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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49366 Based on observations and staff interviews, the facility failed to label and date leftover food items stored for use and failed to discard a dented can stored for use. These practices occurred in 1 of 1 walk-in cooler and 1 of 1 dry goods storage area and had the potential to affect food served to the residents who resided in the facility. The findings included: An initial tour of the kitchen occurred on 11/5/24 at 9:54 AM. The following concerns were identified: a. Items in the walk-in cooler that were labeled with a preparation date, but no use-by date included: -a resealable container of sliced red onion dated 11/1/24. -a resealable container of scallions dated 11/1/24. -a bag of shredded carrots, opened and resealed with plastic wrap dated 11/1/24. -a bag of cheddar cheese cubes, opened and resealed with plastic wrap dated 11/1/24. -a bag of shredded white cheddar cheese, opened and resealed with plastic wrap dated 11/1/24. b. An unopened bag of chopped cabbage dated 10/25/24 was observed in the walk-in cooler with a manufacturer's use-by date 10/29/24. c. A 6-pound, 12 ounce can of sweetened applesauce dented on the bottom seal was observed in the dry goods storage area ready for use. An interview with the Executive Chef on 11/5/24 at 11:39 AM was conducted. The Dietary Manager was out on vacation. He stated the facility used a three-day system for food storage. The Executive Chef indicated the date on the label was a preparation date and the staff needed to fill out the entire label, to include the use-by date on opened and prepared items. He stated cans with a dent on the edge or seal should not be used. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 11/6/24 at 3:50 PM revealed he expected staff to follow the policy and procedures for labeling food items and proper storage for canned goods. He added the Dietary Manager typically checked the dates for stored food and stated when she was not working, the staff needed to follow the policies and procedures.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40476 Based on observations, record reviews, and staff interviews, the facility failed to implement infection control policies and procedures when the Nurse did not don a gown to provide wound care for a resident on enhanced barrier precautions (EBP). In addition, Nurse #1 failed to follow the facility's policy and procedure for clean dressings which included changing gloves and performing hand hygiene after removing the old dressing. The deficient practice occurred for 1 of 3 staff observed for infection control practices. The findings included: Review of the facility's policy for Enhanced Barrier Precautions (EBP) dated 04/01/2024 revealed the EBP will be implemented for the prevention of transmission of multidrug-resistant organisms. EBP employs gown and glove use during high resident care activities such as: Dressing Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, changing briefs or assisting with toileting, Device Care or use: central line, urinary catheter, feeding tube and tracheostomy, Wound Care: any skin opening requiring a dressing. Review of the facility's policy and procedure on clean dressings last revised in March 2022 revealed the following procedure: - Use disposable cloth (paper towel is adequate) to establish a clean field on residents' overbed table. Place all items to be used during the procedure on the clean field. - Wash and dry your hands thoroughly. - Position resident. Place disposable cloth next to the resident (under the wound) to serve as a barrier to protect the bed linen. - Put on gloves. Loosen tape and remove dressing. - Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. - Put on new gloves. - Pour liquid solutions directly onto gauze sponges on their papers. - Wear gloves while holding gauze to catch irrigation solutions that are poured directly over the wound. - Apply treatments as indicated. - Dress wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Discard disposable items into the designated container. Discard all soiled laundry, linen, towels and washcloths into the soiled laundry container. Remove disposable gloves and discard them into designated containers. Wash and dry your hands thoroughly. Review of the facility's policy and procedure on handwashing last revised in August 2022 revealed the following procedure: - Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: - Before and after coming on duty. - Before and after direct contact with the residents - Before performing any non-surgical invasive procedures - Before handling clean or soiled dressing, gauze pads, etc. - After handling used dressing, contaminated equipment, etc. On 11/06/24 at 12:04 PM an observation was made of Nurse #1 entering Resident #3's room to provide wound care. Resident #3 was under EBP for a wound located on his left heel. The EBP signage located on Resident #3's door instructed staff to wear a gown and gloves during high contact resident care activities such as wound care for chronic wounds. Gowns were available directly outside of the resident's door in the hall in a three-compartment container. She was observed entering the resident's room, performing hand hygiene and applying gloves. Nurse #1 had Resident #3's wound care supplies in a container placed on the resident's bedside dresser. Resident #3 was observed sitting in a recliner chair and he placed the footrest up so his heels were in the air. Nurse #1 removed the old dressing and discarded the dressing in the trash can. The Nurse was observed using the same gloves to cleanse the wound with normal saline, paint the wound with betadine and apply calcium alginate (used in wound care to absorb drainage and promote wound healing). Nurse #1 was then observed wrapping Resident #3's heel with gauze. Nurse #1 then removed the gloves and discarded them into the trash can. She gathered the supplies and returned to the medication cart where she sanitized her hands. An interview on 11/06/24 at 12:15 PM with Nurse #1 revealed the facility did not have a wound nurse, it was up to the nurses working on the hall to complete and provide wound care. She stated she worked 4 days a week and every other weekend, so she changed Resident #3's dressing frequently. Nurse #1 was asked if Resident #3 was under any kind of precautions and replied yes, Enhanced Barrier Precautions which meant she needed to wear a gown and gloves before entering the resident's room. Nurse #1 stated she would typically wear a gown while providing wound care however it had just slipped her mind to put it on. She stated she would normally put on a gown while providing any wound care in the building. Nurse #1 stated she had also forgotten to wash her hands and change gloves in between removing the soiled dressing and applying new treatment to the wound and, after removing her gloves in the room. She stated she had just become nervous during the encounter and had forgotten. She stated she knew the policy and knew the process of wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 11/06/24 at 12:43 PM with the Director of Nursing (DON), who was also the Infection Preventionist (IP), revealed it was her expectation for the Nurse to follow infection control guidelines and wound care guidelines while providing wound care. She stated they were auditing staff to ensure they were following infection control guidelines and procedures and said she would be adding the Nurse and wound care to the auditing tool. She stated Nurse #1 should have worn a gown during the wound care for Resident #3. An interview on 11/06/24 at 12:50 PM with the Administrator revealed Nurse #1 should have followed the infection control policy and guidelines regarding wound care and Enhanced Barrier Precautions.