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 _____	02/15/2023

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
E 000	Initial Comments An unannounced Recertification survey was conducted 2/13/2023 to 2/15/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # KN3P11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 2/13/2023 to 2/15/2023. Event ID# KN3P11.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within	F 640		3/17/23

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

Electronically Signed | 03/03/2023

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 _____	02/15/2023

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 640	Continued From page 1 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment for 1 of 1 sampled resident reviewed for discharge (Resident #1). Findings included: Resident #1 was admitted to the facility on 10/17/22. Record review revealed Resident #1 had discharged return not anticipated to the assisted living section of the facility on 11/4/22. Review of Resident #1's medical record revealed	F 640	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F640 Encoding/Transmitting Resident Assessments	

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 _____	02/15/2023

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 640	Continued From page 2 a discharge return not anticipated assessment dated 11/4/22 had been started but not completed. During an interview with the Administrator on 2/15/22 at 12:36 PM, she stated their MDS assessments were contracted from an outside agency. She explained they realized on 2/12/23 the discharge assessment for Resident #1 had not been completed. She stated she would expect the MDS assessments to be completed timely. A telephone interview was conducted with the contracted MDS nurse on 2/15/23 at 1:12 PM. She stated that she had thought the MDS discharge assessment had been completed. She explained she was not a Registered Nurse (RN) so once she completed the assessment, she would send an email to the facility to notify them the MDS assessment was ready to be closed and transmitted by a Registered Nurse at the facility.	F 640	During the annual survey, it was found that resident #1 did not have a discharge assessment completed when ending their Certified stay. The discharge assessment for Resident #1 was completed on 2/15/2023 and will be submitted as allowed by the State. A lookback period of 90 days was completed to ensure all residents who had been discharged from certified beds to ensure a discharge assessment was completed. The audit was completed on 2/14/23 and resulted in 4 additional missing assessments. These assessments will be completed by 2/17/23. Education was provided by the Administrator to the Director of Nursing, Assistant Director of Nursing, and Minimal Data Set Registered Nurse ensuring completion of a discharge assessment when a resident leaves a Medicare stay. Education was completed on 2/13/23. Moving forward, an audit will be completed by the MDS RN or designee once a week for 4 weeks for all discharges ensuring assessments for the week were completed and transmitted as required. Monitoring will be forwarded to the facility QAPI committee to determine if further oversight is needed. Audits will be reviewed through the facility's routine QAPI meeting. Responsible Team Member: DON, MDS RN Date of Compliance: 2/17/23 Date of Completion: 3/17/2023	

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 _____	02/15/2023

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 812	Continued From page 3	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to remove expired food stored for use from the walk-in refrigerator, failed to date meat that was thawing, failed to allow clean dishes to air dry before they were stacked (placed on top of each other while still wet). The failures had the potential to affect food served to residents. The findings included: 1. An initial observation of the walk-in refrigerator conducted on 2/13/23 from 11:25 AM to 11:50 PM with the Dietary Director (DD) revealed the following food items stored past the	F 812	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 812 Food Procurement, Store/Prepare/Serve- Sanitary Immediately, the facility removed the	4/7/23

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 _____	02/15/2023

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 812	Continued From page 4 use by date and/or without a date to indicate how long the item was good for: - A 10-quart container of bean soup which was ¾ full dated 2/9/23. - 20 ham slices in a zip lock bag dated 2/8/23. - ¼ of a 2-pound pre-packaged ham was wrapped in plastic wrap without a date. - A metal container of ham slices with an unreadable date. The DD confirmed this was unreadable. - A plastic container containing approximately 2 cups of egg salad dated 2/7/23. - A plastic container containing approximately 5 cups of tuna salad dated 2/8/23. - A 12-quart container of cooked meatballs in sauce dated 2/3/23. - Canned peaches in a plastic container dated 2/7/23. - A metal pan of 12 thawed chicken breast with no date on the pan. The DD stated the chicken breast were served on Saturday 2/10/23. - A 10-pound box of mushrooms which had ¼ remaining that were covered in brown spots and were dated 1/18/23. - A 10-pound thawed, uncooked pork roast with no date. The DD stated the pork roast had been pulled from the freezer on Friday 2/10/23 and pork roast was served on Sunday 2/12/23 and this was pork was not used. - 5 pounds of thawed ground beef with no date. During the initial tour the DD stated that all food without an expiration date such as cooked food is kept for three days, and frozen food is pulled from the freezer to thaw in the refrigerator 48 hours prior to being cooked. A follow-up interview was completed with the	F 812	expired food and unlabeled meat. The clean dishes that were not completely dry prior to stacking were rewashed and dried appropriately under the supervisor of the Director of Dining services. All current residents have the potential to be affected by the alleged practice. On 2/13/2023 the Director of Dining Services checked all refrigerators and freezers for expired items and items being stored incorrectly, including items not labeled and dated appropriately with no negative findings. Education was completed with staff by the Director of Dining Services on 3/2/23 including the facility policy of Food Storage. This policy included food without an expiration date, such as cooked food, should be kept for three days and frozen food should be pulled to thaw in the refrigerator 48 hours prior to being cooked. Staff was educated to understand all expired items must be removed from use and discarded immediately as well as food that is being thawed must be labeled and dated for date opened to thaw as well as a “use by” date. Further education was completed on 3/2/23 to explain that dishes are not to be stacked until they are completely dried. In addition to education, more racks for drying dishes were purchased on 3/3/23 to ensure dishes were able to be spaced out while drying and stored in compliance with F812. A label marker was also purchased and implemented in our facility processes 3/2/2023. To ensure compliance, Three times a week for 5 weeks, the Administrator or	

