STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345201	A. BUILDING ______ B. WING ______	C 01/14/2017

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
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, the facility failed to maintain housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior by having an inoperable, soiled toilet in 1 out of 6 bathrooms observed. Bathroom #218 and #219. Findings included: Observations on 1/12/17 at 9:44 AM in the bathroom of room #218 revealed toilet full of foul smelling feces, toilet paper, and paper towels. The toilet handle was broken and would not flush. Observations on 1/12/17 at 10:25 AM in the bathroom of room #218 revealed toilet full of foul smelling feces, toilet paper, and paper towels. The toilet handle was broken and would not flush. Observations on 1/12/17 at 11:46 AM in the bathroom of room #218 revealed toilet full of foul smelling feces, toilet paper, and paper towels. The toilet handle was broken and would not flush. Observations on 1/12/17 at 2:18 PM revealed Housekeeper #1 in room #218 cleaning the floor with a broom and dust pan. Observations on 1/12/17 at 3:33 PM in the bathroom of room #218 revealed toilet full of foul smelling feces, toilet paper, and paper towels. The toilet handle was broken and would not flush. Observations on 1/13/17 at 8:57 AM in the bathroom of room #218 revealed toilet full of foul smelling feces, toilet paper, and paper towels. The toilet handle was broken and would not flush. The odor of bowel movement was noted in the	F 253	Preparation, submission and implementation of the 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. Toilet in bathroom #218 was replaced completely on 1/13/2014 by the Maintenance Supervisor. All residents and resident rooms have the potential affected to be affected by the deficient practice. An audit of all toilets in the facility completed on 1/16/2017, revealed no other broken and/or dirty, inoperable toilets. Department managers have been in-serviced by the Executive Director & Nurses and Nurse Aids have been educated by the Director of Nursing and/or Assistant Director of Nursing, on inputting toilets and other items that need attention from Maintenance, into the Building Engines system. Additional access to Building Engines has been given to the Housekeeping Director. The facility has also implemented a	2/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/08/2017

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

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F 253	Continued From page 1 hall way outside of room #218. A maintenance request dated 12/19/16 revealed toilet in room #219 was stopped up and repaired by the Maintenance Technician. The bathroom in room #219 was a shared bathroom with room #218. Residents in rooms #218 and #219 were not interviewable. On 1/12/17 at 11:44 AM an interview with Housekeeper #1 revealed she was responsible for cleaning the 200 Hall. She stated her work hours were from 8 AM to 3 PM. Housekeeper #1 stated she would clean the resident's rooms daily including the bathroom. On 1//12/17 at 3:04 AM an interview with Nurse Aide #3 revealed she was responsible for the 200 Hall. The nurse aide stated there was no problems or concerns with dirty bathrooms or issues with the toilets on the hall. The nurse aide went on to say the rooms and bathrooms was supposed to be cleaned daily by housekeeping and any issues would be reported to housekeeping or maintenance. On 1//13/17 at 8:57 AM an interview with Nurse Aide #1 revealed the shared bathroom for room #218 and #219 would be dirty with bowel movement, paper towels, and toilet paper almost every day by the resident in room #219. Nurse Aide #1 went on to say the toilet would become stopped up and the staff would have to call maintenance and housekeeping to unstop the toilet and to clean. Nurse Aide #1 could not recall when she last notified maintenance of the toilet in room #218/ #219 needing repair. On 1/13/17 at 9:01 AM an interview with the Maintenance Director indicated he did not recall any maintenance requests for the toilet in room #218 being stopped up or dirty. He went on to say that sometimes residents would put paper towels	F 253	notebook/binder system with a log, for daily notification/communication to the Housekeeping staff. This log will be reviewed by the Housekeeping and Maintenance supervisors daily. To ensure continued compliance, additional support is being provided to the contracted Housekeeping Supervisor, from the division supervisor. Audits will be conducted and reviewed daily for 4 weeks by the Department Managers to include the ADNS, Social Services Dept, Housekeeping Supervisor, Business Office Manager and Unit Managers. Results of the audits will be reviewed by the Executive Director OR designee weekly for 3 months, then tracked and monitored via the QAPI process for 6 months to ensure continued compliance.	

