STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING _____ B. WING _____	C 09/14/2012

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

(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
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to treat 1of 1 resident who had a supra-pubic catheter (Resident #6) with dignity and respect as evidenced by exposed catheter tubing. Resident #6 was admitted to the facility on 4/8/2004 with diagnoses of neurogenic bladder, renal insufficiency and dementia. During the initial dining observation on 9/10/12 at 11:55PM, the resident was observed sitting in his wheelchair at the dining table wearing a shirt and pants. The resident's shirt was open from the bottom with the supra-pubic catheter exposed from the right side of his abdomen. Urine was visible in the tubing as the drainage tubing hung down the right side of the wheelchair and connected to a drainage bag that was located in the rear of the wheelchair. The drainage bag was concealed by a privacy cover. On 9/10/12 at 4:44 PM, the resident was observed sitting in his wheelchair in the hallway. He was wearing a shirt and pants. The resident's shirt was open at the bottom with the supra-pubic catheter exposed from the right side of his abdomen. Urine was visible in the tubing as the drainage tubing hung down the right side of the	F 241	**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **F-241** **1) Resident #6 was assisted by staff to change into a larger shirt that covered the supra pubic catheter after discussion with the surveyor.** **2). Any resident in center having a supra pubic catheter has the potential to be affected by stated deficient practice. After the aforementioned observation by the surveyor; all residents with supra pubic catheters were audited for dignity issues.** **3). The Director of Clinical Education and the Social Services Director will present staff re-education on resident dignity as it relates to clothes, appearances and all tubing covered to provide dignity and respect for all residents along with the audit tool to be utilized for on-going substantial compliance.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 10/5/12

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 241	Continued From page 1 wheelchair and connected to a drainage bag that was located in the rear of the wheelchair. The drainage bag was concealed by a privacy cover. On 9/11/12 at 10:02 AM, the resident was observed sitting in his wheelchair in the dining area. . He was wearing a shirt and pants. The resident's shirt was open at the bottom with the supra-pubic catheter exposed from the right side of his abdomen. Urine was visible in the tubing as the drainage tubing hung down the right side of the wheelchair and connected to a drainage bag that was located in the rear of the wheelchair. The drainage bag was concealed by a privacy cover. On 9/11/12 at 12:05 PM, the resident was observed in his wheelchair in the dining room. He was wearing a shirt and pants. The resident's shirt was open at the bottom with the supra-pubic catheter exposed from the right side of his abdomen. Urine was visible in the tubing as the drainage tubing hung down the right side of the wheelchair and connected to a drainage bag that was located in the rear of the wheelchair. The drainage bag was concealed by a privacy cover. On 9/12/12 at 11:42 AM, the resident was observed sitting in his wheelchair in the hallway. He was wearing a shirt and pants. The resident's shirt was open at the bottom with the supra-pubic catheter exposed from the right side of his abdomen. Urine was visible in the tubing as the drainage tubing hung down the right side of the wheelchair and connected to a drainage bag that was located in the rear of the wheelchair. The drainage bag was concealed by a privacy cover.	F 241	**The unit managers will complete the "F 241 supra pubic audit tool" weekly for 4 weeks, then bi-weekly for 1 month, then frequency determined by the QAPI committee members.** **4). The Director of Nursing Services will report the results of the audits during the QAPI meeting for timeframe to be determined by the committee members based on maintaining substantial compliance with the regulation.** **The Director of Nursing Services is responsible for monitoring the aforementioned plan of correction with ultimate responsibility by the Executive Director.**	

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F 241	Continued From page 2 On 9/13/12 at 11:15 AM, Nursing Assistant #3 was interviewed. She stated that she is the aide caring for Resident #6. She stated that she knew not to leave the supra-pubic catheter exposed when the resident is in the wheelchair. She stated the catheter tubing is supposed to be tucked inside the top of the resident ' s pants and then run the drainage tubing behind the resident to allow the drainage tubing to run down to the privacy bag that hangs on the lower bottom of the wheelchair. On 9/13/12 at 12:30 PM the 2nd floor Unit Manager was interviewed. She stated that the nursing assistants knew to keep the supra-pubic catheter covered when the resident was up.	F 241		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide an odor free environment on 2/3 floors. On 9/10/12 at 12:10pm, strong odors of urine and feces were observed on 2nd floor in the dining room and between rooms 201 and 211. On 9/10/12 between 2:30 PM-5:00 PM during	F 252	**F-252** **1) The 2nd and 3rd floor areas described by the surveyors were deep cleaned, soiled linen barrels were emptied and cleaned, and Air Fresheners implemented.** **2) All center residents have the potential to be affected by the stated deficient practice. All areas of the center were audited for stated deficient practice and corrected accordingly.** **3) The Director of Clinical Education will in-service staff about the deficient practice, the regulation regarding maintaining a clean homelike environment, and the audit tool to be utilized to monitor for stated deficient practice.**	10-22-12

