PRINTED: 01/29/2013

SIAIEKENT NO PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION UING	(X3) DATE S COMPLI	
		346625	B. WING	3	01/	16/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
THE GAR	dens of taylor glen	I RET COM	1	3700 TAYLOR GLEN LANE		
				CONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
SS=B	resident's status. A registered nurse muse ach assessment with participation of health A registered nurse muse assessment is completed in the complete assessment is completed. The participation of the assessment must significate portion of the assessment in a result of the completed in a resident assessment in a resident assessment in a resident assessment in a resident assessment. Clinical disagreement material and false state. This REQUIREMENT by: Based on staff interview.	t accurately reflect the set conduct or coordinate in the appropriate professionals. set sign and certify that the seted. ompletes a portion of the in and certify the accuracy of essment. Medicaid, an individual who certifies a material and sident assessment is y penalty of not more than sment; or an individual who causes another individual d false statement in a se subject to a civil money an \$5,000 for each does not constitute a ement. is not met as evidenced ew and record review, the tely code 1 (Resident #7) of (MDS's), and failed to ree's signature on 4	F 2	When the deficient was discovered for resident (3, 4, 7 and set assessments we by the registered in the accuracy of the of the assessment thank that the assess signed. The minimum data for residents in bed for the period beging 2012 through Januar were reviewed by the plan team (nursing, social services, actival administration) for certifying the accurately completed. Not assessments were for deficient practice. A review of the proof the signing by the remurse of sections the was conducted by the Director of Nursing strator. The following addressed in this remurse of the procedures the process the	practice each d 8), the minimum ere reviewed urse certifying portion hey completed ments were set assessments s that were scheening October 1, ary 16, 2013, he care dining services, vities, therapy and signing and acy of the assessi o other resident ound to be of cedure for egistered ey completed he interim and Admini- ling items were view. ure for how to	duled

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; VHCMH

Facility ID; 980257

OLIVILIV	OT ON MEDIONINE &	MEDIO NO OLIVIOLO				T	1333
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURV COMPLETED	
		345525	B. WIN	IG		01/16/2013	
	ROVIDER OR SUPPLIER DENS OF TAYLOR GLEN	RET COM	•	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LANE CONCORD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 278	assessments. The fin 1. Resident #7 was a 3/22/12. Cumulative		F	278	 Proper and accurate coding of the minimum data set The signing and dating of the minimum data set 		
	The quarterly MDS d	ated 11/12/12 indicated ations of all four extremities aily functions or placed			 The signing and dating of the care area assessments, when applicable Updating of the care plan to include tha 	t	and the second s
		M, Resident #7 was h a walker through the living com. She was able to feed			the registered nurse sig indicates that the accu- racy of the information has been verified.		
	#1 indicated Residen	on 1/16/13 at 3:50 PM, Nurse t #7 had no impairment in had some difficulty with her			 A change in resident's condition must be documented on the 24 hour report noting that 		
	#2 acknowledged that assessment for range She stated that the re	on 1/16/13 at 6:40 PM, Nurse at she had done the quarterly e of motion for Resident #7. esident had impairment in t she had coded the MDS			 the care plan has been updated. Filing of the minimum data set in the resident' minimum data set chart. 	s	
	11/29/12. There was had completed the nu and no Registered No assessment completi	n admission MDS dated no signature to indicate who ursing sections of the MDS, urse (RN) signature verifying ion. on 1/16/13 at 5:30 PM,			The care plan team meets wee The care plan team consists of Director of Nursing, Director o Social Services, Director of Act Director of Dining Services, Th	the f ivities, erapy and	1/24/1
	Administrative Staff #				Administrator. During that me		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING		(X3) DATE SURVEY COMPLETED				
		345525	B. WiN	G		01/1	6/2013
	(EACH DEFICIENC	I RET COM ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	37 C(EET ADDRESS, CITY, STATE, ZIP CODE 00 TAYLOR GLEN LANE DNCORD, NC 28027 PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278	assigned MDSs to be RNs gave her the conwere written on pape computer, printed the the MDS charts. The alert the nurse that the ready for signatures. During an interview of #1 stated she had do not signed it. Nurse #1 completion was divid the social worker activated them on the constant of the social worker activated them on the constant of the months of the months of the months of the months of the MDS to be RNs gave her the convert written on paper computer, printed the MDS charts. The alert the nurse that the ready for signatures. 4. Resident #4 was a 10/18/12. The admission of the months of	e divided among 4 RNs. The impleted assessments which it; she entered them into the im out and placed them in re was no formal process to be printed assessments were in 1/16/13 at 6:30 PM, Nurse in the assessment but had it indicated that MDS ed between 4 nurses, and wally printed the MDSs and harts. Quarterly MDS dated in a signature to indicate who cursing sections of the MDS, were (RN) signature verifying ion. In 1/16/13 at 5:30 PM, it indicated that she is divided among 4 RNs. The impleted assessments which in the interest in the	F.	278	care plan team. They will that the minimum data so been correctly coded, the data set has been signed registered nurse/Director in the appropriate section the accuracy of the portion assessment they complete the care area assessment will also be audited. The team meeting is reviewed with the physician. The Administrator and/or of Nursing will bring any dispractice of the completed care audits to the quarter assurance meeting.	et has e minimum by the of Nursing s verifying n of the ed. The (when applica care plan weekly the Director eficient weekly	able)

