

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	FEB 9 2012	(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure accuracy of the MDS (Minimum Data Set) assessment for 1 (Resident #168) of 3 sampled residents with pressure ulcers. The findings include:</p>	F 278	<p>A Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.</p> <p>F278</p> <ol style="list-style-type: none"> The MDS coordinator corrected Resident #168 assessment on 1-11-2012 to reflect accurate coding of pressure ulcers. The DON, ADON and MDS coordinators reviewed current residents with skin impairment to ensure accurate coding of pressure ulcers were noted. No further inaccuracies were found. The DON and ADON educated the wound nurse and MDS coordinators on the policy and procedure for completing resident assessments and coding of pressure ulcers. The Administrator/DON will conduct QI monitoring of resident assessments for accurate coding of pressure ulcers three times a week x 4 weeks, then twice a week x 4 weeks, then weekly x 4 weeks, and then monthly x 9 months. The Administrator/DON will report results of QI monitoring to the Risk Management/Quality Monitoring Committee monthly x 12 months for continued compliance and/or revision. 	2-9-12	

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

Amr. Roquemore RN NHA Administrator TITLE: Administrator DATE: 1-29-12

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.

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 278	Continued From page 1 Resident #168 was admitted to the facility on 08/15/11. Cumulative diagnoses included status post hip fracture and hip surgery, difficulty swallowing and stage 4 renal disease. The " Admission Skin Sweep " form dated 08/15/11 revealed that Resident #168 had an open area to the sacrum and bilateral blood blisters on his heels. Admission nurse's notes dated 08/15/11 at 4 PM included " open area to coccyx ". There was no documentation of the size or condition of the open area, nor was there any further documentation about the blood blisters on the heels. The admission Minimum Data Set (MDS) dated 08/22/11 indicated that Resident #168 had three (3) stage 4 pressure ulcers, the tissue type for the most advanced stage ulcer was necrotic and no stage 4 pressure ulcer was present at admission. The August 2011 Treatment Record (TR) indicated that as of 08/22/11 Resident #168 received daily treatments for blood blisters to both heels and a blood blister on the left 5th toe. The treatment to the coccyx was discontinued on 08/22/11. There were no other pressure related treatments. During an interview on 01/11/12 at 3:37 PM, the Wound Nurse (WN) indicated that she had mistakenly coded the MDS for stage 4 pressure ulcers and necrotic tissue. The WN indicated that the resident had no stage 4 pressure ulcers or areas of necroses at the time of the assessment.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279			

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 279	Continued From page 2 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan for 1 (Resident #168) of 3 sampled residents with pressure ulcers. The findings include: Resident #168 was admitted to the facility on 08/15/11. Cumulative diagnoses included status post hip fracture and hip surgery, difficulty swallowing and stage 4 renal disease. The " Admission Skin Sweep " form dated 08/15/11 revealed that Resident #168 had an open area to the sacrum and bilateral blood	F 279	F279 1. Resident #168 no longer resides in facility. 2. The DON and ADON reviewed the charts of current residents to ensure those with impaired skin integrity comprehensive care plans addressed specific area with appropriate goals and interventions in place. The DON and ADON educated current licensed nurses were on the policy and procedure for developing comprehensive care plans. 3. The Administrator/DON will conduct QI monitoring of comprehensive care plans for residents with pressure ulcers indicating specific areas and interventions three times a week x 4 weeks, then twice a week x 4 weeks, then weekly x 4 weeks, and then monthly x 9 months. 4. The Administrator/DON will report results of QI monitoring to the Risk Management/Quality Monitoring Committee monthly x 12 months for continued compliance and/or revision.	2-9-12	

