NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER - ASHEVILLE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Comment Comment Street Address Participation Comment Comment Comment Street Address Participation Comment Comment Comment Street Address Participation Comment Comment Comment Street Address Participation Comment Commen	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
GOLDEN LVINGCENTER - ASHEVILLE SOUMARY STATEMENT OF DEFICIENCIES INTERNATION Description Description <thdescription< th=""> Description <th< th=""><th></th><th></th><th>345010</th><th>B. WING</th><th></th><th>06/14/2016</th></th<></thdescription<>			345010	B. WING		06/14/2016
GOLDER LUNNCCENTER - ASHEVILLE ASHEVILLE, NC 28804 (M) ID TRG SUMMARY STATEMENT OF DEFICIENCIES (EXCH DEFICIENCES DE YFLUL RECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EXCH DEFICIENCY MIST BE PRECEDS BY FLUL RECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EXCH DEFICIENCY OF USED BY FLUL RECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EXCH DEFICIENCY OF USED BY FLUL RECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EXCH DEFICIENCY) PREFIX (EXCH DEFICIENCY) 000 (CROSS REFERENCE) 000 (CROSS REFERENCE) K 000 INITIAL COMMENTS K 000 K 000 (CROSS REFERENCE) CROSS REFERENCE) 000 (CROSS REFERENCE)<	NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
Mean REAL CORPUSITION OF USCIDENTIFYING INFORMATION) PREFX TAG CEARLY CORECTIVE ACTIONS HOULD BE CROSS-REFIRENCE to THE APPROPRIATE COMMENT K 000 INITIAL COMMENTS K 000 INITIAL COMMENTS K 000 INITIAL COMMENTS K 000 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 II(222) construction, one story, with a complete automatic sprinkler system and using special locking. In the exit conference all deficiencies noted were discussed and acknowledged with administration. K 032 7/24/16 K 032 Nr He of survey the licensed bed capacity = 77 Total Certified Bed Count 77 NF Census 63 K 032 7/24/16 Not less than two exits, remote from each other, are as follows: NFA 101 LIFE SAFETY CODE STANDARD K 032 Y/24/16 Not less than two exits, remote from each other, are forcharel axit, greens than tor passageway. Only one of these two exits may be a horizontal exit. Grees shall not return through the zone of fire origin. 18.24.1, 18.24.2, 19.24.1, 19.24.2 Preparation 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 soley because	GOLDEN I	IVINGCENTER - ASHE	VILLE			
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 II(222) construction, one story, with a complete automatic sprinkler system and using special locking. In the exit conference all deficiencies noted were discussed and acknowledged with administration. Image: Complete all deficiencies noted were discussed and acknowledged with administration. At time of survey the licensed bed capacity = 77 Total Certified Bed Count 77 NF Census 63 K 032 The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD K 032 Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 Preparation 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	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II(222) construction, one story, with a complete automatic sprinkler system and using special locking. In the exit conference all deficiencies noted were discussed and acknowledged with administration. At time of survey the licensed bed capacity = 77 Total Certified Bed Count 77 NF Census 63 The deficiencies determined during the survey are as follows: SS=F Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fre section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not returt through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on June 14, 2016 at approximately 10:00 AM onward, the following deficiencicis were noted: The standard is	K 000	This Life Safety Coo	de(LSC) survey was	K 000		
K 032Census 63K 032The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARDK 032SS=FNot less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)Preparation 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		at 42CFR 483.70(a); Health Care section publications. This but construction, one sto automatic sprinkler s locking. In the exit co noted were discusse administration. At time of survey the	i using the 2000 Existing of the LSC and its referenced hilding is Type II(222) ory, with a complete system and using special onference all deficiencies and acknowledged with e licensed bed capacity = 77			
Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)Preparation 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	K 032	Census 63 The deficiencies dete are as follows:	ermined during the survey	K 032		7/24/16
The delayed egress feature did not function for it is required by provisions of federal and	SS=F	are provided for each building. Not less that fire section shall be a smoke-proof enclosu passageway. Only o a horizontal exit. Egr return through the zo 18.2.4.2, 19.2.4.1, 19 This STANDARD is 42 CFR 483.70 (a) Based on observation approximately 10:00 deficiencies were no	h floor or fire section of the an one exit from each floor or a door leading outside, stair, ure, ramp, or exit ne of these two exits may be ress shall not one of fire origin. 18.2.4.1, 9.2.4.2 not met as evidenced by: ons, on June 14, 2016 at AM onward, the following ted: The standard is		of correction does not constitute admission or agreement by the provide the truth of facts alleged or the conclusions set forth in the statement o deficiencies. The plan of correction is	r of f
30RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		The delayed egress	feature did not function for			