OLITICIT	O OK WEDIONINE &	MILDIOAID OLITAIOLO				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345525	B. WING		01	/16/2013
	ROWDER OR SUPPLIER DENS OF TAYLOR GLEN	RET COM	s	TREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LANE CONCORD, NC 28027		• "
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 278	The CAAS (Care Are form dated 10/25/12 had no signature and (registered nurse) fo no signature and dat the care plan decisio On 1/16/13 at 9:10 A interviewed. She wa	a Assessments) summary was reviewed. The form I date from the RN r CAA process and there was e of the person completing n. M, Nurse #1 was s aware that nobody had AS and the care planning	F 27	78		
	12/19/12. The admis (MDS) assessment varieference date of 12. The CAAS summary reviewed. The form from the RN (registe and there was no sign	admitted to the facility on esion Minimum Data Set was completed with the //26/12. form dated 12/26/12 was had no signature and date red nurse) for CAA process mature and date of the ne care plan decision.				
F 279 SS=B	been signing the CA decision but it will ge 483.20(d), 483.20(k) COMPREHENSIVE A facility must use the to develop, review a comprehensive plan The facility must develop the	as aware that nobody had AS and the care planning of fixed. (1) DEVELOP CARE PLANS he results of the assessment and revise the resident's	F 2'	79 F279 When the deficient processident (3, 4, 8 and 9) plans were reviewed, and signed by the region nurse certifying the acoof the care plan.), the care corrected stered	1/17/

CENTER	STON WILDICANL &	VILDIOAID SERVICES		<u>i</u>		7	1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		345525	B. WING			01/16/2013	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LANE				
THE GAR	DENS OF TAYLOR GLEN	RET COM		С	ONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT: (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE
F 279	medical, nursing, and needs that are identif assessment. The care plan must d to be furnished to atta highest practicable pl psychosocial well-bei §483.25; and any ser be required under §4 due to the resident's	bles to meet a resident's i mental and psychosocial ied in the comprehensive escribe the services that are ain or maintain the resident's nysical, mental, and	F	279	The care plans for residents in that were scheduled for the p beginning October 1,2012 thr January 16, 2013, were revie by the careplan team (nursin dining services, social services activities, therapy and admin for signing and certifying the accuracy of the care plans the completed. No other residen care plans were found to be a deficient practice.	period rough wed g, s, distration)	
	by: Based on record rev facility failed to devel plan for 3 (Residents sampled residents. The resident #9 was at 10/2/12. On 10/3/12 at the resident had a unitary she was started on at the care plan reveal interventions specific the plan interview of the care UTI. 2 a. Resident #4 was	The findings include: Idmitted to the facility on a urine specimen indicated inary tract infection (UTI) and intibiotic therapy. Ided no problem of UTI and no Into UTI. In 1/16/13 at 6:30 PM, Nurse In plan should have included Is admitted to the facility on			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 Nursir and Administrator. This was with each registered nurse assigned the responsibility fo the care plan. The following items were addressed in this review. • The procedure for ho process the care plan. • Importance of completion dates as assigned. • Updating of the care To include that the responsibility for the care.	ng done r w to is. e- d plan	
	10/18/12 with multipl	e diagnoses including urinary ssion Minimum Data Set					

