diet. Review of the care plan, revised 03/13/15, revealed Resident #105 received NE, mechanical soft diet due to the [DIAGNOSES REDACTED]. Care plan interventions included to provide diet as ordered, comfort foods, food substitutes and snacks between meals, as requested. Review of the facility's Nutritionally Enhanced Diet policy, undated, revealed a NE diet was designed for those whose consumption did not always meet nutritional needs, at risk for/[DIAGNOSES REDACTED]. The NE diet provided increased calories (2900 - 3100) with protein (85 - 95 grams) provided in small volume portions. NE foods included juice, cereal, and meat/meat substitute. Review of the list of food dislikes per menu items for Resident #105 revealed the facility had approximately 726 foods documented that Resident #105 disliked to include fortified milk and fortified orange juice and various beef, pork and chicken entrees. Resident #105 was observed on 04/29/15 at 12:49 PM feeding him self lunch. He received chopped chicken, peas/carrots, fortified mashed potatoes, cake, coffee and lemonade. Resident #105 did not receive milk. Review of the NE menu revealed fortified milk should have also been provided. Resident #105 was observed on 05/01/15 at 8:56 AM feeding him self breakfast. He received French toast with syrup, scrambled eggs, oatmeal, sausage, orange juice, coffee, and an 8 ounce carton of whole milk. Review of the tray card for Resident #105 revealed he received juice of the day, cereal of choice and scrambled eggs. These foods were not documented as fortified. Review of the NE menu revealed fortified juice and fortified milk should have been provided. Resident #105 was observed on 05/01/2015 at 1:17 PM in the 2nd floor dining room feeding him self lunch. He received a hamburger on a bun, cabbage, roasted red skinned potatoes, iced tea, 8 ounces of whole milk, water, banana cake and coffee. Review of the tray card for Resident #105 revealed he did not receive a NE food item for this lunch meal. Review of the NE menu revealed Resident #105 should have received fortified mashed potatoes and fortified milk. During an interview on 05/01/15 at 5:51 PM, the director of food service (DFS) stated that when Resident #105 was admitted to the facility in October 2014, his food dislikes were documented in the computer in error and included approximately 50 pages of food items to include fortified juices, fortified milk and some entrees. The DFS stated the food dislikes for Resident #105 had not been updated since he was admitted which may explain why he had not received the fortified milk/juices/mashed potatoes and some entrees. She stated some fortified foods did not print on the Resident's tray card since the foods were recorded in the computer as a disliked food item. The DFS stated that there may have been some meals Resident #105 did not receive fortified food items because of all the disliked foods listed in the computer for him. The DFS also stated that the tray card should record the word fortified next to the food item that would be nutritionally enhanced so that the dietary staff would know to plate that specific food item. The DFS stated that it was the expectation that residents receive a diet as ordered by the physician with their food preferences honored. During an interview on 05/05/2015 at 01:52 PM, the consultant registered dietitian (RD) stated Resident #105 was readmitted to the facility in December 2014 after surgery and in March 2015 his diet was changed to NE due to involuntary weight loss. The RD stated that the tray card should record the word fortified beside the menu item that was NE. The RD reviewed the weight history for Resident #105 since his readmission to the facility and stated that his weight was currently stable. The RD stated the goal for Resident #105 was to provide him with a diet as ordered and to honor his food preferences. During an interview on 05/05/2015 at 6:38 PM the director of nursing (DON) reported that she expected residents to receive their diet as ordered by the physician and according to their preferences. The DON further stated that she expected nursing staff to review the resident's tray card when they set up the meal to make sure the resident received all food items as per the tray card, if something was missing, the DON stated nursing staff should call the dietary department to have that food item provided to the resident.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Store, cook, and serve food in a safe and clean way** Based on observations, staff interviews and review of facility records, the facility failed to maintain hot foods at least 135 degrees F on the tray line, remove contamninated gloves prior to contacting food, store frozen foods in sealed containers and remove an expired nutritional supplement from cold storage for 2 of 2 kitchen observations. 