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

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/10/201 MAPPROVEI D. 0938-039
STATEMENT (TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345010	B. WING			06/	/14/2016
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHE	/ILLE		50	00 BEAVERDAM ROAD		
				A	SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 032	1.0	e 1 gement at exit door near	КC	032	state law.		
	room 216. The special not respond to applic	al locking arrangement did ation of pressure to the door release sequence did not			Sidle law.		
	function. The electror	nagnetic lock did release alarm system and loss of			K 032 NFPA 101 LIFE SAFETY COD STANDARD EXIT DOORS	E	
	NFPA 101, 19.2.4.1,	19.2.4.2, 7.2.1.6.1(c)			Golden Living Center - Asheville (GLC-Asheville) ensures delayed egre	SS	
	This deficiency affect compartments.	ed one of two smoke			feature for special locking arrangemen exit doors functions correctly and relea with activation of the fire alarm system	ase	
		n minimum standards as the risk of death or injury oke			and loss of power to locking system.The corrective action accomplishedMaintenance Director called Senior		
		one.			Technology, technical department abo the egress of the door located near Ro	om	
					#216. By doing some find tuning the d was working as designed. This was completed on June 16, 2016.	oor	
					 Life safety concerns having the potential to affect residents have been identified by: Exit doors were checked 		
					ensure special Locking arrangement functions correctly and release with activation of the fire alarm system and		
					loss of power to locking system. This completed on June 14, 2016 3. The measures put in place or		
					systemic changes made are: Staff and Leadership Team (comprised of		
					Department Heads and their assistant and Unit Manager/Coordinator) have b re-inserviced on July 5, 2016 and new	been	
					employees will be educated on the importance of ensuring exit doors are checked and operate correctly.		
					Leadership Team during Room Round	S	

Event ID: KBWV21

Facility ID: 922979

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 11/10/2016 M APPROVED D. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		345010	B. WING _			06	/14/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER - ASHEV	/ILLE			00 BEAVERDAM ROAD SHEVILLE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 032 K 076 SS=E	NFPA 101 LIFE SAFE Medical gas storage a shall be protected in a Standard for Health C (a) Oxygen storage lo 3,000 cu.ft. are enclo separation. (b) Locations for supp 3,000 cu.ft. are vente 4-3.1.1.2 (NFPA 99), 18.3.2.4, 19.3.2.4	ETY CODE STANDARD and administration areas accordance with NFPA 99, care Facilities. bcations of greater than sed by a one-hour		032	 will be checking the exit doors. This monitoring will be completed five days week for four weeks, three times a weet the following four weeks and then one time a week for four weeks. 4. GLC-Asheville will monitor the corrective plan to ensure the practice corrected and will not reoccur is the monitoring tool will be presented to the Executive Director (ED) and/or Director Nursing Services (DNS) at Morning/Stand-Down Meetings. The I will report the findings of the reviews to Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. 5. The correction date for substantia compliance is July 24, 2016. 	ek was e or ED o ne	7/24/16