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1) MULTIPLE CONSTRUCTION BUILDING			SURVEY PLETED
		345525	B. WIN				11/16/2013
THE GARI	OVIDER OR SUPPLIER DENS OF TAYLOR GLEN SUMMARY ST		ID	37	EET ADDRESS, CITY, STATE, ZIP CODE 700 TAYLOR GLEN LANE ONCORD, NC 28027 PROVIDER'S PLAN OF CORRE	ection	(X5)
(X4) ID PREFIX TAG	Continued From page (MDS) assessment of Resident #4's cognitive had an indwelling cate There was no care pleare/treatment for the catheter. On 1/16/13 at 9:10 A interviewed. She againdwelling catheter silplanned but it was not 2 b. Resident #4 was 10/18/12 with multiple contracture. The adar (MDS) assessment of Resident #4's cognitive had limitation in ranguand lower extremities.	y MUST BE PRECEDED BY FULL. SCIDENTIFYING INFORMATION) a 5 ated 10/25/12 indicated that we status was intact and she heter. sident #4 was reviewed. an to address the a use of the indwelling M, Nurse #1 was reed that the use of the hould have been care of. admitted to the facility on the diagnoses including mission Minimum Data Set lated 10/25/12 indicated that we status was intact and she the of motion on both upper states. sident #4 was reviewed. lan to address the contracture on both lower	PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOROSS-REFERENCED TO THE APPEDEFICIENCY) 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. Ar alert from the 24 hour report is sent via the electronic health record to the care plan team. All members of the caplan team, as well as, administrator and phy have instant notification of a change in resident condition. The Direct	ould BE PROPRIATE I- Ir Ir Ir Ir Ir Ir Ir Ir Ir	COMPLETION DATE
	should have been ac 2 c. Resident #4 was	reed that the contracture Idressed in the care plan. s admitted to the facility on	ALANA		of Nursing will follow to be sure that the ca plan has been change	re	
	10/18/12 with multipl retention. The admis	e diagnoses including urinary ssion Minimum Data Set					

