DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FEB 21 2013

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345525	A. BUILDING _____ B. WING _____	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF TAYLOR GLEN RET COM	3700 TAYLOR GLEN LANE CONCORD, NC 28027

(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 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately code 1 (Resident #7) of 5 Minimum Data Sets (MDS's), and failed to ensure Registered Nurse's signature on 4 (Residents #3, #4, #7 and #8) of 5 MDS	F 278	F278 When the deficient practice was discovered for each resident (3, 4, 7 and 8), the minimum data set assessments were reviewed by the registered nurse certifying the accuracy of the portion of the assessment they completed and that the assessments were signed. The minimum data set assessments for residents in beds that were scheduled for the period beginning October 1, 2012 through January 16, 2013, were reviewed by the care plan team (nursing, dining services, social services, activities, therapy and administration) for signing and certifying the accuracy of the assessments they completed. No other resident assessments were found to be of deficient practice. A review of the procedure for the signing by the registered nurse of sections they completed was conducted by the Interim Director of Nursing and Administrator. The following items were addressed in this review. • The procedure for how to process the minimum data set and care plans. • Importance of completion dates as assigned	1/17/13 1/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Miriam Sweeney Administrator 2/17/13

(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 278	Continued From page 1 assessments. The findings include: 1. Resident #7 was admitted to the facility on 3/22/12. Cumulative diagnoses included status post surgery for a hip fracture and dementia. The quarterly MDS dated 11/12/12 indicated Resident #7 had limitations of all four extremities that interfered with daily functions or placed resident at risk of injury. On 1/16/13 at 8:20 AM, Resident #7 was observed walking with a walker through the living area into the dining room. She was able to feed herself breakfast. During an interview on 1/16/13 at 3:50 PM, Nurse #1 indicated Resident #7 had no impairment in arm movement, but had some difficulty with her legs due to arthritis. During an interview on 1/16/13 at 6:40 PM, Nurse #2 acknowledged that she had done the quarterly assessment for range of motion for Resident #7. She stated that the resident had impairment in one leg only, and that she had coded the MDS incorrectly. 2. Resident #8 had an admission MDS dated 11/29/12. There was no signature to indicate who had completed the nursing sections of the MDS, and no Registered Nurse (RN) signature verifying assessment completion. During an interview on 1/16/13 at 5:30 PM, Administrative Staff #2 indicated that she	F 278	• Proper and accurate coding of the minimum data set • The signing and dating of the minimum data set • The signing and dating of the care area assessments, when applicable • Updating of the care plan to include that the registered nurse signature indicates that the accuracy of the information has been verified. • A change in resident's condition must be documented on the 24 hour report noting that the care plan has been updated. • Filing of the minimum data set in the resident's minimum data set chart. The care plan team meets weekly. The care plan team consists of the Director of Nursing, Director of Social Services, Director of Activities, Director of Dining Services, Therapy and Administrator. During that meeting, an audit will be completed by the	1/24/13

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F 278	Continued From page 2 assigned MDSs to be divided among 4 RNs. The RNs gave her the completed assessments which were written on paper; she entered them into the computer, printed them out and placed them in the MDS charts. There was no formal process to alert the nurse that the printed assessments were ready for signatures. During an interview on 1/16/13 at 6:30 PM, Nurse #1 stated she had done the assessment but had not signed it. Nurse #1 indicated that MDS completion was divided between 4 nurses, and the social worker actually printed the MDSs and placed them on the charts. 3. Resident #7 had a quarterly MDS dated 11/22/12. There was no signature to indicate who had completed the nursing sections of the MDS, and no Registered Nurse (RN) signature verifying assessment completion. During an interview on 1/16/13 at 5:30 PM, Administrative Staff #2 indicated that she assigned MDSs to be divided among 4 RNs. The RNs gave her the completed assessments which were written on paper; she entered them into the computer, printed them out and placed them in the MDS charts. There was no formal process to alert the nurse that the printed assessments were ready for signatures. 4. Resident #4 was admitted to the facility on 10/18/12. The admission Minimum Data Set (MDS) assessment was completed with the reference date of 10/25/12.	F 278	care plan team. They will verify that the minimum data set has been correctly coded, the minimum data set has been signed by the registered nurse/Director of Nursing in the appropriate sections verifying the accuracy of the portion of the assessment they completed. The the care area assessment (when applicable) will also be audited. The care plan team meeting is reviewed weekly with the physician. The Administrator and/or the Director of Nursing will bring any deficient practice of the completed weekly care audits to the quarterly quality assurance meeting.	2/7/13

