STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0607	A. BUILDING: _____ B. WING _____	C 11/07/2024

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) COMPLETE DATE
L 000	INITIAL COMMENTS A state licensure complaint investigation was conducted on 11/05/24 through 11/07/24. Event ID: B5DZ11. The following intakes were investigated: NC00222890 and NC00218781. 1 of the 2 allegations resulted in deficiency.	L 000		
L 078	.2305(C) QUALITY OF CARE 10A-13D.2305 (c) The facility shall not utilize any chemical or physical restraints for the purpose of discipline or convenience, and that are not required to treat the patient's medical condition. An evaluation shall be done to ensure that the least restrictive means of restraint have been initiated on patients requiring restraints. This Rule is not met as evidenced by: Based on record review, review of the video recording, and family member and staff interviews, the facility restrained Resident #155 by preventing him from exiting the bed by placing a club chair and recliner against the bed for the purpose of fall prevention for 1 of 3 residents reviewed for restraints (Resident #155). Findings included: Resident #155 was admitted to the facility 09/16/24 with diagnoses of Parkinson's disease and cognitive communication deficit. An initial nursing assessment dated 9/17/2024 assessed Resident #155 to be severely	L 078	The submission of the following allegation of compliance does not constitute an admission or agreement by the provider as to whether there were alleged deficient practices relative to permitting residents to return to the facility. 1. Corrective Action: 5 day reportable completed with complete investigation and details. Accused staff suspended while investigation pending and two CNA employees terminated due to substantiated report. Interviews and investigative process started immediately. All potentially affected residents were checked for innapropriate restraints in	11/8/24

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

Electronically Signed | 11/29/24

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L 078	Continued From page 1 cognitively impaired. Resident #155 required extensive assistance of one staff member for most activities of daily living. A care plan dated 9/23/2024 revealed a focus area related to falls. The goal was for Resident #155 to not experience a fall or have any fall related injuries through the next review date. Interventions included an increase of visual monitoring, continuation of therapy services and a concave mattress. An interview conducted on 11/06/24 at 11:27AM with Nurse Aide (NA) #1 revealed on 10/07/24 she had come in around 6:30 PM and was told Resident #155 had fallen and the staff needed assistance in getting him back to his bed. She stated NA #2 and NA #3 were in the room and they assisted him back to bed. Resident #155 was assessed by Nurse #2 prior to the NAs assisting him in bed and had observed no injuries. NA #1 stated Resident #155 was agitated with staff, stating he was going to hit them. NA #1 stated Nurse #2 told her to push his recliner chair and a club chair against the side of his bed so he could not fall back out. NA #1 stated she did as she was told and placed the leather recliner chair with the back facing the head of the resident alongside the bed and placed the club chair with the back facing the resident's legs alongside the lower portion of the bed. The other side of the resident's bed was placed against the wall. The interview revealed Resident #155 would not have been able to move the chairs himself to get out of bed. NA#1 stated Resident #155 calmed down and had fallen asleep, so she went back to her hallway she was assigned. The interview revealed Family Member #1 rang his call bell shortly after requesting assistance in his room. NA #1 stated when she entered the room the	L 078	place. Interviews conducted for alert and oriented residents in regard to abuse/use of restraints as well as skin checks for the non alert/oriented residents. 2. Identification of other residents who could be affected: All residents on the healthcare unit have the potential to be affected. 3. Systemic Change: On 10/08/2024 the DON or designee began in-servicing staff (Full time, Part time and PRN) on Abuse and restraint policy with emphasis on inappropriate use of restraints, abuse reporting policy, facility abuse coordinator. Any staff member (full time, part time, and PRN) and members of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. Review will be held by the Quality Assurance Process to verify that change has been sustained. Two Taylor Glen CNA were terminated as well as a do not return notice issued to a SHIFTKEY agency employee. The Shiftkey agency as well as certified nursing personnel registries were notified. 4. Monitoring: Auditing began on 10/09/2024 for any item in resident room that could be used as a restraint with no deficiency. Audit continues 3 times a week for four weeks by Director of Nursing or Designee. Audit will be completed 11/08/2024 unless discrepancy noted audits will be extended another week for any discrepancy. Audits will be taken to Quality Assurance for review, if more auditing needed it will be	