~=!(!	C T CT TO TOTALE OF	MEDIO/ ND OFFICEO	*			2.110 111	5. 0000 000
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345525	B. WIN	G		01/1	6/2013
	ROVIDER OR SUPPLIER DENS OF TAYLOR GLEN	RET COM		3	EET ADDRESS, CITY, STATE, ZIP CODE 700 TAYLOR GLEN LANE ONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TO BE	(X5) COMPLETION DATE
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.		F	The care plan team meets The care plan team consist Director of Nursing, Director of Director of Dining Service Administrator. During the an audit will be complete care plan team. They will that the care plan has been and has been signed by th nurse/Director of Nursing completed the care plan. plan team meeting is revi with the physician.		of the //s or of Activities, and meeting, by the erify updated registered who he care	
	12/19/12 with multiple Depression and Anxie assessment dated 12 Resident #3's cognit she was receiving psy (Zoloft, Elavil and Rer	ety. The admission MDS /26/12 indicated that ive status was intact and /chotropic medications meron).			The Administrator and/or the of Nursing will bring the result deficient practice to the quart quality assurance meeting.	s of any	47/15
F 280 SS=B	plan to address the us medications. On 1/16/13 at 9:10 All interviewed. She agre psychotropic medicati addressed in the care 483.20(d)(3), 483.10(eed that the use of the ions should have been plan.	F	280	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.	d	
	The resident has the	right, unless adjudged		l			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345525	B. WIN	G		01/16/	2013
	ROVIDER OR SUPPLIER DENS OF TAYLOR GLEN	RET COM		37	EET ADDRESS, CITY, STATE, ZIP CODE 700 TAYLOR GLEN LANE ONCORD, NC 28027		
(X4) ID PRÉFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 280	participate in plannin changes in care and A comprehensive car within 7 days after the comprehensive asses interdisciplinary team physician, a register for the resident, and disciplines as determand, to the extent prathe resident, the resident legal representative;	wise found to be the laws of the State, to g care and treatment or treatment. re plan must be developed	IL.	The care plans for resident that were scheduled for the beginning October 1,2012 January 16, 2013, were responded by the careplan team (nurse for the procedurate signing by the register nurse for the care plan the completed was conducted the Interim Director of N		period rough wed g, s, istration) No to be	1/17/1
	by: Based on record revinterview, the facility the care plans after ulcers for 2 (Resider residents with pressinclude: 1. Resident #8 was a 11/22/12. Cumulative generalized muscle and osteomalacia. Review of the care puthat Resident #8 was a 11/22/14.	T is not met as evidenced view, observation and staff failed to review and revise residents developed pressure at #4 and #8) of 2 sampled ure ulcers. The findings admitted to the facility on e diagnoses included weakness, pernicious anemia olan dated 12/6/12 revealed is at risk for pressure ulcers ty, muscle weakness and			with each registered nurse assigned the responsibility for the care plan. The following items were addressed in this review. • The procedure for he process the care pla • Importance of compation dates as assigned. • Updating of the care include that the registing signature indicates the accuracy of the information has been verified.	ow to ns. ole- ed e plan to istered nurse that the	

PRINTED: 01/29/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		ILTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	CORRECTION	IDENTIFICATION NUMBER:	A, BUIL	DING			
		345525	B. WIN	G		01/16/	2013
	ROVIDER OR SUPPLIER]	.		TADDRESS, CITY, STATE, ZIP CODE TAYLOR GLEN LANE		
THE GAR	DENS OF TAYLOR GLEN	I RET COM		CON	CORD, NC 28027		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X5) COMPLETION DATE
	REGULATORY OR Continued From pag pain. Review of pressure of 12/28/12, Resident # ulcer on her buttocks. The care plan was not pressure ulcers. During an interview of Nurse #1 stated that updated by the nurse Resident #8's care pupdated when the probserved. 2. Resident #4 was an 10/18/12 with multiperetention. The admit (MDS) assessment Resident #4's cognithad no pressure ulcertealed that Resident #4's cognithad no pressure ulcertealed with Duodein 12/18/12, Resident pressure ulcertealed with Duodein 12/30/12. On 1/9/1	e 8 Ilcer records revealed that on 8 had a stage 2 pressure 5 and a stage 1 on her elbow. Ot revised to reflect actual 2 on 1/16/13 at 11:11 AM, 2 care plans should be 2 swhen changes occur, and 3 should have been 3 ressure ulcers were first 3 admitted to the facility on 3 le diagnoses including urinary 3 sion Minimum Data Set 3 dated 10/25/12 indicated that 3 tive status was intact and she 3 er. 3		280		t's te alth sci- ced ort as An our e cord am. care as, ohysician, ation of at condition. rsing will e that the changed. weekly. s of the or of Activities,	1-23
	a stage II pressure treatment ordered f	ulcer to the left buttock. The for the left buttock pressure Duoderm and to be changed			Administrator. During that an audit will be completed care plan team. They will to	t meeting, by the	·