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 279	<p>Continued From page 3</p> <p>blisters on his heels. Admission nurse's notes dated 08/15/11 at 4 PM included " open area to coccyx ". There was no documentation of the size or condition of the open area, nor was there any further documentation about the blood blisters on the heels.</p> <p>Weekly " Care Management Summary Notes " revealed the following: 08/16/11: " treatment to coccyx "; 08/23/11: " hydrogel dressing to coccyx, skin prep to heels twice a day, float heels"; 08/30/11: " skin checks daily " .</p> <p>The admission Minimum Data Set (MDS) dated 08/22/11 indicated that Resident #168 had memory problems, was severely impaired in daily decision making; required extensive assistance with bed mobility and transfers; had three (3) stage 4 pressure ulcers, the longest length being 5.0 cm (centimeters), the widest width being 5.1 cm, no depth; and the tissue type for the most advanced stage ulcer was necrotic. The Care Area Assessment (CAA) for pressure ulcers was triggered but was not developed.</p> <p>An additional form with a hand-written title " Initial Care Plan " , dated 08/23/11, included a problem of risk for skin breakdown. The goal was for Resident #168 to remain free of new skin breakdown. Approaches included encourage/assist resident to change position frequently, report new/suspicious areas to wound nurse/doctor. The care plan did not specify the areas of actual breakdown, or any specific interventions for the areas of breakdown.</p> <p>During an interview on 01/11/12 at 3:37 PM, the Wound Nurse (WN) indicated it was her</p>	F 279			

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 346258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 279	Continued From page 4 responsibility to write the care plans related to pressure ulcers. The WN acknowledged that she had not developed an individualized care plan for Resident #168's pressure ulcers.	F 279	F280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to revise the care plan for 2 (Residents # 15 & # 121) of 3 sampled residents with pressure ulcers. The findings include: 1. Resident #15 was admitted to the facility on	F 280	1. The wound nurse revised Resident #15 and #121 Comprehensive Care Plans on 1-12-2012 to ensure current problems, goals and approaches addressed the affected area. 2. The DON, ADON and MDS coordinators reviewed the Comprehensive Care Plans for current residents with skin impairment to ensure problems, goals and approaches addressed the affected area and depicted current status. Inaccurate and incomplete information was updated by the DON, ADON, and MDS coordinators. The DON and ADON educated current licensed nurses on the policy and procedure for developing a plan of care to ensure current problems, goals and approaches addressed the affected skin impairment and revised as indicated. 3. The Administrator/DON will conduct QI monitoring of Comprehensive Care Plans to ensure current problems, goals and approaches address the skin impairment three times a week x 4 weeks, then twice a week x 4 weeks, then weekly x 4 weeks, and then monthly x 9 months 4. The Administrator/DON will report results of QI monitoring to the Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	2-9-12	

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 346258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 280	<p>Continued From page 5</p> <p>12/12/11 with multiple diagnoses including Fracture of the Femur. The admission MDS (Minimum Data Set) assessment dated 12/20/11 indicated that Resident #15 had moderate cognitive impairment and had a stage 1 pressure ulcer.</p> <p>The admission nurse's notes dated 12/12/11 at 3:00 PM indicated " redness noted to sacral area and bilateral heels " .</p> <p>The physician's order dated 12/12/11 was " periguard to sacrum/buttock every shift and as needed, skin prep to bilateral heels twice a day and float heels at all times " .</p> <p>The nurse's notes dated 12/21/11 revealed that the resident was seen by the wound care specialist and the coccyx wound was unstageable with 100 % necrotic tissue measuring 6 x 13 cm (centimeter). On 12/28/11, the treatment to the coccyx pressure ulcer was changed to Santyl ointment.</p> <p>The care plan was reviewed. One of the care plan problem dated 01/01/12 was " has actual skin breakdown. At risk for further skin breakdown/infection secondary to impaired mobility, incontinence of bowel and Foley catheter placement " . The goal was " resident will have no further skin breakdown greater than stage 1 per weekly skin checks x 90 days " . The care plan problem and goal did not address the actual unstageable pressure ulcer on the coccyx.</p> <p>On 01/11/12 at 4:45 PM, the wound nurse was interviewed. She stated that she was responsible in developing and revising the care plan for</p>	F 280			