1. Review of the facility's undated policy Holding and Serving revealed hot foods should be held at a continuous temperature of 135 degrees Fahrenheit or above on the serving line to prevent food borne illness. During kitchen observations of the tray line meal service, the following concerns were noted regarding food temperature: · On 04/29/15 from 12:00 PM until 12:45 PM, the lunch meal tray line was observed in progress. On 04/29/15 at 12:32 PM, temperature monitoring revealed the country potatoes were 100 degrees Fahrenheit (F). · On 04/30/15 from 08:12 AM to 08:23 AM temperature monitoring of the breakfast tray line revealed the following foods were on the tray line with temperatures less than 135 degrees Fahrenheit: o Cream of wheat was 130 degrees F o Sausage patties were 118 degrees F o Scrambled eggs were 130 degrees F During an interview on 04/30/15 at 8:40 AM with dietary staff #3 he stated that hot foods should be kept on the tray line at least 145 degrees F. Dietary staff #3 stated he tried to conduct temperature monitoring prior to and at some point during the tray line service, usually every 45 minutes, unless he got busy and was unable to complete a second check. Dietary staff #3 further stated that he conducted temperature monitoring for the main menu items that morning (04/30/15) prior to the start of the tray line to include the eggs, but that he did not conduct temperature monitoring of the sausage patties because the breakfast meats were alternates available to residents upon request. Dietary staff #3 further stated that he routinely conducted

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F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 15) temperature monitoring prior to the start of the tray line for main menu items, but not always for alternate menu items. During an interview on 04/30/15 at 8:51 AM, the director of food service (DFS) stated that hot foods were to be held on the tray line at a temperature of at least 135 degrees. The DFS stated that temperature monitoring was conducted prior to the start of the tray line, hot foods were not placed on the tray line more than 15 minutes before the start of the tray line, and foods were held on the tray line for up to 1 hour. The DFS further stated that after 45 minutes a second temperature check was conducted. The DFS stated that at times foods were placed on the steam table 30 minutes or more before the start of the tray line, stored in large batches and left uncovered throughout the tray line service. The DFS stated these were possible reasons why some foods were not holding a temperature of at least 135 degrees F for the duration of the tray line. The DFS also stated that in April 2015 she identified that a couple of the food delivery carts were missing doors and submitted a request to the maintenance director for repairs. Additionally, she requested the maintenance director to look at the steam table on 04/30/15 as a result of the survey to identity why foods were not holding temperature on the steam table. During an interview on 05/07/2015 at 4:42 PM the maintenance director stated that he replaced doors to a food cart in March 2015 and was asked by the DFS to check the steam table on 04/30/15. He found that the 2 middle bays of the steam table were 15 - 20 degrees less than the other 3 bays. The maintenance director stated that the temperature gauges could be bad, but since the heating elements were still working he did not make any repairs, but rather asked the DFS to continue to monitor the food temperatures 2. The facility policy Disposable Gloves dated 2011, recorded in part, that the appropriate use of utensils (gloves) is essential to preventing food borne illness. Single-use gloves should be used for only one task, gloves must be worn when touching any food item, bare hand contact with foods is prohibited and gloves should be used for no other purpose and discarded when damaged or soiled. During meal tray line observations the following concerns were noted regarding the use of gloves and direct contact with food: · On 04/29/15 from 12:00 PM until 12:45 PM, the lunch tray line was observed in progress. During the tray line, dietary staff #3 was observed to pick up hot dogs and hamburger patties during temperature monitoring and sliced bread while plating with his gloved hands. These same gloves were also used to open a box of alcohol wipes, remove the packaging from alcohol wipes, and open and close the walk-in refrigerator door. Hand hygiene was not conducted between these tasks and gloves were not removed prior to contacting food during the meal service. · On 04/30/15 from 08:03 AM until 08:40 AM, the breakfast meal tray line was observed in progress. Dietary staff #3 was observed to pick up a box of alcohol wipes, open several pacakages of alcohol wipes and donned his glasses with his gloved hands and then picked up sausage patties during temperature monitoring with the same gloved hands. Hand hygiene was not conducted between these tasks and gloves were not removed prior to contacting food during the meal service. · On 04/30/15 at 08:12 AM, dietary staff #3 removed his gloves, completed hand hygiene, turned off the water faucet with ungloved hands, dried his hands with a paper towel, opened the oven door, removed a pan of sausage patties from the oven and with his ungloved hands moved sausage patties to one side of a stainless steel pan and poured more sausage patties into the same pan. Hand hygiene was not conducted between these tasks. During an interview on 04/30/15 at 08:40 AM, dietary staff #3 stated that he usually plated toast with utensils, but that he will also plate toast with gloved hands, being careful not to use soiled gloves to plate foods. Dietary staff #3 stated that if the gloves became soiled, he was trained to remove them, complete hand hygiene and put on new gloves. During an interview on 04/30/15 at 08:51 AM the director of food service (DFS) stated that cooks should handle food with utensils, or with clean gloved hands, but not with ungloved hands. The DFS stated that food should be discarded if handled with soiled utensils or soiled ungloved hands. The DFS stated that when gloves become soiled, staff should remove the gloves, wash hands and put on clean gloves because staff should not serve foods that have been touched with soiled gloves. 