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F 252	Continued From page 3 continuous observation, strong odors of urine and feces were observed on 2nd floor between rooms 201 and 211. On 9/11/12 at 8:15 AM, strong odors of urine and feces were observed at the exit from the elevator on 2nd floor and between rooms 201 and 211. On 9/11/12 at 2:30 PM, strong odors of urine and feces were observed at the exit from the elevator on 2nd floor and between rooms 201 and 211. On 9/12/12 at 8:35 AM, strong odors of urine and feces were observed at the exit from the elevator on 3rd floor and between rooms 301 and 303. On 9/12/12 at 9:30 AM, strong odors of urine and feces were observed at the exit from the elevator on 2nd floor and between rooms 201 and 211. On 9/12/12 at 11:05 AM, strong odors of urine and feces were observed at the exit from the elevator on 3rd floor and between rooms 301 and 303. On 9/13/12 at 8:55 AM, strong odors of urine and feces were observed at the exit of the elevator on 2nd floor. On 9/13/12 at 10:00 AM, Housekeeper #2 was interviewed. She stated that her routine every morning included cleaning all resident rooms followed by the common areas then the nurses station. She stated that the nursing assistants were responsible for removing soiled briefs and dirty linen from the resident rooms. Floor techs removed the large containers of trash and soiled	F 252	**The management staff will include monitoring the environment for odors with daily rounds audit. The Executive Director will randomly audit the manager rounds sheets and verify the areas reported by the staff.** **4) The Executive Director will report the results of the manager's audits during the QAPI meeting for timeframe to be determined by the committee members based on maintaining substantial compliance with the regulation.** **The Housekeeping Director is responsible for monitoring the aforementioned plan of correction with ultimate responsibility by the Executive Director.**	

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F 252	Continued From page 4 briefs from the floor and take them to the dumpster at 2:30 PM each day. An additional dump of trash was scheduled each evening before 8:00 PM. She also stated that diapers were changed at 7:00 AM daily just prior to shift change. She stated that the waste from 3rd shift was not removed from the floor until after the first shift housekeeping staff arrived at 7:00 AM each morning. On 9/13/12 at 11:30 AM, strong odors of feces observed at the exit of the elevator on 2nd floor and between rooms 201 and 203. The dirty linen cart was observed sitting in the hallway outside of room 201, near the elevator, with the personal items section of the cart overly stuffed with soiled items and the top was not closed. On 9/13/12 at 12:24 PM, the 2nd floor Unit Manager was interviewed. She stated that she encouraged staff to eliminate odors when they noticed them. When the odors linger, she stated she notified housekeeping so that they can identify the source of the odor and use disinfectant in the room and/or mop the floors. On 9/13/12 at 4:30 PM, strong odors of urine and feces were observed at the exit of the elevator on 2nd floor and between rooms 201 and 211.	F 252		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329	**F-329** **1) Resident 165 had Valporic Acid level obtained and results were within therapeutic range.**	10-22-12