Event ID: VHCM11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	TIPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
AND PLAN UF	CONTECTION	,5200	A. BUILE		-	
		345525	B. WING			3/2013
	OVIDER OR SUPPLIER DENS OF TAYLOR GLEN	RET COM	- Lance	STREET ADDRESS, CITY, STATE, ZIP 3700 TAYLOR GLEN LANE CONCORD, NC 28027	CODE	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE. CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X 5) COMPLETION DATE
F 280	pressure ulcer was n	M, Resident #4 was nent for the left buttock ot due to be changed. The ulcer was covered with	F2	the care plan has b has been signed by nurse/Director of N completed the care plan team meeting weekly with the ph	the registered lursing who e plan. The care is reviewed	:
	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		-	The Administrator a of Nursing will bring any deficient practi quality assurance m	g the results of ice to the quarterly	2/7/13 continue
F 334 SS=B	IMMUNIZATIONS The facility must deventhat ensure that (i) Before offering the each resident, or the representative receivenefits and potential immunization; (ii) Each resident is immunization Octobe annually, unless the contraindicated or the immunized during the contraindicated or the immunized during the contraindicated or the immunized during the contraindicated or the immunization; and (iv) The resident's indocumentation that following: (A) That the reside representative was	za AND PNEUMOCOCCAL relop policies and procedures e influenza immunization, e resident's legal ves education regarding the al side effects of the offered an influenza er 1 through March 31 immunization is medically ne resident has already been nis time period;	F	F334 (flu vaccine When the deficient passed discovered, all recharts were reviewe letter is being sent to resident and responsiparty. The letter will the latest informatic current calendar year the Centers for Disease regarding the flu vacconsent form will also with the letter for the and the responsible party to review and sign.	practice esident d. A o each sible I include on for the er from ese Control ccine. A so be included e resident party	1/18/13

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.

PRINTED: 01/29/2013 FORM APPROVED OMB NO. 0938-0391

OLIVILIY	O FOR MEDIOANE G	MEDIO/ND OE/WIOLO					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL			(X3) DATE SURVEY COMPLETED	
		345525	B. WIN	G		01/16	3/2013
	ROVIDER OR SUPPLIER DENS OF TAYLOR GLEN	I RET COM		37	EET ADDRESS, CITY, STATE, ZIP CODE 700 TAYLOR GLEN LANE ONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 334	influenza immunization contraindications or recontraindications or recontraindications or recontraindications or recontraindications or recontraindication, each relegal representative resident is of immunization; (ii) Each resident is of immunization, unless medically contraindical ready been immunication, unless medically contraindical ready been immunication; and (iv) The resident or the representative has the immunization; and (iv) The resident's medicumentation that in following: (A) That the resident representative was pure the benefits and pote pneumococcal immunication or recontraindication or recontraindication or recontraindication or recontraindication in the finimunization, unless that the resident recontraindication in the finimunization, unless that the resident recontraindication, unless that the resident recontraindication or recontraindication, unless that the resident recontraindication or recontraindication, unless that the resident recontraindication or recontraindication, unless that the resident recontraindication, unless that the resident recontraindication or recontraindication, unless that the resident recontraindication or recontraindication, unless that the resident recontraindication or recontraindication or recontraindication, unless that the resident recontraindication or recontraindication	t either received the on or did not receive the on due to medical efusal. elop policies and procedures pneumococcal esident, or the resident's eccives education regarding ntial side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; are resident's legal e opportunity to refuse edical record includes edicated, at a minimum, the at or resident's legal rovided education regarding intial side effects of nization; and at either received the mization or did not receive munization due to medical efusal. based on an assessment memendation, a second nization may be given after 5 rest pneumococcal emedically contraindicated or sident's legal representative	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