3. The facility policy, Storage of Refrigerated Foods, undated, recorded in part to monitor all items daily for expiration dates or use by dates and discard all outdated items immediately. The facility policy Storage of Frozen Foods, dated 2011, recorded in part to properly re-seal packages of frozen foods that have been opened to prevent freezer burn and spoilage. During an observation on 04/26/15 of the cooler and the freezer the following concerns were noted: · The cooler was observed on 04/26/15 at 02:51 PM with a 240 milliliter container of a renal nutritional supplement with a manufacturer's use by date stamp of 02/09/15. · The freezer was observed on 04/26/15 at 03:00 PM with the following foods open to air: o Corn on the cob - 1 case o Green peas - 2 cases o Beef liver - 1 case o Cookie dough - 1 case o Wheat dinner rolls - 1 case o Fish - 1 case During an interview on 04/26/15 at 03:00 PM with the director of food service (DFS) she stated the items observed stored open to air were delivered on Friday, 04/24/15. Review of the menu and interview with the DFS revealed the frozen foods were either on the menu or served between 04/24/15 - 04/26/15. The DFS confirmed that all frozen foods should be stored in sealed containers to prevent freezer burn. The DFS revealed that she routinely checked refrigeration units when she worked and removed expired items, but that the renal supplement was missed. The DFS stated she checked cold storage for labeling, dating and packaging, but when she was not present, it was the cook's responsibility, but these items were missed. During an interview on 04/26/15 at 03:02 PM, dietary staff #4 stated she was in/out of the freezer that day, and knew that she was responsible to check refrigeration units when she worked. Dietary staff #4 stated that she checked the freezer that day, but did not conduct a complete check of items in the freezer for labeling, dating and packaging. She stated the boxes of frozen foods left open to air were missed.
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** Based on observations and staff interviews the facility failed to secure prescribed medications and narcotics for discharged residents in 1 of 1 room used for medication storage and failed to remove expired medications from 2 of 4 medication carts. The findings included: 1. During an observation on 05/07/15 at 11:30 AM the Director of Nursing's office was located on the main entrance hall of the facility next to the main lobby. The door of the office was open and there was no one in the room. There were clear plastic bags in the corner of the room that was visible from the hallway with packages of medications visible in the bags. During observations on 05/07/15 at 5:20 PM the door of the Director of Nursing's office was open and there were multiple clear plastic bags with medications of pills and liquids in bubble packages, vials and boxes and also bottles of stock medications stacked in a corner of the room that were visible from hallway. The DON unlocked a bathroom door in her office and inside the bathroom was a large cardboard box that did not have a lid that was full of narcotics and a large yellow plastic storage box with a black lid that was sitting on the floor of the bathroom that was also full of narcotics. During an interview on 05/07/15 at 5:25 PM with the Director of Nursing (DON) she explained all of the medications for residents who were discharged from the facility were stored in her office. She verified there was no inventory of any of the medications but the narcotics had the narcotic count sheets wrapped around each container of narcotics. She stated the medications had been stored in her office during the last year and the pharmacy they contracted with was supposed to pick up the medications for disposal. She verified the door of her office was usually left open and she was not always in the office during the day when she was at work. During a telephone interview on 05/07/15 at 5:30 PM with the Clinical Pharmacist he explained the facility did not have a pharmacy located on site and had been told the DON's office had been selected to store medications of discharged residents until they could be disposed. He explained the process for disposal was the North Carolina Division of Mental Health Services was responsible for the disposal of medications in nursing homes. He stated he was supposed to pick up the medications periodically and take them to mental health personnel and they audited the medications and witnessed the disposal of them. He stated he tried to pick up the medications every 6 months for disposal. He explained if there was a discrepancy when the medications were counted before disposal it went back to the facility for evaluation or action. He verified narcotics were supposed to be kept under double lock at all times and the non-narcotic