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F 329	Continued From page 5 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to monitor the Depakote (medication used for Seizures) blood level for one (1) of ten (10) sampled residents reviewed for unnecessary drugs. (Resident #165) The findings include: A review of the facility Policy and Procedure Manual on Medication Monitoring page 3 included to monitor medications with Narrow Therapeutic Index (NTI) including: Valproic acid (Depakote) levels to be titrated to specific blood levels for therapeutic efficiency to avoid toxic levels.	F 329	**2) Any resident prescribed medications classified as having narrow therapeutic index have the potential to be affected by the stated deficient practice. Residents on drugs classified as having narrow therapeutic index were audited to ensure levels were ordered according to the center policy.** **The systemic changes will be accomplished by the Director of Education re-educating nursing staff, pharmacy consultant, and practitioners writing orders based on the center's policy regarding management of drugs with narrow therapeutic ranges.** **The Clinical Service Consultant will re-educate Nursing Administration regarding the corporate procedure for Clinical Stand Up and reviewing all new admission charts for appropriate processing and orders, including orders for monitoring medications with narrow therapeutic ranges.** **3) The Assistant Director of Nursing Services or designee will audit all residents prescribed medications having narrow therapeutic range on a weekly basis to ensure the facility guidelines for monitoring medications is in place.**	

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F 329	Continued From page 6 Resident #165 was originally admitted to the facility on 7/26/2012 and readmitted on 8/2/2012 with admitting diagnoses including Epilepsy and recurrent Seizures; Neuropathic induced Parkinsonism, Schizophrenia and Dementia with Psychotic features and Diabetes Mellitus. A review of Resident #165 medications included physician order dated 8/2/2012 for Depakote ER (Extended Release) 500mg (milligram) tablets: two tablets (1000 mg) in the morning and one tablet (500mg) in the evening for Seizures. Further review of the Medication Administration Records (MAR) revealed Depakote ER was scheduled at 9:00 AM and 9:00 PM. Further review of the medical records reveled Resident #165 had been on Depakote ER at the time of original admission but no base level Depakote blood level data was available either obtained in the facility or from the hospital discharge records. Resident #165 included physician orders dated 8/2/12 to receive 100 mg Chlorpromazine once daily, Aspirin 81 mg once daily and Risperdal 3 mg two times daily among several other medications. A review of the current and thin medical chart did not reveal any documented Depakote (measured as Valproic Acid) levels measured or any orders pending to obtain the Depakote levels. A review of the nursing notes including the dates 8/16/2012 and 8/31/2012 revealed Resident #165 had repeated psychotic behaviors and had problems with increased aggressive behaviors documented with confusion which was treated appropriately.	F 329	**4) The Assistant Director of Nursing will report the results of the audit during the QAPI Committee meeting for timeframe to be determined by the committee members based on maintaining substantial compliance with the regulation.** **The Director of Nursing Services is responsible for monitoring the aforementioned plan of correction with ultimate responsibility by the Executive Director.**	

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F 329	Continued From page 7 An interview with nurse #3 on 9/12/12 at 11:58 AM revealed that all laboratory orders were initiated by the physician and once the orders were received nurses would transcribe and document for processing in the calendar of Laboratory requisition sheets. The interview revealed that sometimes the consultant pharmacist made recommendations and requested to obtain the blood levels on medications like Depakote ER if missed by the physician or Nurse Practitioner. Resident #165 had no such orders and no blood level of Depakote had been measured from the time of original admission or readmission. An interview with the Nurse Practitioner (NP) on 9/13/12 at 12:47 PM revealed that she always ordered blood levels for Depakote in the first two week of admission and repeated every 6 months as needed. For Resident #165 it was missed during the initial admission or readmission process. The NP stated that she was not aware why this was not brought to the attention by the pharmacist during his monthly pharmacy consultant reviews. An interview with Director of Nursing (DON) on 9/13/12 at 4:08 PM revealed that all laboratory orders were handled by the physician and the pharmacy consultant. She was not aware that for Resident #165 the blood level checks for Depakote were missed.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428	**F-428** **1) Resident #165's record and orders were reviewed with the Consultant Pharmacist by center Administration. All residents were audited to ensure any medications that require monitoring had appropriate orders and schedule.**	10-22-12

