STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/11/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - CHARLOTTE	**2616 EAST 5TH STREET** **CHARLOTTE, NC 28204**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system utilizing special locking. In the exit conference all deficiencies noted were discussed and acknowledged with administration. At time of survey the: Total Certified Bed Count =120 Census =98 The deficiencies determined during the survey are as follows:	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 8/11/15 at approximately 12 PM onward, the following deficiencies were noted: The building construction type was non-compliant, specific findings include; The sagging in the ceiling at the east nurses station in combination with the penetration around the sprinkler head does not meet the required fire resistance rating.	K 012	Preparation on and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. This plan of correction is submitted as the facility's	9/25/15

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

Electronically Signed | 08/28/2015

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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K 012	Continued From page 1 Reference NFPA 101, 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This deficiency affected one of seven smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 012	credible allegations of compliance. 1. The facility will repair ceiling on East Wing unit beginning September 8,2015 to be completed by September 11,201 to meet building construction type. The ceiling repair will also resolve penetration issues by meeting the required fire resistance rating. 2. Each resident has the potential to be affected by this deficient practice. Ceilings throughout the facility will be observed to identify other life safety issues pertaining to this deficient practice. 3. QI monitoring tools will be utilized to monitor ceilings on a weekly basis X 12 weeks. 4. Results of the QI tools will be forwarded to QAPI meetings monthly X 3 months to ensure compliance.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		9/25/15

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K 076	Continued From page 2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 8/11/15 at approximately 12 PM onward, the following deficiencies were noted: The oxygen storage was non-compliant, specific findings include; the oxygen storage room at the east nurses station had combustible items and supplies stored within 5'-0" of the E sized O2 tanks. Ref: 2000 NFPA 101 Section 18.3.2.4, 1999 NFPA 99 Section 8-3.1.11.2, CMS S&C 07-10 In storage locations protected by automatic sprinkler system where the volume of oxygen is less than 3000 cubic feet (approx. 120 E sized cylinders) oxidizing gases shall be separated from combustible materials by a minimum distance of 5'-0" or be enclosed with 1/2 hour fire resistant rated construction or in a flammable liquid storage cabinet. Volumes of oxygen less than 300 CF of O2 (approx. 12 E sized cylinders) may be kept in each smoke compartment at location open to the corridor. This deficiency affected one of seven smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 076	1. By August 31, 2015, the facility will relocate 02 tanks to an area which will allow a clearance of 5'-0" from other supplies. 2. Each resident has the potential to be affected by this deficient practice. Storage rooms throughout the facility will be monitored to ensure 02 tanks are stored in its proper location and to ensure there is a 5'-0" clearance from other supplies. 3. Current nurses will be educated on the proper location of O2 storage by September 25, 2015. QI monitoring tools will be utilized 5 days a week X 12 weeks, to monitor the storage of 02 tanks and to ensure there is 5'0" clearance from other supplies. 4. Results of the QI tools will be forwarded to QAPI monthly X 3 months to ensure compliance.	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser	K 211		9/25/15

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K 211	Continued From page 3 capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on 8/11/15 at approximately 12 PM onward, the following deficiencies were noted: The Alcohol Based Hand Rub (ABHR) dispensers were non-compliant, specific findings include: the ABHR in medical records and the Laundry were over or within six inches of the light switches. Reference: CMS S&C 05-33 ABHR dispensers are not installed over or adjacent to an ignition source. This deficiency affected two of seven smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 211	1. By 8/12/15, the alcohol based hand rub dispensers in medical records and laundry were removed away from the light switches. 2. Each resident has the potential to be affected by this deficient practice. Alcohol based hand rub dispensers will be observed throughout the facility, to ensure its location is not within six inches of a light switch. 3. QI monitoring tools will be utilized weekly X 12 weeks to ensure dispensers are not located within 6 inches of any light switches. 4. Results of the QI monitoring tools will be forwarded to the QAPI meeting monthly X 3 months to ensure compliance.	