medications should be stored under single lock at all times. He stated he had not been offered any other options for medication storage in the facility but the narcotics had to be stored under double lock and the non-narcotics under single lock. During a follow up interview on 05/07/15 at 5:38 PM the DON verified the information the Clinical Pharmacist shared was accurate. She further verified her office was not always locked so narcotics were not under double lock at all times. She also stated the non-narcotic medications in her office were not locked when she was out of her office because the door was left open most of the time while she was at work. 2. Inspection was conducted on 05/05/15 at 2:06 PM of the 200 hall medication cart which revealed the following expired medications a) One bubble packed card of Hydrocodone/APAP (a narcotic pain medication) 5-500 milligrams (mg) with 19 pills

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F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 16) left stamped with the pharmacy labeled expiration date of 12/05/14. b) A partially used bottle of Atropine sulfate ophthalmic solution 1% (prescription eye drops) was opened with no resident identifier or dispensing information and was dated as opened on 04/15/15. c) A partially used bottle of Lumigan solution 0.01% (prescription eye drops) was open and not dated when it was opened or expiration. d) Two partially used bottles of Travatan Z 0.004% (prescription eye drops) was open and not dated when it was opened or expiration. The 2 bottles were labeled for 2 different residents. An interview was conducted on 05/05/15 at 2:36 PM with Nurse #1 regarding the 2nd floor medication administration cart. Nurse #1 revealed the medications were currently in use and were available for residents receiving those medications. When asked about the facility's system for checking the medication carts for expired medications, she indicated each nurse administering medications from the cart was responsible for checking for expired medications prior to administration of the medication, for removing them from the cart and reordering new mediations. Nurse #1 revealed that she missed looking at these medications expiration dates and labeling. Nurse #1 further revealed the medications listed above were not labeled correctly, were expired and should have been removed from the medication cart. 3. An inspection was completed on 05/05/15 at 3:23 PM of the 300 hall medication cart revealed the following expired medication. a) One opened bottle of morphine sulfate 100mg per 5ml solution (liquid narcotic pain medication) was dated as opened on 05/28/14 and was stamped with the manufacturer's expiration date of November 2014. An interview was conducted on 05/05/15 at 3:53 PM with Nurse #2 regarding the 3rd floor medication administration cart. Nurse #2 revealed the medications were currently in use and were available for residents receiving those medications. When asked about the facility's system for checking the medication carts for expired medications, she indicated each nurse administering medications from the cart was responsible for checking for expired medications prior to administration of the medication, for removing them from the cart and reordering new mediations. Nurse #2 revealed that she missed looking at these medications expiration dates and labeling. Nurse #2 further revealed the medications were not labeled correctly, were expired and should have been removed from the medication cart. An interview was conducted on 05/05/15 at 2:45 PM with the Director of Nursing (DON) regarding the 2nd and 3rd floor medication administration carts with expired medications. The DON revealed it was her expectation in regard to expired medications that she expected each nurse administering medications to check the medication carts for expired medications and to remove any expired medications from the cart prior to administration. The DON indicated that expired medications should not be available for use on the medication carts, should be discarded or returned to the pharmacy. The DON confirmed the medications reviewed on the medications carts were expired.
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews the facility failed to transcribe a physician's order correctly for [MEDICATION NAME] for 1 of 37 sampled residents reviewed for medications. (Resident #12). The findings included: Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#12 was moderately impaired in cognition for daily decision making. A review of a physician's order dated 03/27/15 indicated [MEDICATION NAME] 0.5 milligrams 1 PO (by mouth) every 12 hours as needed (PRN) anxiety. A review of a facility document titled Physician's Pharmacy order for: Resident #12 indicated order dated 03/28/15 indicated communication method: phone for [MEDICATION NAME] tablet 0.5 mg. Give 0.5 mg by mouth every 12 hours as needed for pain. During a telephone interview on 05/05/15 at 8:59 AM with Nurse #9 she confirmed she had transcribed the order for [MEDICATION NAME] for Resident #12. She stated the physician's order was for [MEDICATION NAME] 0.5 mg by mouth every 12 hours PRN for anxiety but she had transcribed it incorrectly for pain. During an interview on 05/07/15 at 4:31 PM with the Director of Nursing she confirmed the [MEDICATION NAME] order for [REDACTED].