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F 278	Continued From page 3 The CAAS (Care Area Assessments) summary form dated 10/25/12 was reviewed. The form had no signature and date from the RN (registered nurse) for CAA process and there was no signature and date of the person completing the care plan decision. On 1/16/13 at 9:10 AM, Nurse #1 was interviewed. She was aware that nobody had been signing the CAAS and the care planning decision but it will get fixed. 5. Resident #3 was admitted to the facility on 12/19/12. The admission Minimum Data Set (MDS) assessment was completed with the reference date of 12/26/12. The CAAS summary form dated 12/26/12 was reviewed. The form had no signature and date from the RN (registered nurse) for CAA process and there was no signature and date of the person completing the care plan decision. On 1/16/13 at 9:10 AM, Nurse #1 was interviewed. She was aware that nobody had been signing the CAAS and the care planning decision but it will get fixed.	F 278		
F 279 SS=B	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	F279 When the deficient practice resident (3, 4, 8 and 9), the care plans were reviewed, corrected and signed by the registered nurse certifying the accuracy of the care plan.	1/17/13

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F 279	Continued From page 4 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan for 3 (Residents #3, #4 and #9) of 9 sampled residents. The findings include: 1. Resident #9 was admitted to the facility on 10/2/12. On 10/3/12 a urine specimen indicated the resident had a urinary tract infection (UTI) and she was started on antibiotic therapy. The care plan revealed no problem of UTI and no interventions specific to UTI. During an interview on 1/16/13 at 6:30 PM, Nurse #1 indicated the care plan should have included UTI. 2 a. Resident #4 was admitted to the facility on 10/18/12 with multiple diagnoses including urinary retention. The admission Minimum Data Set	F 279	The care plans for residents in that were scheduled for the period beginning October 1,2012 through January 16, 2013, were reviewed by the careplan team (nursing, dining services, social services, activities, therapy and administration) for signing and certifying the accuracy of the care plans they completed. No other resident care plans were found to be of deficient practice. A review of the procedure for the signing by the registered nurse for the care plan they completed was conducted by the Interim Director of Nursing and Administrator. This was done with each registered nurse assigned the responsibility for the care plan. The following items were addressed in this review. • The procedure for how to process the care plans. • Importance of completion dates as assigned • Updating of the care plan To include that the regis-	

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F 279	Continued From page 5 (MDS) assessment dated 10/25/12 indicated that Resident #4's cognitive status was intact and she had an indwelling catheter. The care plan for Resident #4 was reviewed. There was no care plan to address the care/treatment for the use of the indwelling catheter. On 1/16/13 at 9:10 AM, Nurse #1 was interviewed. She agreed that the use of the indwelling catheter should have been care planned but it was not. 2 b. Resident #4 was admitted to the facility on 10/18/12 with multiple diagnoses including contracture. The admission Minimum Data Set (MDS) assessment dated 10/25/12 indicated that Resident #4's cognitive status was intact and she had limitation in range of motion on both upper and lower extremities. The care plan for Resident #4 was reviewed. There was no care plan to address the care/treatment of the contracture on both lower and upper extremities. On 1/16/13 at 9:10 AM, Nurse #1 was interviewed. She agreed that the contracture should have been addressed in the care plan. 2 c. Resident #4 was admitted to the facility on 10/18/12 with multiple diagnoses including urinary retention. The admission Minimum Data Set	F 279	tered nurse signature indicates that the accuracy of the information has been verified. • A change in resident's condition must be documented in the interdisciplinary note in the electronic health record. The interdisciplinary note is alerted on the 24 hour report noting that there has been a change in resident condition. An alert from the 24 hour report is sent via the electronic health record to the care plan team. All members of the care plan team, as well as, administrator and physician, have instant notification of a change in resident condition. The Director of Nursing will follow up to be sure that the care plan has been changed.	