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 280	<p>Continued From page 6</p> <p>wounds/pressure ulcers. She acknowledged that the pressure ulcer on the coccyx for Resident #15 had declined from a stage 1 to a stage IV and that she had failed to revise the care plan to reflect the current problem, goal and approaches of the pressure ulcer.</p> <p>On 01/12/12 at 10:35 AM, Resident #15 was observed during the dressing change. The pressure ulcer on the coccyx was deep, large and with necrosis.</p> <p>2. Resident #121 was admitted to the facility on 07/17/2011 and readmitted on 08/22/2011 and 12/07/2011. Resident #121's accumulative diagnoses included Pneumonia, Diabetes Mellitus II, Hypertension, Acute kidney failure, Dysphasia, Difficulty in Walking, and Post Operative Fracture to Neck of the Femur.</p> <p>The Significant Change MDS (minimum data set) assessment dated 12/13/2011 indicated that Resident #121 had long term and short term memory problems and her cognitive skills for daily decision making was severely impaired. The MDS assessment indicated that Resident #121 was at risk of developing pressure ulcers and that the resident had a Stage I and a Stage II pressure ulcer.</p> <p>Review of the Skin Grid-Pressure form dated 12/07/2011 indicated that Resident #121 had a pressure ulcer to the coccyx present on admission. The documentation indicated that the wound was Stage II measuring 1cm x 1.5cm x 0.0cm.</p> <p>Review of a Wound Care Specialist Evaluation</p>	F 280			

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 280	<p>Continued From page 7</p> <p>dated 12/21/2011 also indicated that the pressure ulcer to the coccyx was resolved.</p> <p>Review of the CAA (care area assessment) dated 12/26/2011 revealed in the pressure ulcer area a note that read in part, " resident with a history of healed pressure ulcers. Resident with no skin issues noted at this time. "</p> <p>The care plan dated 12/26/11 was reviewed. One of the care plan goals was that the area to the coccyx would decrease in size by 0.5cm. The wound bed would be beefy red without purulent drainage by the next review. The approaches included the staff would provide treatment to the coccyx as ordered.</p> <p>An interview was conducted with Nurse #1 on 1/10/2012 at 9:15 AM. Nurse #1 stated that the Treatment Nurse was responsible for pressure ulcer or wound assessments and care plan updates.</p> <p>On 01/10/2012 at 11 AM, the care plan was reviewed with the Wound Nurse. The Wound Nurse said it is her responsibility to enter the pressure ulcer assessments into the MDS and to update the care plans for pressure ulcers or wounds. The Wound Nurse said that the pressure ulcer on the resident's coccyx had healed and that she had failed to revise the care plan to reflect the current problem(s).</p> <p>An observation of Resident's #121 during incontinent care was conducted on 01/12/2012 at 2 PM. The coccyx area was observed to be healed with pink scarring noted. The skin at the coccyx area was intact.</p>	F 280			

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain a physician order prior to continuing antibiotic therapy for 1 (Resident #167) of 8 sampled residents. The findings included:</p> <p>Resident # 167 was readmitted to the facility on 09/21/11. Cumulative diagnoses included clostridium difficile (c. diff), an intestinal infection.</p> <p>Review of physician orders dated 11/10/11 revealed an order for Vancomycin (an antibiotic) taper with the final step being 250 milligrams (mg) every third day for 14 days. The physician orders for January 2012 included, " Vanco (Vancomycin) oral solution 250 mg/5 ml (milliliter) po (by mouth) Q (every) 3 days X (times) 14 days. 14th day is 1/5/12 " .</p> <p>The Medication Administration Record (MAR) for January 2012 included, " Vanco (Vancomycin) oral solution 250 mg/5 ml (milliliter) po (by mouth) Q (every) 3 days X (times) 14 days. 14th day is 01/05/12 " . Date boxes for 1/3, 1/6, 1/9, 1/12, 1/15, 1/18, 1/21 and 1/24 were heavily outlined and the boxes for the intervening days were crossed through. The MAR indicated that the Vancomycin was given on 1/3/12, 1/6/12 and 1/9/12.</p> <p>During an interview on 01/12/12 at 11:50 AM,</p>	F 281	<p>F281</p> <ol style="list-style-type: none"> The ADON obtained clarification orders on 1-12-2012 for Resident #167 to continue antibiotic therapy for an additional week. The DON and ADON reviewed MARs for current residents on antibiotic therapy to ensure antibiotics are administered per physician's orders and include a stop date. The DON and ADON educated current licensed nurses on obtaining, writing and transcribing physician orders to the MAR with a designated stop date. The DON/ADON will conduct QI monitoring of obtaining, writing and transcribing physician orders for antibiotic therapy to the MAR with a designated stop date three times a week x 4 weeks, then twice a week x 4 weeks, then weekly x 4 weeks, then monthly x 9 months. The DON/ADON will report results of QI monitoring to the Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision. 	2-9-12	