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 _____	02/15/2023

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 812	Continued From page 5 dietary director on 2/13/23 at 3:16 PM who stated that she did not know why there had been expired food in the walk-in refrigerator. The DD stated that food that was cooked should have had a label with the day it was made and a use by date. The DD director explained that items like the raw ground beef should have had a date it was put in the refrigerator to thaw. An interview was completed with Cook #1 on 2/13/23 at 3:34 PM who stated that the process for labeling food was for example, if the food had been mixed vegetables he would have put a date the mixed vegetables were put in the refrigerator with plastic wrap over them. Cook #1 stated for ham slices he would had put the date of prepping and for raw chicken he would have put the date it had been put in the metal bin and placed in the refrigerator. Cook #1 stated that the policy is prepared food is thrown out after 3 days. 2. During a follow up visit to the kitchen of the dishwashing area on 2/13/23 at 3:40 PM revealed four, 4-quart plastic containers were stacked inside each other and 3 of the containers had noticeable condensation (water) inside the containers. The DD was made aware of the plastic containers at 3:46 PM and stated these were "wet nested" (containers stacked inside each other while still wet) and should have been left to air dry on the dish rack. An interview was completed with Dishwasher #1 on 2/13/23 at 3:50 PM who stated that dishes were to be put on a rack to air dry. Dishwasher #1 was shown the wet containers and he stated that some containers may be a little wet and he would still stack them or would get a clean towel to dry them off.	F 812	designee will complete Dietary Audits to ensure compliance with food storage and the stacking of dishes. Any immediate concerns will be brought to the Director of Dining Services, IL Director and/or Administrator to ensure immediate correction and appropriate actions are taken to remain in compliance. The audits will be reviewed by the facility QAPI Committee to determine if further auditing is necessary. Responsible Role: Director of Dining Services Date of Compliance: 3/2/2023 Date of Completion: 4/7/2023	

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 _____	02/15/2023

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 812	Continued From page 6 An interview was completed with the Administrator on 2/15/23 at 2:42 PM who stated that it would be her expectation that food is labeled and dated and thrown away if expired and dishes are dry when stacked.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		4/14/23

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 _____	02/15/2023

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 867	Continued From page 7 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health	F 867		

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 _____	02/15/2023

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 867	Continued From page 8	F 867		

outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data

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 _____	02/15/2023

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 867	Continued From page 9 resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor these interventions the committee put into place in May 2021. This was for 1 re-cited deficiency which was originally cited on 5/26/2021 (F812) and on the current recertification/complaint survey on 2/15/2023 (F812). The continued failure of the facility during the two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. The findings included: This tag is cross referred to: F812: Based on observation, staff interviews and record review the facility failed to remove expired food stored for use from the walk-in refrigerator, failed to date meat that was thawing, failed to allow clean dishes to air dry before they were stacked (placed on top of each other while still wet). The failures had the potential to affect food served to residents. During the Federal Monitoring Comparative Survey conducted on May 26, 2021, the facility failed to ensure sanitary practices were carried out in the kitchen. The facility failed to discard buttermilk by its use by date; failed to perform hand hygiene to prevent cross contamination of clean dishes during dishwashing and while plating food; failed to ensure gloves used while temping	F 867	F867 QAPI/QAA Improvement (Food Procurement, Store/Prepare/Serve-Sanitary) On 2/14/2023 an Ad Hoc QAPI Meeting was held with the Taylor Glen QAPI team and Regional Director of Operations To discuss the Food Procurement/Storage tag from 2021 and again in 2023. Facility QAPI Plan was updated to reflect a focus area of Dietary Services and Food Procurement and Storage compliance for this facility. Regional Director of Operations and Administrator for facility reviewed previous 2567's from 2021 to current to ensure knowledge of previous citations and processes implemented moving forward. Education was provided to the QAPI committee by the Regional Director of Operations to ensure the knowledge of previous citation lookback and ensuring QAPI processes put in place are maintained for ensuring compliant practice. Moving forward, the QAPI committee will continue to meet Monthly (as needed), Quarterly, and hold Ad Hoc QAPIs on an as needed basis to ensure processes to maintain compliant practices are in place. Minutes of the committee meetings will be forwarded to the Regional Director of Operations to determine further monitoring. For the rules around this plan of correction, these minutes will be forwarded on a monthly basis for 2	

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 _____	02/15/2023

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 867	Continued From page 10 and plating food, were not cross contaminated by the food thermometer which had been improperly stored in a staff members pocket; and failed to allow clean dishes to air dry when they were wet stacked (placed on top of each other while still wet). The failures had the potential to affect three (3) of three (3) residents. The Administrator was interviewed on 2/15/2023 at 1:57 PM and she explained the facility conducted quarterly QAPI meetings that included the dietary director. The Administrator reported staff turnover in the dietary department was the cause of the breakdown in the system related to sustaining the corrective actions that were put in place in May 2021.	F 867	months and reviewed by the Regional Director of Operations. Responsible Party: Administrator Date of Compliance: 2/14/23 Date of Completion: 4/14/2023	