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F 279	Continued From page 6 (MDS) assessment dated 10/25/12 indicated that Resident #4's cognitive status was intact and she had UTI (urinary tract infection) listed under infections.. The care plan for Resident #4 was reviewed. There was no care plan to address the care/treatment for UTI. Review of the records revealed that Resident #4 was treated with antibiotics for UTI on 10/26/12, 11/10/12, 12/2/12 and 12/20/12. On 1/16/13 at 9:10 AM, Nurse #1 was interviewed. She agreed that the UTI should have been addressed in the care plan. 3. Resident # 3 was admitted to the facility on 12/19/12 with multiple diagnoses including Depression and Anxiety. The admission MDS assessment dated 12/26/12 indicated that Resident #3 ' s cognitive status was intact and she was receiving psychotropic medications (Zoloft, Elavil and Remeron). The care plan was reviewed. There was no care plan to address the use of the psychotropic medications. On 1/16/13 at 9:10 AM, Nurse #1 was interviewed. She agreed that the use of the psychotropic medications should have been addressed in the care plan.	F 279	The care plan team meets weekly. The care plan team consists of the Director of Nursing, Director of Social Services, Director of Activities, Director of Dining Services and Administrator. During that meeting, an audit will be completed by the care plan team. They will verify that the care plan has been updated and has been signed by the registered nurse/Director of Nursing who completed the care plan. The care plan team meeting is reviewed weekly with the physician. The Administrator and/or the Director of Nursing will bring the results of any deficient practice to the quarterly quality assurance meeting. F280 When the deficient practice was discovered for each resident (4 and 8), the care plans were reviewed, corrected and signed by the registered nurse certifying the accuracy of the care plan.	1/24/13 2/7/13
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280		

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F 280	Continued From page 7 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to review and revise the care plans after residents developed pressure ulcers for 2 (Residents #4 and #8) of 2 sampled residents with pressure ulcers. The findings include: 1. Resident #8 was admitted to the facility on 11/22/12. Cumulative diagnoses included generalized muscle weakness, pernicious anemia and osteomalacia. Review of the care plan dated 12/6/12 revealed that Resident #8 was at risk for pressure ulcers due to limited mobility, muscle weakness and	F 280	The care plans for residents in that were scheduled for the period beginning October 1,2012 through January 16, 2013, were reviewed by the careplan team (nursing, dining services, social services, activities, therapy and administration) certifying the accuracy of the care plans they completed. No other care plans were found to be of deficient practice. A review of the procedure for the signing by the registered nurse for the care plan they completed was conducted by the Interim Director of Nursing and Administrator. This was done with each registered nurse assigned the responsibility for the care plan. The following items were addressed in this review. • The procedure for how to process the care plans. • Importance of completion dates as assigned • Updating of the care plan to include that the registered nurse signature indicates that the accuracy of the information has been verified.	1/17/13 1/18/13

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F 280	Continued From page 8 pain. Review of pressure ulcer records revealed that on 12/28/12, Resident #8 had a stage 2 pressure ulcer on her buttocks and a stage 1 on her elbow. The care plan was not revised to reflect actual pressure ulcers. During an interview on 1/16/13 at 11:11 AM, Nurse #1 stated that care plans should be updated by the nurses when changes occur, and Resident #8's care plan should have been updated when the pressure ulcers were first observed. 2. Resident #4 was admitted to the facility on 10/18/12 with multiple diagnoses including urinary retention. The admission Minimum Data Set (MDS) assessment dated 10/25/12 indicated that Resident #4's cognitive status was intact and she had no pressure ulcer. Review of the admission records dated 10/18/12 revealed that Resident #4 was admitted to the facility with " dark pink areas on the right buttocks " . The weekly pressure ulcer records were reviewed. The records indicated that on 12/18/12, Resident #4 had developed a stage II pressure ulcer to the left buttock. This was treated with Duoderm and was healed up on 12/30/12. On 1/9/13, Resident #4 had developed a stage II pressure ulcer to the left buttock. The treatment ordered for the left buttock pressure ulcer (stage II) was Duoderm and to be changed every 3 days.	F 280	• A change in resident's condition must be documented in the interdisciplinary note in the electronic health record. The interdisciplenary note is alerted on the 24 hour report noting that there has been a change in resident condition. An alert from the 24 hour report is sent via the electronic health record to the care plan team. All members of the care plan team, as well as, administrator and physician, have instant notification of a change in resident condition. The Director of Nursing will follow up to be sure that the care plan has been changed. The care plan team meets weekly. The care plan team consists of the Director of Nursing, Director of Social Services, Director of Activities, Director of Dining Services, therapy and Administrator. During that meeting, an audit will be completed by the care plan team. They will verify that	1-24-13

