

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

PRINTED: 01/10/2012  
FORM APPROVED  
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345525	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/22/2011
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NAME OF PROVIDER OR SUPPLIER  THE GARDENS OF TAYLOR GLEN RET COM	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LANE CONCORD, NC 28027
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(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
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F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(1)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>A. When the deficient practice was discovered, a sign was immediately posted containing the appropriate information. (Attachment A)</p> <p>B. The sign was attached to the existing notice which is hung behind the nursing station which is centrally located on the nursing unit. The existing notice is 11 3/4" w by 17 1/4" long. It is hung 37" above the floor which makes it wheelchair accessible.</p> <p>C. The Director of Social Services will notify current residents/families of the information in a letter and during the admissions process for a new resident. (Attachment B)</p> <p>D. The Director of Social Services will notify residents of where the</p>	<p>12-21-11</p> <p>12-21-11</p> <p>1-19-12</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Miriam Steiner, Administrator</i>	TITLE Administrator	(X6) DATE 1-19-2012
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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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OMB NO. 0938-0391A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345625	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING <u>h</u>		(X3) DATE SURVEY COMPLETED  12/22/2011
NAME OF PROVIDER OR SUPPLIER  THE GARDENS OF TAYLOR GLEN RET COM			STREET ADDRESS, CITY, STATE, ZIP CODE 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 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section;  A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.  A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.  The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This	F 156	<u>n</u> information is located in monthly meetings.  E. The Director of Social Services will complete the attached audit, (Attachment C) As the information changes, the Director of Social Services will update and post the new information immediately. The Administrator will complete this audit in the absence of the Director of Social Services.  F. The Director of Social Services will bring the results to the quarterly Quality Assurance meeting. The next scheduled QA meeting is 2-23-12.	Monthly ongoing  Monthly X 12 months  Quarterly starting 2-23-12	

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NAME OF PROVIDER OR SUPPLIER  THE GARDENS OF TAYLOR GLEN RET COM			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LANE CONCORD, NC 28027		
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F 156	<p>Continued From page 2</p> <p>includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interviews, the facility failed to post state agency information. The findings included:</p> <p>On 12/21/2011 at 5:26 PM., an observation revealed there was not a sign posted with information on the name, address and contact information for the Division of Health Service Regulation (DHSR) and the complaint intake unit information.</p> <p>On 12/21/2011 at 5:26 PM., Administrative staff #1 stated she did not know that the information for the DHSR and Complaint intake unit was not posted. An observation of the skilled nursing area revealed that there was no posting of state agency information.</p> <p>On 12/22/11 at 8:43 AM., Administrative staff #2</p>	F 156	<p><u>F1617</u></p> <p>A. When the deficient practice was discovered, the bulletin board was moved to a more accessible location in the nursing area. A sign stating "State Survey Results" was posted on the bulletin board identifying the location of the state survey results.</p> <p>B. The bulletin board is 2 feet high by 3 feet wide. It is hung 37" from the floor making it wheelchair accessible. The chain length is 12". The white notebook is a standard size (10" wide x 11 1/2" long). It has a clear cover in which you can insert the front and side labels that read "State Survey Result". (Attachment D) The notebook is placed inside a hanging folder attached to the wall.</p>	12-21-11	1-19-12

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NAME OF PROVIDER OR SUPPLIER  THE GARDENS OF TAYLOR GLEN RET COM			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LANE CONCORD, NC 28027	
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F 156	Continued From page 3 stated the information for the state complaint unit was only on the facility contract, signed at admisdod. She further indicated that she reviewed the agency numbers with the resident and/or responsible party each time the resident was admitted to the skilled nursing unit.	F 156	The 2567 has been enlarged for easier reading (Attachment E)	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by:  Based on observation and staff interviews, the facility failed to display the Survey Results information without residents/ visitors having to ask where the Survey Results information was located. The findings included:  On 12/21/2011 at 5:20 PM., survey results were noted to be posted on a small bulletin board located in a corner near the living room area on the skilled nursing unit. The Bulletin Board was approximately 4 1/2 feet from the floor. There was not a sign identifying that the survey results were posted there.  On 12/21/2011 at 5:26 PM., Administrative staff	F 167	D. The Director of Social Services will notify current residents/families in a letter. (Attachment B) The Director of Social Services will notify the resident/family for a new resident during the admission process.  E. The Director of Social Services will notify residents of where the information is located in monthly meetings.  F. The Administrator will check the state survey notebook once a day Monday-Friday between the hours of 8:00am and 5:00pm to verify the contents are in place. This will be done weekly for one month and monthly and annually as surveys occur	1-19-12  Monthly ongoing  weekly for one month; monthly and annually as surveys occur