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F 253	Continued From page 2 in the toilet which would stop the toilet up. On 1/13/17 at 9:08 AM an interview with the Maintenance Technician revealed the staff had not reported to him any concerns regarding the toilet in room #218/ #219 being stopped up or dirty. On 1/13/17 at 9:12 AM an interview with the Housekeeping Manager indicated the resident in Room #219 had a history of having bowel movements in the toilet and then placing clothes items, paper towels, and excess toilet paper in the toilet. The Housekeeping Manager stated the toilet would become stopped up and the staff would call maintenance to fix. The Housekeeping Manager also stated that Resident #8 had complained to the staff about toilet being frequently dirty and stopped up. The Housekeeping Manager went on to say the bathrooms was supposed to be cleaned daily by the housekeeping staff and the housekeeper working on the hall should have cleaned that bathroom on 1/12/17. The Housekeeping Manager stated the rooms had not been cleaned yet today. The Housekeeping Manager stated there was a communication problem in all departments regarding the toilets needing to be cleaned because the condition of the toilet in room #218 should have been reported to housekeeping and maintenance. On 1/13/17 at 10:30 AM an interview with the Director of Nursing (DON) revealed there had been problems with the shared toilet in room #218 being dirty and stopped up. The DON stated she had instructed the staff to keep a check on the bathroom after the resident in room #219 had used the toilet. The DON indicated she expected for the housekeepers to clean the bathrooms daily. The DON went on to say she felt a staff member should have noticed the toilet had a	F 253		

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F 253	Continued From page 3 broken handle and was dirty. The DON indicated there had been no complaints from family or residents regarding dirty or inoperable toilets. On 1/13/17 at 11:05 AM an interview with the Administrator indicated she expected for the housekeepers to clean the bathrooms daily. The Administrator stated it was well known that the resident in room #219 would place items in the toilet which would stop up the toilet. The Administrator also stated she expected for the staff to notify maintenance to unstop the toilet and housekeeping to clean the toilet. On 1/13/17 at 11:10 AM an interview with resident #8 indicated she had resided in room #218 with shared toilet in room #219 until a month ago. Resident #8 stated she had problems for about 6 months with the toilet being stopped up by the resident in room #219. Resident #8 went on to say the toilet would be full of bowel movements and toilet paper and she would have to wait for housekeeping or maintenance to unstop the toilet and clean it. Resident #8 stated the smell would get really bad and it would happen 1 to 2 times a week. Resident #8 indicated she had notified the staff of her concerns and she was given a choice to move to another room and she declined. On 1/13/17 at 2:04 PM an interview with the Maintenance Technician indicated the handle on the toilet was broken in room #218 which caused it not to flush. The Maintenance Technician went on to say that in the process of trying to unstop the toilet, the bowl cracked so he had to replace the toilet.	F 253		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		2/14/17

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F 323	Continued From page 4 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review the facility failed to utilize the manufacturer's recommended size sling when transferring 1 of 4 sampled residents (Resident #2). Findings included: Review of the (brand name) manufacturer's user guide for the total body mechanical lift sling color/size guide revealed a red (S) sling was recommended for a weight range of 77-132 lbs. The manufacturer's total body mechanical lift sling color/size guide recommended the purple (LL) sling for a weight of 220-350 lbs. Review of Resident #2's Lift Mobility Status	F 323	Preparation, submission and implementation of the 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. The facility has a red sling for lift transfers of Resident #2. Staff will be educated, by the Director Of Nursing Services on the proper use of lift	