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F 280	Continued From page 9 On 1/16/13 at 3:20 PM, Resident #4 was observed. The treatment for the left buttock pressure ulcer was not due to be changed. The left buttock pressure ulcer was covered with Duoderm when observed. The care plan was reviewed. The care plan was not revised to address the care/treatment for the stage II pressure ulcer. On 1/16/13 at 9:10 AM, Nurse #1 was interviewed. She agreed that the care plan should have been revised when the resident had developed a stage II pressure ulcer.	F 280	the care plan has been updated and has been signed by the registered nurse/Director of Nursing who completed the care plan. The care plan team meeting is reviewed weekly with the physician. The Administrator and/or the Director of Nursing will bring the results of any deficient practice to the quarterly quality assurance meeting.	2/7/13 → continued
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza	F 334	F334 (flu vaccine) When the deficient practice was discovered, all resident charts were reviewed. A letter is being sent to each resident and responsible party. The letter will include the latest information for the current calendar year from the Centers for Disease Control regarding the flu vaccine. A consent form will also be included with the letter for the resident and the responsible party party to review and sign. sign.	1/18/13 2-18-13

F280

The Director of Social Services sends a letter to the resident and responsible party inviting them to a care plan meeting. If there is not a response, she follows up with a telephone call and/or an email asking if they are planning to attend. If the resident is able to participate but the responsible party does not respond, the Director of Social Services meets with the resident. The Director of Social Services reviews the care plan that was prepared by the care plan team with the resident and with the responsible party. If a resident and responsible party have questions she can not answer, she schedules a meeting for them with the appropriate member of the care plan team. She documents in the electronic health record the meeting and specifies who attended. Any changes that come about as a result of the care plan meeting will be updated immediately by the Director of Nursing/MDS Coordinator in the care plan. The Director of Social Services Immediately notifies the appropriate member of the care plan team regarding the need to make a change to the care plan.

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F 334	Continued From page 10 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	A policy and procedure was written and implemented. The care plan team and nursing staff received copies of the policy and procedure. It was reviewed with them by the Administrator. The policy was placed in the nursing policy manual. The Director of Social Services will send an annual letter to the resident and/or the responsible party during the month of August. The letter will include the latest information for the current calendar year from the Centers for Disease Control regarding the flu vaccine. A consent form will also be included with the letter for the responsible party to review and sign. The interdisciplinary notes in the electronic health record tracks what has been sent. The Director of Social Services will run a weekly report to show which consent forms have or have not been returned. For those responsible parties	1/18/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345525	A. BUILDING _____ B. WING _____	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF TAYLOR GLEN RET COM	3700 TAYLOR GLEN LANE CONCORD, NC 28027

(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 334	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop policies and procedures for administration of influenza and pneumococcal vaccines, and failed to document education prior to administering influenza vaccines for 2 (Residents #7 and #13) of 3 sampled residents. The findings included: 1. Upon request for its influenza and pneumococcal immunization policies and procedures, the facility provided the following: (1) Centers for Disease Control (CDC) " Vaccine Information Statement " for the influenza vaccine dated 2012-2013, (2) the CDC " Pneumococcal Polysaccharide Vaccine " information statement dated 10/6/09, (3) an undated " Annual Influenza Vaccine Administration Consent Form ", (4) an undated " Pneumococcal Polysaccaride Vaccine Administration Consent Form ", and (5) an " Influenza/Pneumonia Vaccine Record " form dated 10/15/02. During an interview on 1/16/13 at 5:15 PM, Administrative Staff #1 stated that the facility did not have formal policies and procedures for influenza and pneumococcal immunizations. 2. Resident #7 was admitted to the facility on 3/22/12. Record review revealed an " Annual Influenza Vaccine Administration Consent Form " signed	F 334	who have not returned their consent form, the Director of Social Services will follow up with either a telephone call, an email or another letter. Nursing will document in the interdisciplinary note of the electronic health record that the flu vaccine has been given. The Administrator and/or the Director of Nursing will review this procedure and status twice a year during the flu season of September through March at the scheduled quarterly quality assurance meeting. F334 (pneumonia vaccine) When the deficient practice was discovered, all resident charts were reviewed. A letter is being sent to each resident and responsible party. The letter will include the latest information for the current calendar year from the Centers of Disease Control regarding the pneumonia vaccine. A consent form will also be included	1-18-13 1-18-13 (letter)