Facility ID: 980257

CLIVICA	OT ON MEDICANE &	I				200 5 177 5	D) 5 V
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345525	B. WIN	IG		01/	16/2013
	ROVIDER OR SUPPLIER DENS OF TAYLOR GLEN	I RET COM		3	REET ADDRESS, CITY, STATE, ZIP CODE 700 TAYLOR GLEN LANE CONCORD, NC 28027		
					1		т
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
					who have not returned		
F 334	Continued From page	e 11	F	334	their consent form, the		
					Director of Social Services		
					will follow up with either		
					a telephone call, an email		
	TIL DECLUDENTING				or another letter. Nursing		
		is not met as evidenced			will document in the		
	by: Based on record revi	iew and staff interview, the			interdisciplinary note of		
		op policies and procedures			the electronic health		
		nfluenza and pneumococcal			record that the flu		
		o document education prior	ŀ		vaccine has been given.		
	to administering influe				The Administrator and/or		
	The findings included	l3) of 3 sampled residents.			-		
	The indinge medaca	•			the Director of Nursing		
	1. Upon request for it		ļ		will review this procedure		
	pneumococcal immur		1		and status twice a year		
		ty provided the following: (1) Control (CDC) " Vaccine	1		during the flu season of		
		nt" for the influenza vaccine			September through March		
		the CDC "Pneumococcal			at the scheduled quarterly of	luality	
		ine " information statement			assurance meeting.		
		undated "Annual Influenza			1	***	
	undated "Pneumoco	on Consent Form ", (4) an occal Polysaccaride Vaccine			F334 (pneumonia vaco	<u>cine)</u>	1-18-13
		ent Form " , and (5) an " a Vaccine Record " form			Miles the deficient practice		2-18-13
	dated 10/15/02.	(Vascino recora Torri			When the deficient practice		(Jetter)
					was discovered, all resident	-0"	(Perico)
	During an interview of	on 1/16/13 at 5:15 PM,			charts were reviewed. A let		
	Administrative Staff #	#1 stated that the facility did			is being sent to each residen	ι	
	not have formal polic	ies and procedures for occocal immunizations.			and responsible party. The		
	minuonza ana pheum	COCCAI BIBNIGHEARCHA.			letter will include the latest		
	2. Resident #7 was a	admitted to the facility on			information for the current		
	3/22/12.	-			calendar year from the Cent		
					of Disease Control regarding		
		led an "Annual Influenza			the pneumonia vaccine. A		
	vaccine Administration	on Consent Form " signed			consent form will also be inc	luded	

DEPARTM	IENT OF TIERETTY	LARDICAID CEDVICES					0. 0930-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING			COMPLET	
		245525	B. WIN	G		01/1	6/2013
		345525		0705	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PRO	OVIDER OR SUPPLIER				00 TAYLOR GLEN LANE		1
THE GARE	ENS OF TAYLOR GLE	N RET COM		Co	NCORD, NC 28027		
(X4) ID PREFIX TAG	ACA OLI OCCIOICI	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE OPRIATE	(X5) COMPLETION DATE
F 354	Continued From page 10/12/11 by the respondence influenza/Pneumon that she had the information opportunity to declinate administration. During an interview Administrative Stafnot require signed annually, nor proof 3. Resident #13 was 11/28/12. Record review review review Administrative Stafnot require review review review review Administration. Record review review review review Administration opportunity to declinate administration. During an interview Administrative Stafnot require signed annually, nor proof 483.30(e) POSTE INFORMATION			334 F 35	with the letter for the resider and responsible party to revise 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 place in the nursing policy manua. The Director of Social Servi 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 calendaryear from the Centers for Disease Control regarding the pneumonia vaccine. A form will also be included with the letter for the responsible party to review and sign. The interdisciplinary notes in the electronic hear record tracks what has be sent. The Director of Social Servi	ed I. ces e er ma- ar consent on-	1/18/13
	o Facility name.	ie. er and the actual hours worked			Services will run a weekly report to show which	,	