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F 428	Continued From page 8 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the consultant pharmacist failed to bring a discrepancy related to monitoring of Depakote (medication used for Seizures) blood level for one (1) of ten (10) sampled residents reviewed for unnecessary drugs. (Resident #165) The findings include: A review of the facility Policy and Procedure Manual on Medication Monitoring page 3 included the responsibility of the consultant pharmacist to monitor medications with Narrow Therapeutic Index (NTI) including: Valproic acid (Depakote) levels to be titrated to specific blood levels for therapeutic efficiency to avoid toxic levels. Resident #165 was originally admitted to the facility on 7/26/2012 and readmitted on 8/2/2012 with admitting diagnoses including Epilepsy and recurrent Seizures; Neuropathic Induced Parkinsonism, Schizophrenia and Dementia with Psychotic features and Diabetes Mellitus. A review of Resident #165 medications included physician order dated 8/2/2012 for Depakote ER	F 428	**2) All residents prescribed anticonvulsants and/or medications that have requirements to be monitored, have the potential to be affected by this deficient practice. The completed list of all residents' that receive Anticonvulsant medications and/or drugs with monitoring requirements has been given to the consultant pharmacist to ensure that monitoring of any anticonvulsants and/or drugs with therapeutic levels has been reviewed and recommendations to the physician has been made.** **3) The systemic changes will be accomplished by the Director of Education re-educating nursing staff, pharmacy consultant, and practitioners writing orders based on the center's policy regarding management of drugs with narrow therapeutic ranges.** **Audit tools will be utilized tracking all medications that require therapeutic monitoring. An audit will be completed at admission of all residents by the ADNS tracking any drugs with narrow therapeutic ranges. The DNS will complete a weekly audit on any resident having drugs that need therapeutic monitoring based on pharmacy reports with specific medications to ascertain therapeutic monitoring occurred. After each Consultant Pharmacist visit the**	

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F 428	Continued From page 9 (Extended Release) 500 mg (milligram) tablets: two tablets (1000 mg) in the morning and one tablet (500 mg) in the evening for Seizures. Further review of the Medication Administration Records (MAR) revealed Depakote ER was scheduled at 9:00 AM and 9:00 PM. Further review of the medical records reveled Resident #165 had been on Depakote ER at the time of original admission but no base level Depakote blood level data was available either obtained in the facility or from the hospital discharge records. Resident #165 included physician orders dated 8/2/12 to receive 100 mg Chlorpromazine once daily, Aspirin 81 mg once daily and Risperdal 3 mg two times daily among several other medications which could alter Depakote blood levels. A review of the current and thin medical records did not reveal any documented Depakote (measured as Valproic Acid) levels measured or any orders pending to obtain the Depakote levels. A review of the nursing notes including the dates 8/16/2012 and 8/31/2012 revealed Resident #165 had repeated psychotic behaviors and had problems with increased aggressive behaviors documented with confusion which was treated appropriately. Further review of the consultant pharmacist ' s monthly review completed on 8/8/2012 had no documentation with reference to need of Depakote monitoring levels and had not acknowledged the use of Depakote at this dose and the need of any blood level data. An interview with nurse #3 on 9/12/12 at 11:58	F 428	**Director of Nursing will audit the report against the list obtained from pharmacy monthly on-going.** **4) The Director of Nursing will report the results of the audit during the QAPI Committee meeting for timeframe to be determined by the committee members based on maintaining substantial compliance with the regulation.** **The Director of Nursing Services is responsible for monitoring the aforementioned plan of correction with ultimate responsibility by the Executive Director.**	

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F 428	Continued From page 10 AM revealed that all laboratory orders were initiated by the physician and once the orders were received nurses would transcribe and document for processing in the calendar of Laboratory requisition sheets. The interview revealed that sometimes the consultant pharmacist made recommendations and requested to obtain the blood levels on medications like Depakote ER if missed by the physician or Nurse Practitioner. Resident #165 had no such orders and no blood level of Depakote had been measured from the time of original admission or readmission. An interview with the Nurse Practitioner (NP) on 9/13/12 at 12:47 PM revealed that she always ordered blood levels for Depakote in the first two week of admission and repeated every 6 months as needed. For Resident #165 it was missed during the initial admission or readmission process. The NP stated that she was not aware why this was not brought to the attention by the pharmacist during his monthly pharmacy consultant reviews. An interview with the consultant pharmacist was completed on 9/13/12 at 12:32 PM. The interview revealed that such discrepancies of monitoring were not brought to the attention of the physician during the first month of reviews. The interview revealed that Resident #165 did not have any base Depakote blood level data either from the hospital or at the facility. The consultant pharmacist was not aware that any Valproic acid blood levels were available on the chart. An interview with Director of Nursing (DON) on 9/13/12 at 4:08 PM revealed that all laboratory	F 428		