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083	
(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 281	Continued From page 9 Nurse #1 acknowledged that she had administered the Vancomycin on 01/6/12. Nurse #1 indicated that she should have gotten a clarification order from the physician prior to giving it, since the MAR indicated that the drug should be stopped on 01/5/12 but the outlined date boxes continued past 1/5/12. During an interview on 01/12/12 at 11:55 AM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON acknowledged that there was no physician order to administer the Vancomycin after 1/5/12. The ADON said that she had spoken with the physician on 01/4/12 and the physician told her at that time that he wanted the resident to continue the Vancomycin until seen by the infectious disease physician, but she did not write that as an order. Neither the DON nor the ADON had an explanation for the outlined dates on the MAR extending past 01/5/12 and up to 01/24/12. In a follow-up interview, the DON indicated that the resident had an appointment with the infectious disease physician on 01/30/12.	F 281		
F 286 SS=B	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure 15 months of MDS assessments were easily accessible for 4 (Residents 15, # 131, # 27 & # 114) of 11	F 286	F286 1. The MDS coordinators printed Resident #15 MDS on 1-9-2012, obtained signatures and filed on the chart. Resident #27 MDS was printed, signed and filed on the chart on 1-10-2012. Resident #131 MDS was printed, signed and filed on the chart on 1-11-2012. Resident #114 MDS was printed, signed and filed on the chart on 1-12-2012.	

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 286	<p>Continued From page 10 sampled residents. The findings include:</p> <p>1. Resident #15 was admitted to the facility on 12/12/11. The admission MDS (Minimum Data Set) assessment was completed on 12/20/11. This assessment was not found on the active records.</p> <p>On 01/09/11 at 3:27 PM, MDS Nurse #1 was interviewed. She stated that 15 months of MDS assessments should be kept on the active chart. She further stated that she didn't know why the admission MDS assessment for Resident #15 was not on the chart. At 4:05 PM, she provided a copy of the MDS assessment dated 12/20/11 with no signatures. She stated that she printed it from the computer because she could not find the one with signatures.</p> <p>2. Resident #27 was admitted to the facility on 12/20/10. Record review revealed no annual Minimum Data Set (MDS) or Care Area Assessment (CAA) in the resident's chart.</p> <p>During an interview on 01/10/12 at 3:35 PM, MDS Nurse #2 said that an annual assessment was done on 12/03/11, was signed off and must have gone to medical records to be filed on the chart. MDS Nurse #1 then printed the resident's annual MDS dated 12/03/11.</p> <p>On 01/12/12 at 10:50 AM, MDS Nurse #2 stated fifteen months of Minimum Data Sets should be on the chart. The CAA's were so thick, they were kept in the MDS office in the file cabinet. After the MDS and CAA's were signed, they were sent to medical records to be filed. She stated they knew they were having some problems of getting them on the charts and thought it had been</p>	F 286	<p>Continued from page 10</p> <p>2. The MDS coordinators reviewed current residents medical records to ensure 15 months of resident assessments were signed and on the chart. The MDS coordinators will print, obtain signatures and file each resident's assessment on the medical record daily. The DON educated the MDS coordinators and Medical Records clerk on the policy and procedure for maintaining 15 months of resident assessments in the medical record.</p> <p>3. The Administrator/DON will conduct QI monitoring to ensure 15 months of resident assessments are signed and on the medical record three times a week x 4 weeks, then twice a week x 4 weeks, then weekly x 4 weeks, and then monthly times 9 months.</p> <p>4. The Administrator/DON will report results of QI monitoring to the Risk Management/Quality Improvement Committee for continued compliance and/or revision.</p>	2-9-12	