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
MND PLAN O	FCORRECTION	INCIDENT AND A STATE OF THE STA	A, BUIL		A. 1. 20 mg			
		345525	B. WIN	G		01/1	6/2013	
	ROVIDER OR SUPPLIER	N RET COM		37	EET ADDRESS, CITY, STATE, ZIP CODE 00 TAYLOR GLEN LANE ONCORD, NC 28027			
(X4) ID PREFIX TAG	# ## ### #############################	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	t t	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 356	by the following cate unlicensed nursing s resident care per shing a Registered nurse. A Registered nurse of the cate of the c	gories of licensed and staff directly responsible for lift: ses. lical nurses or licensed is defined under State law). aides. Set the nurse staffing data a daily basis at the beginning must be posted as follows: e format. in a daily accessible to	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 stainformation form was correct and relocated as requested. The RN Supervisor for each shift is responsible for comp the form and posting it on the bulletin board. This was communicated to the RN Supervisors by the Adminstrator	oleting he	1/15/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345525	B. WIN	3		01/1	6/2013
	ROVIDER OR SUPPLIER DENS OF TAYLOR GLEN	RET COM		37	EET ADDRESS, CITY, STATE, ZIP CODE 700 TAYLOR GLEN LANE ONCORD, NC 28027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE	
F 356			F	856	The form shows the date, resident census for the Medic certified beds, staffing for day and night shift (12 hour shifts), number of registered nurses, the number of license practical numbers and the number of certified nursing aides, the scheduled hours for each position and the action hours worked for each position hours worked for each position and the census for the certified bedsignated staff who post 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 Nursin will bring the audit results to the quarterly quality assurant meeting.	ed ual on. ude	2/7/13

PRINTED: 02/18/2013 FORM APPROVED OMB NO. 0938-0391

IDENTIFICATION NUMBER: 346525 A BULLDINS 01-MAIN SUILDING 1-MAIN SUILDING NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TAYLOR GLEN RET COM STREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LAWE CONCORD, NO. 28027 PROVIDERS FLAN OF CORRECTION (EACH DESIGNORY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 Exhiting Health Care section of the LSC and its referenced publications. This facility is Type II Profected 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.			(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
NAME OF PROVIDER OR SUPPLIER THE GARDENS OF TAYLOR GLEN RET COM CAN D	ND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	NG 01 - MAIN BUILDING .	COM CETES				
This Life Safety Code (LSC) survey was conducted as per Tipe Code of Federal Register at 42 CFR 483.70 (a) CFR#: 42 CFR 483.70 (a) NOTE: There were no Life Safety Code Deficiencies noted during the survey.			345525	B. WING _		02/13/2013				
PREFIX TAB REGULATIONY OR LSC IDENTIFYING INFORMATION REGULATIONY OR LSC IDENTIFYING INFORMATION PROPRIED IN TAB REGULATIONY OR LSC IDENTIFYING INFORMATION REGULATIONY OR LSC IDENTIFYING INFORMATION REGULATIONY OR LSC IDENTIFYING INFORMATION INFORM					STREET ADDRESS, CITY, STATE, ZIP CODE 3700 TAYLOR GLEN LANE					
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.	PREFIX	GEACH DESIGNANCY	Y MI IST BE PRECEDED BY FULL I	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ONTO BE COWNERTION				
THILE (X8) DATE	TAG	INITIAL COMMENTAL This Life Safety Conducted as per Tat 42 CFR 483.70() Health Care section publications. This from truction and is sprinkler system. CFR#: 42 CFR 48	ode (LSC) survey was The Code of Federal Register a); using the 2000 Existing n of the LSC and its referenced acility is Type II Protected s equipped with an automatic 3.70 (a)	K 000	DEFICIENCY)					
	,		DEDICUODI IER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE				

by deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 lys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

Event ID: VHCM21 Facility ID: 980257

If continuation sheet Page 1 of 1