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NAME OF PROVIDER OR SUPPLIER  THE GARDENS OF TAYLOR GLEN RET COM			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LANE CONCORD, NC 28027	
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F 167	Continued From page 4 #1 stated the Survey Results should be labeled so anyone would know where it was and could read it without having to ask nursing staff for the results.  On 12/22/2011 at 7:40 AM., Administrative staff # 4 stated the Survey Results should be posted in the nursing area in an area that the residents can easily access including wheelchair residents. Residents and visitors should not have to ask where the results are posted.	F 167	(Attachment F 167) G. The Administrator will bring the results to the quarterly QA meetings. The next scheduled QA meeting is 2-23-12.	Quarterly QA meeting starting 2-23-12
F 371 SS=E	483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by:  Based on observation and staff interviews, the facility failed to maintain sanitary conditions in the kitchen when kitchen staff failed to remove gloves, wash hands and reapply clean gloves between kitchen tasks. The findings included:  On 12/21/2011 at 11:06 AM., kitchen staff #1 was observed to remove two pieces of bread from the bread wrapper with her gloved hands, put melted butter on each piece of bread and placed it on the grill. Without removing her gloves, she placed	F 371	F371 A. Deficient practice was discovered during meal preparation and prior to being served. When the deficient practice was discovered, the staff was immediately in-serviced by the Director of Dining Services.  B. The Director of Dining Services in-serviced the staff. (Attachments F-01F agenda; H-01 = in-service attendance record, I-10 = materials/handouts)	12-21-11  1-18-12

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NAME OF PROVIDER OR SUPPLIER  THE GARDENS OF TAYLOR GLEN RET COM			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LANE CONCORD, NC 28027		
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F 371	<p>Continued From page 5</p> <p>cheese on the bread and grilled the cheese sandwich. While the sandwich was being cooked, kitchen staff #1 used the same gloved hands to move pots, pans and touched utensils to stir other food items. After she removed the sandwich from the grill with a flat utensil, she placed the sandwich on a cutting board and cut the sandwich in half, picked up the sandwich with her gloved hand and put it on a plate.</p> <p>During interview at 11:10 AM., kitchen staff #1 stated she always wore gloves when she prepared food and, normally, did not change her gloves during the meal preparation. She stated she removed her gloves and changed them if she changed tasks such as answering the telephone.</p> <p>On 12/21/2011 at 11:12 AM., Administrative staff #3 stated kitchen staff #1 should have removed her gloves, washed her hands and put on new gloves when she went from preparing the sandwich to touching the utensils and pans of food. He further stated that these were two different kitchen tasks and kitchen staff had been instructed to change gloves and wash their hands between kitchen tasks.</p>	F 371	<p>C. The Director of Dining Services will do a Random weekly audit x 4 weeks and monthly and annually, as surveys occur. (Attachment)</p> <p>D. If an employee is observed with improper glove use/hand washing, etc, this will be addressed as a performance issue through the progressive disciplinary process.</p> <p>E. The Director of Dining Services will bring the results to the quarterly Quality Assurance meetings. The next quarterly QA meeting is scheduled for 2-23-2012.</p>	<p>weekly x 4 weeks; then monthly and annually as surveys occur</p> <p>Quarterly starting 2-23-12</p>	

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NAME OF PROVIDER OR SUPPLIER  THE GARDENS OF TAYLOR GLEN RET COM			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LANE CONCORD, NC 28027		
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K 000	INITIAL COMMENTS  There were no Life Safety Code Deficiencies noted at time of survey on 1/11/2012.	K 000			

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

TITLE

(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.