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L 078	Continued From page 2 family member was upset because of the chair placement but had already moved the chairs. NA #1 stated she notified Nurse #2 and went back to her assignment on another hall. An interview conducted on 11/06/24 at 11:45 AM with Nurse Aide #2 revealed Resident #155 had experienced a fall on 10/07/24 around shift change at 6:30 PM. She stated Nurse #2 went into the room and evaluated him. NA #2 stated she assisted NA #1 and NA #3 to get the resident into the bed using a mechanical lift and then left the room. NA #2 stated she did not see NA #1 place the chairs up against Resident #155's bed nor had seen anyone do that in the past. NA #2 stated she did not hear Nurse #2 tell NA #1 to place the chairs against the resident's bed to prevent him from falling. An interview conducted on 11/06/24 at 12:55 PM with Nurse Aide #3 revealed she had worked the 7:00 AM to 7:00 PM shift and Resident #155 had experienced a fall right at shift change around 6:30 PM out of the bed onto the floor beside his bed. She stated Nurse #2 had assessed him and asked the Nurse Aides to assist him back into bed. She heard Nurse #2 say to NA #1 to move the resident's chairs towards his bed to prevent him from falling again. NA #3 stated she told the NAs that she did not think it was a good idea and that she needed to leave for the day because it was 7:00 PM and her shift had ended. The interview revealed NA #3 witnessed NA #1 place the leather recliner chair with the back facing the head of the resident against the side of his bed along with the club chair placed alongside of the bottom half of the resident's bed with the back facing the resident's legs. The interview revealed Resident #155 could not have gotten out of bed. NA #3 stated she then left the room and the	L 078	completed at that time. Completion date: 11/08/24	

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L 078	Continued From page 3	L 078		

facility for the day.

An interview conducted on 11/06/24 at 12:00 PM with Nurse #2 revealed Resident #155 had experienced a fall on 10/07/24 at shift change. Nurse #2 stated she went into the room and assessed him observing no injuries and asked the NAs to assist him back into the bed. Nurse #2 stated she did not tell the NAs to place chairs against his bed nor did she see chairs placed against his bed. Nurse #2 stated she saw Family Member #1 after the incident and Family Member #1 had not reported any concerns to her.

An interview conducted on 11/06/24 at 1:38 PM with Family Member #1 revealed she had gone into Resident #155's room around 7:00 PM on 10/07/24 when Nurse #2 notified her of the residents fall. Family Member #1 found his bed against the right-hand side of the wall as she entered the room with a recliner chair pushed up against the top half of the bed and a club chair pushed at the lower portion of the bed. She stated Resident #155 had his legs across the bed pushing against the club chair on the lower portion of the bed. The interview revealed there was no space between the back of the recliner and Resident #155's bed. She stated he was unable to move the leather recliner chair and was trapped in the bed. The interview revealed she was very upset but did not tell anyone about it that night. She stated she moved the chairs herself and waited until the next day to talk to the Administrator about what had happened.

On 11/06/24 at 2:38 PM the facility provided the surveyor with the video surveillance footage dated 10/07/24. At 6:45 PM staff were observed in Resident #155's room assisting him after a fall with the door closed. Nurse #2 exited the room at

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L 078	Continued From page 4 6:52 PM leaving NA #1, NA #2 and NA #3 in the room with the door closed. NA #1, NA #2 and NA #3 were observed leaving the room at 6:53 PM and turning the light off, two chairs were noted along Resident #155's bed in the video footage. Family Member #1 was observed entering the resident's room at 7:18 PM and did not return to the hallway. An interview conducted with the Administrator and Director of Nursing on 11/06/24 at 12:46 PM revealed they had become aware of the incident on 10/08/24 when Family Member #1 came to the Administrator upset about two chairs being pushed up against the resident's bed to prevent him from falling. The Administrator stated it was a large high back leather recliner chair and a facility cloth club chair that had been placed alongside the resident's bed. The other side of the bed was alongside a wall. The interview revealed they had initiated an investigation into the incident and could not identify which staff member placed the chairs alongside the bed. The Administrator stated he had obtained statements from all staff that were working on 10/07/24 and reviewed video camera footage from outside of the resident's room. The facility suspended the 3 NAs pending the investigation and ultimately terminated their contracts with the facility. The investigation was substantiated due to video footage which showed two large chairs placed against the resident's bed. The interview revealed at no time were staff members to restrain a resident in the bed by placing chairs against the bed to prevent a fall. The interview revealed he had provided education to all staff members following the incident.	L 078		