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	345525	A. BUILDING _____ B. WING _____	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF TAYLOR GLEN RET COM	3700 TAYLOR GLEN LANE CONCORD, NC 28027

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F 334	Continued From page 12 10/12/11 by the responsible party (RP). Her " Influenza/Pneumonia Vaccine Record " revealed that she had the influenza vaccine on 10/3/12. There was no documentation that the RP had received education about the vaccine or had an opportunity to decline the vaccine prior to its administration. During an interview on 1/16/13 at 5:15 PM, Administrative Staff #1 stated that the facility did not require signed authorizations for vaccines annually, nor proof that education was provided. 3. Resident #13 was readmitted to the facility on 11/28/12. Record review revealed an " Annual Influenza Vaccine Administration Consent Form " signed 5/14/12 by the responsible party (RP). Her " Influenza/Pneumonia Vaccine Record " revealed that she had the influenza vaccine on 10/4/12. There was no documentation that the RP had received education about the vaccine or had an opportunity to decline the vaccine prior to its administration. During an interview on 1/16/13 at 5:15 PM, Administrative Staff #1 stated that the facility did not require signed authorizations for vaccines annually, nor proof that education was provided.	F 334	with the letter for the resident and responsible party to review and sign. A policy and procedure was written and implemented. The care plan team and nursing staff received copies of the policy and procedure. It was reviewed with them by the Administrator. The policy was placed in the nursing policy manual. The Director of Social Services will send an annual letter to the resident and/or the responsible party during the month of August. The letter will include the latest information for the current calendar year from the Centers for Disease Control regarding the pneumonia vaccine. A consent form will also be included with the letter for the responsible party to review and sign. The interdisciplinary notes in the electronic health record tracks what has been sent. The Director of Social Services will run a weekly report to show which	1/18/13
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345525	A. BUILDING _____ B. WING _____	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF TAYLOR GLEN RET COM	3700 TAYLOR GLEN LANE CONCORD, NC 28027

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F 356	Continued From page 13 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to complete the staffing information accurately. The findings include: On 1/15/12 at 4:30 PM and 1/16/13 at 9:00 AM, the daily staffing sheets were observed. The staffing sheets were not completed accurately. The census and the staffing for the assisted living were included in the daily staffing sheets.	F 356	consent forms have or have not been returned. For those responsible parties who have not returned their consent form, the Director of Social Services will follow up with either a telephone call, an email or another letter. Nursing will document in the interdisciplinary note of the electronic health record that the pneumonia vaccine has been given. The Administrator and/or the Director of Nursing will give the vaccine report at the scheduled quarterly assurance meeting. F356 When the deficient practice was discovered, the daily staffing information form was corrected and relocated as requested. The RN Supervisor for each shift is responsible for completing the form and posting it on the bulletin board. This was communicated to the RN Supervisors by the Adminstrator.	1/15/13

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	345525	A. BUILDING _____ B. WING _____	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF TAYLOR GLEN RET COM	3700 TAYLOR GLEN LANE CONCORD, NC 28027

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F 356	Continued From page 14 On 1/16/13 at 9:10 AM, Nurse #1 was interviewed. She indicated that she did not know that the daily staffing sheet was only for the certified beds.	F 356	The form shows the date, resident census for the Medicare certified beds, staffing for day and night shift (12 hour shifts), number of registered nurses, the number of licensed practical numbers and the number of certified nursing aides, the scheduled hours for each position and the actual hours worked for each position. An in-service was given to designated staff who post the daily staffing only to include the hours being serviced and the census for the certified beds per shift. A daily audit, Monday-Friday, will be completed by the Administrator. The Administrator on call will complete the audit on their scheduled weekend. The Administrator and/or the Director of Nursing will bring the audit results to the quarterly quality assurance meeting.	2/7/13

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	345525	A. BUILDING 01 - MAIN BUILDING B. WING _____	02/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF TAYLOR GLEN RET COM	3700 TAYLOR GLEN LANE CONCORD, NC 28027

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type II Protected construction and is equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a) NOTE: There were no Life Safety Code Deficiencies noted during the survey.	K 000		

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