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F 428	Continued From page 11 orders were handled by the physician and the pharmacy consultant. She was not aware that for Resident #165 the blood level checks for Depakote were missed.	F 428		
F 469 SS=C	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to maintain an effective pest control program for 3/3 resident floors. The findings include: 1. On 9/11/12 at 9:55 AM, a roach, approx one inch in length, was observed crawling across the floor in the hallway on 2nd floor. On 9/12/12 at 2:35 PM, the Maintenance Director was interviewed. He stated there are families that have brought bags of clothing into the facility with rodents in them. He stated that, after each exterminator treatment, he noticed a significant decrease in the number of rodents in the effected areas. The Maintenance Director stated that any staff can report rodents by phone or verbally notify him. He documents the concern in the concern log. He notifies the exterminator who responds within 24 hours. He stated that he has told nursing staff to notify him as soon as they	F 469	**F-469** **1) The pest company was notified to come spray the facility for a bug observed on the 2nd floor and a bug noted on the door frame of 312.** **2) All areas of the center have the potential to be affected. The facility had the Pest Control in the facility and all areas were sprayed for pest control and management. The facility will audit areas for signs of any pest and the removal of any bugs affected by the facility spraying.** **3) The Director of Clinical Education will in-service staff regarding maintaining a pest free environment. How to report any concerns, whom to report theses concerns to. The Director of Education will also discuss other means of clutter free rooms to help manage the pest.** **The management staff will include monitoring the environment for pest with daily rounds audit. The Executive Director will randomly audit the manager rounds sheets and verify the areas reported by the staff are being treated by facility pest contractor.**	10-22-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346008	A. BUILDING _____ B. WING _____	C 09/14/2012

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

(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
F 469	Continued From page 12 see any rodents so he can get in contact the exterminator to treat the effected areas. On 9/13/12 at 10:00 AM, Housekeeper #2 was interviewed. She stated that her routine every morning started in the residents' rooms in addition to the bathrooms, nursing station and common areas. She stated that she uses a scraper to remove dead bugs. She stated that roaches are everywhere, especially underneath the night stands in the resident rooms. She stated she has witnessed the exterminator in the building at least twice a month. Stated she has seen an improvement for a few days after the treatment. She stated that residents keep bags of snacks in their rooms and those are the rooms that seem to have the problem with roaches. On 9/13/12 at 11:30 AM, the Director of Housekeeping was interviewed. She stated that she had noticed roaches in the building and the exterminator has been in the facility a lot. She stated she could tell a difference for about 7 days after the exterminator treated the facility. The Director or Housekeeping stated there are residents who hoard food in their rooms, especially snacks. She stated that the hoarding has contributed to the problem. The contract was reviewed. The contract has been in place since 2/19/2009 with automatic renewal. The contract stated that treatment for roaches, ants, crickets, silverfish, fleas, ticks, moths, spiders and mice is provided monthly and as needed. The concern log was also reviewed. Since January 17, 2012, there have been 43 entries of rodent sightings (roaches, ants and mice) on all 3 floors. Upon review of the service	F 469	**4) The Executive Director will report the results of the manager's audits during the QAPI meeting for time frame to be determined by the committee members based on maintaining substantial compliance with the regulation.** **The Housekeeping Director and the Maintenance Manger is responsible for monitoring the aforementioned plan of correction with ultimate responsibility by the Executive Director.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING _____ B. WING _____	C 09/14/2012

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

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F 469	Continued From page 13 logs, the last pest control service was provided on 8/30/12. Other treatment dates included 8/12/12, 7/27/12, 7/20/12, 7/16/12, 7/12/12, 6/11/12, 5/29/12, 3/27/12, 2/19/12, 2/7/12, and 1/3/12. 2. Observation on 300 hallway on 9/11/12 at 12:10 PM revealed an insect crawling up the door frame of room 312. The insect was dark brown and approximatly 1/4 inch long. At this time NA #2 stated she had seen lots of bugs on the hallway in the past and this one looked like a roach to her. During an interview on 9/13/12 at 10:35 AM, Nurse #1 stated the facility had problems with bugs. Nurse #1 stated at one time (could not state exactly when) the crash cart was full of bugs. Nurse #1 reported that the facility treated and sprayed for bugs/insects however, they were often still evident.	F 469		