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F 323	Continued From page 5 Assessment dated 07/09/2016 revealed she could not bear weight, needed a full body lift and needed a red: small sling. A review of the documentation for staff training on lifts and transfers on 07/27/2016 at 2:30 PM by the DON and Therapy Director was completed. This training included return demonstrations. It revealed NA #1 and NA #2 attended this training. A review of Resident #2's Minimum Data Set (MDS) dated 10/19/2016 revealed Resident #2 needed extensive assistance for her Activities of Daily Living (ADL) care including transfers. Her diagnosis included Cerebral Palsy, Hypertension, and Anxiety. Review of Resident #2 most recent weight on 12/13/2016 was 119 lbs. Observation on 01/12/2017 at 3:30 PM was made of Resident #2 being transferred from her wheelchair to her bed using a total body mechanical lift and purple sling. Nurse Aide (NA) #2 stated during the observation this was not her usual sling. Her usual sling was in the laundry. NA #1 stated to NA #2 they were going to " twist the bottom " of the sling since it was not her usual sling used for transfers. During the transfer Resident #2 slipped and called out loudly " Oh! " as she was being raised by the total body mechanical lift. Interview on 01/12/2017 at 3:30 PM with NA #1 revealed the Kardex/Care Plan for residents indicated what color/size sling and type of lift to use to transfer residents. Review of the Resident #2 Kardex/Care Plan dated 1/12/2017 revealed that transfers for Resident #2 were to be done by sit to stand lift. Interview on 01/12/2017 at 3:30 PM with NA #1 revealed they had tried the sit to stand lift and it did not work for Resident #2 so she was reassessed for the mechanical lift by nursing. She	F 323	slings, per the manufacturer guidelines to include right size/color. Current residents who utilize a lift for transfers have been reviewed by the DNS, and rooms audited by Unit Managers to locate and ensure the correct sling are available. Current residents who require lifts for transfers, have had a new lift evaluation completed by the DNS and Unit Managers. Care plans have been updated as necessary. Additional slings have been ordered by the Central Supply Clerk, to ensure back ups are available and readily accessible. Licensed nurses will be in-serviced, by the Director of Nursing and/or Designee, on the requirement for completion of the lift evaluation on admission, and as needed to include the size of sling to be provided on the plan of care for each resident. Director of Nursing Services, along with the Interdisciplinary Team to include the Resident Assessment Coordinator and Unit Managers will assist with monitoring correct sling size available/used. This will be accomplished during the Clinical Start up Meeting, in which a review of new admission charts is conducted, Monday-Friday X 12 weeks. Care Guides will be updated by Unit Managers, as well as Care Plans by the Resident Assessment Coordinator/Care Plan Coordinator, as needed during the Clinical	

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F 323	Continued From page 6 stated this was not the usual sling they used with this resident. The slings were sent to laundry after use to be washed so hers was not available at the time of this transfer. She stated that the sling size went by the resident's weight and the Assistant Director of Nursing (ADON) or the Director of Nursing (DON) assigned the sling size. Interview on 01/13/2017 at 2:56 PM with the DON revealed her expectation was that staff would use the correct color/size sling with the facility lifts for safe transfer of residents. She stated she expected the staff to follow the resident's lift mobility status assessment recommendation of a lift and sling for resident transfers.	F 323	Start Up Meeting to ensure continued compliance. Medical Records Clerk will bring Admission and ongoing chart audits to the Clinical Start Up for review by the Executive Director and/or DNS daily Mon-Friday X 4 weeks. Sling size guides have been posted/provided to staff, by the Director of Clinical Education, with identification of correct sling size based on resident weight. Licensed nurses and nursing assistants will be provided in-service/education, by the Director of Nursing Services, Director of Clinical Education and Unit Managers on following lift guidelines for sling size during use. DON and/or her Designee, Unit Managers - East and West Units,Manager of Duty (on weekends), and Res Assessment Coor/Care Plan Coor, Director of Social Services, Medical Records Clerk and Central Supply Clerk will conduct random audits daily X 4 weeks, then 2 times weekly X 1 month, for a total of 10 residents during each audit; they will document the audit on the Sling Audit QA Tool, to ensure slings are available and the correct sling size/type/color match that on the Care Guide. The QAPI committee will review the findings of the Sling Audit Tool monthly, for 3 months, and take additional corrective action steps as necessary to ensure continued compliance.	