F 0520 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in [DATE]. This was for four recited deficiencies which were originally cited in [DATE] on a recertification and complaint investigation and again on the current recertification survey. The deficiencies were in the areas of choices, accidents, dietary services and quality assessment and assurance. The facility's continued failure to implement and maintain procedures from a Quality Assessment and Assurance Committee, during two federal surveys of record, show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1 a. F 242: Choices: Based on observations, medical record reviews, staff and resident interviews, the facility failed to honor a resident's choice of the time for getting up in the mornings (Resident #29) and failed to honor a resident's food preferences for 2 of 5 sampled residents who were reviewed for choices (Resident #105). During the [DATE] recertification survey and complaint investigation, the facility was cited for failure to honor a resident preference for the type of bathing. The facility was recited during the current recertification survey and complaint investigation for failing to honor food preferences and assisting a resident out of bed at the time requested by the resident. b. F 323: Accidents: Based on observations, resident interviews, staff interviews and medical record review, the facility failed to implement fall interventions as care planned, replace a broken nightlight and operate a free standing fan safely to prevent an accident hazard. Resident #105 did not have a dycem in his wheel chair to prevent falls and Resident #11 did not have a floor mat in place for 2 of 8 sampled residents reviewed with a history of falls. A broken nightlight was not replaced (room [ROOM NUMBER]) and a free standing fan was used in a residents bathroom while wet towels hung covering the motor (room [ROOM NUMBER]) for 2 of 27 sampled resident rooms. During the [DATE] recertification survey and complaint investigation, the facility was cited for failure to supervise cognitively impaired wandering residents. The facility was recited during the current recertification survey and complaint investigation for failing to supervise residents at risk for falls, implementing interventions to prevent falls, and monitoring for accident hazards to include a broken light bulb and a free standing fan. c. F 371: Dietary services: Based on observations, staff interviews and review of facility records, the facility failed to maintain hot foods at least 135 degrees F on the tray line, remove soiled gloves prior to contacting food, store frozen foods in sealed containers and remove an expired nutritional supplement from cold storage for 2 of 2 kitchen observations. During the [DATE] recertification survey and complaint investigation, the facility was cited for failure to maintain warm water used for staff to perform hand hygiene between dietary tasks. The facility was recited during the current recertification survey and complaint investigation for failure to maintain hot foods at least 135 degrees Fahrenheit, perform hand hygiene and remove soiled gloves between dietary tasks, store frozen foods to prevent freezer burn and removed expired nutritional supplements. d. F 520: Quality Assurance (QA): Based on observations, record reviews and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in [DATE]. This was for four recited deficiencies which were originally cited in [DATE] on a recertification and complaint investigation and again on the current recertification survey. The deficiencies were in the areas of choices, accidents, dietary services and quality assessment and assurance. The facility's continued failure to implement and maintain procedures from a Quality Assessment and Assurance Committee, during two federal surveys of record, show a pattern of the facility's inability to sustain an effective Quality Assurance Program. During the [DATE] recertification survey and complaint investigation, the facility was cited for failure to have an effective QA program to supervise wandering residents. The facility was recited during the current recertification survey and complaint investigation for failure to implement and maintain an effective QA program regarding 4 repeat deficiencies in the areas of choices, accidents, dietary services and QA during two federal surveys of record. During an interview on [DATE] at 06:19 PM, the administrator stated that he attributed the repeat deficiencies in the areas of choices, accidents, dietary services and QA to a faulty QAA program, which did not occur under his direction. The administrator further stated that whatever QAA systems were to be implemented in [DATE] were not followed and monitored. The administrator stated he read the minutes from resident council meetings, but he was not aware that residents had current concerns related to resident choice or dietary services. He stated he reviewed the accident/incident event reports daily and was concerned about the large number of incidents occurring. The administrator stated that he had not had

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