Event ID: KBWV21

Facility ID: 922979

If continuation sheet Page 3 of 6

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/10/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING 0	(X3) DATE SURVEY COMPLETED		
		345010	B. WING		06/14/2016
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN I	LIVINGCENTER - ASHEV	/ILLE	-	00 BEAVERDAM ROAD SHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
K 076	Continued From page		K 076		
	approximately 10:00	ns, on June 14, 2016 at AM onward, the following		MEDICAL GAS STORAGE	
	of utility room - locate Cylinders shall be sup secured in accordance NFPA 101, 19.3.2.4, M 4-3.1.1.2 This deficiency affects compartments. Failure to comply with	ic findings include: ted oxygen cylinder on floor d beside room 220. oported by carts, bases, or e with NFPA 99. NFPA 99, 8-3.1.11.1, ed one of two smoke n minimum standards as the risk of death or injury		 Golden Living Center - Asheville (GLC-Asheville) ensures medical gas storage and administration are protect in accordance with NFPA9, Standard Health Care Facilities. The corrective action accomplish Maintenance Director secured the oxy cylinder on the floor of utility room – located beside Room #220. Immediat Re-inservice to all Nursing Staff was completed by the Director of Nursing Services (DNS). This was completed June 14, 2016 before the Life Safety Surveyor left the facility. Life safety concerns having the potential to affect residents have beer identified by: the facility was checked ensure oxygen cylinders are supported atts, bases, or secured in accordance with NFPA 99. This was completed of June 14, 2016 The measures put in place or systemic changes made are: Nursing Staff and Leadership Team (comprise Department Heads and their assistan and Unit Manager/Coordinator) have re-inserviced on June 16, 2016 and n employees will be educated on the importance of ensuring oxygen cylind are supported by carts, bases, or sec in accordance with NFPA 99. Leaders Team during Room Rounds will be 	eted for hed ygen te on to to to to to to to to to to to to to
				cylinders are secure. This monitoring be completed five days a week for for weeks, three times a week the followi four weeks and then one time a week	ur ng

Event ID: KBWV21

Facility ID: 922979

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	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	ECONSTRUCTION 1 - Main Building 01	(X3) DATE SURVEY COMPLETED
	345010		B. WING	06/14/2016	
NAME OF P	ROVIDER OR SUPPLIER	÷	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	LIVINGCENTER - ASHE	VILLE		00 BEAVERDAM ROAD ISHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
K 076 K 147 SS=D	NFPA 101 LIFE SAF Electrical wiring and accordance with Nat (NFPA 99) 18.9.1, 19 This STANDARD is 42 CFR 483.70 (a) Based on observation approximately 10:00 deficiencies were no non-compliant, spec There are segments wire power operated on doors between in located on east and	ETY CODE STANDARD equipment shall be in ional Electrical Code. 9-1.2 9.9.1 not met as evidenced by: ons, on June 14, 2016 at AM onward, the following ted: The standard is	К 076	four weeks. 4. GLC-Asheville will monitor the corrective plan to ensure the practice corrected and will not reoccur is the monitoring tool will be presented to the Executive Director (ED) and/or Directon Nursing Services (DNS) at Morning/Stand-Down Meetings. The will report the findings of the reviews Quality Assurance Performance Improvement Committee (QAPIC). The QAPIC will review and analyze for patterns and trends. The QAPIC will evaluate the results and implement additional interventions as needed to ensure continued compliance. The correction date for substantial compliance is July 24, 2016. K 147 NFPA 101 LIFE SAFETY CC STANDARD Electrical Wiring Golden Living Center - Asheville (GLC-Asheville) ensures electrical w and equipment is in accordance with National Electrical Code. 1. The corrective action accomplists Maintenance Director had a licensed electric company come in and hard of mechanism between interior corridor courtyards located on wire both East	he tor ED The The The The The The The The The The

Event ID: KBWV21

Facility ID: 922979

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING ((X3) DATE SURVEY COMPLETED	
		345010	B. WING		06/14/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	IVINGCENTER - ASH	EVILLE	ŧ	500 BEAVERDAM ROAD	
GOLDEN				ASHEVILLE, NC 28804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
K 147	Continued From pa	ge 5	K 147	,	
	NFPA 101, 19.9.1, 9			 15, 2016. Life safety concerns having the safety	
	I his deficiency affe compartments.	cted two of two smoke		potential to affect residents have b identified by: Exit doors were chec ensure special Locking arrangeme	ked to
		rith minimum standards as es the risk of death or injury		functions correctly and wired in accordance with National Electrica	
	due to fire and/or si	moke.		This was completed on June 15, 2 3. The measures put in place or	
				systemic changes made are: future projects the Maintenance Director ensure equipment is wired accordi	will
				National Electrical Code.4. GLC-Asheville will monitor the	
				corrective plan to ensure the pract corrected and will not reoccur is w	hen
				equipment is wired, the Maintenan Director will be presented to the Ex Director (ED) and/or Director Nurs	kecutive
				Services (DNS) at Morning/Stand-	Down
				Meetings any changes and how th the National Electrical Code. The report the findings of the reviews to Quality Assurance Performance	ED will
				Improvement Committee (QAPIC). QAPIC will review and analyze for patterns and trends. The QAPIC w	vill
				evaluate the results and implemen additional interventions as needed ensure continued compliance.	to
				5. The correction date for substa compliance is July 24, 2016.	inual

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