

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 12/30/2025
NAME OF PROVIDER OR SUPPLIER The Gardens of Taylor Glen Retirement Community		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation, staff interview, and record review, the facility failed to ensure resident privacy and confidentiality by allowing protected health information (PHI) to remain visible on an unattended medication cart computer screen for 1 of 1 medication cart observed for medication administration (The health care unit medication cart). The findings included: A continuous observation was conducted on 12/30/2025 from 8:28 AM until 9:04 AM. At 8:28 AM Nurse #1 walked away from a medication cart located on the health care unit. Although the cart was locked, the computer screen remained visible and displayed the electronic charting system. The screen visibly listed five resident's names and one resident's medication information, including insulin pen details. A group of residents were noted to be around the medication cart at the time of the observation. At 8:34 AM the computer screen saver came on, and the resident information was no longer on the screen. Nurse #1 returned to the medication cart and continued her medication pass. At 8:54 AM Nurse #1 walked away from the medication cart a second time while a residents' personal and medical information remained displayed on the screen. The observation ended at 9:04 AM when Nurse #1 returned to the medication cart. On 12/30/25 at 10:06 AM an interview was conducted with Nurse #1. During the interview she stated she would typically shut the entire computer down when she walked away but acknowledged on this occasion that she did not shut down the computer or use the walk away feature. She stated she was nervous because of the surveyor observing her medication pass and had just made a mistake. On 12/30/25 at 10:00 AM an interview was conducted with the Director of Nursing (DON). During the interview the DON was notified of the observations made by the surveyor and stated all nurses on the health care unit were supposed to use the walk away feature in the electronic charting system. She stated it was a button located at the top of the Medication Administration Record that would hide the screen if the nurses walked away from the medication cart. She stated at all times residents' privacy and personal information should be protected by using the walk away feature on the computer screens. On 12/30/25 at 11:54 AM an interview was conducted with the Administrator. During the interview he stated he would expect nursing staff to follow facility protocol and to keep all resident information confidential.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 345525
		If continuation sheet Page 1 of 1