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 286	<p>Continued From page 11</p> <p>resolved. The MDS personnel and another part time person came in on first shift in October and performed a complete audit of the building. She said all MDS's should have been on the chart.</p> <p>3. Resident #131 was admitted to the facility on 12/09/11. Record review revealed no admission Minimum Data Set (MDS) or Care Area Assessment (CAA) in the resident's chart.</p> <p>On 01/11/12 at 8:30 AM, MDS Nurse #1 printed the admission MDS dated 12/16/11 upon request.</p> <p>On 01/12/12 at 10:50 AM., MDS Nurse #2 stated fifteen months of Minimum Data Sets should be on the chart. The CAA's were so thick, they were kept in the MDS office in the file cabinet. After the MDS and CAA's were signed, they were sent to medical records to be filed. She stated they knew they were having some problems of getting them on the charts and thought it had been resolved. The MDS personnel and another part time person came in on first shift in October and performed a complete audit of the building. She said all MDS's should have been on the chart.</p> <p>4. Resident #114 was admitted to the facility 12/05/2011. A review of the chart revealed that the admission minimum data set (MDS) dated 12/12/2011 and Care Area Assessments (CAA's) were not on the resident's chart.</p> <p>On 01/12/12 at 10:50 AM., MDS Nurse #2 stated fifteen months of Minimum Data Sets should be on the chart. The CAA's were so thick, they were kept in the MDS office in the file cabinet. After the MDS and CAA's were signed, they were sent</p>	F 286			

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 286	Continued From page 12	F 286			
F 314 SS=D	<p>to medical records to be filed. She stated they knew they were having some problems of getting them on the charts and thought it had been resolved. The MDS personnel and another part time person came in on first shift in October and performed a complete audit of the building. She said all MDS's should have been on the chart.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assess pressure ulcers and notify the physician of the development of a new pressure ulcer for 1 (Resident #168) of 3 sampled residents. The findings include:</p> <p>Resident #168 was admitted to the facility on 08/15/11. Cumulative diagnoses included status post hip fracture and hip surgery, difficulty swallowing and stage 4 renal disease.</p> <p>The " Admission Skin Sweep " form dated 08/15/11 revealed that Resident #168 had an open area to the sacrum and bilateral blood blisters on his heels. Admission nurse's notes</p>	F 314	<p>F314</p> <ol style="list-style-type: none"> 1. Resident # 168 no longer resides in the facility. 2. The DON, ADON, Unit Manager and Nurse Supervisors completed skin sweeps on all active residents to identify areas of impaired skin integrity. The DON and ADON updated braden scales to identify risk factors and completed skin grids documenting current measurements. Physician orders were obtained for interventions as indicated. The DON along with American Medical Technology educated current licensed nurses on conducting full body assessments and completing skin sweeps. Skin grids will be completed after skins impairments have been identified using the wound protocol, stage I- skin prep and barrier creams, stage II- hydrogel and hydrocolloids, stage III and IV hydrogel, hydrocolloids, santyl and alginates as indicated. Every 7 days the skin impaired area will be assessed and measured. The care plan will be updated and skin sweeps completed weekly thereafter. 3. The DON/ADON will conduct QI monitoring of to ensure residents with impaired skin integrity have completed skin sweeps, braden scales, skin grids and physician orders for interventions are completed three times a week x 4 weeks, then twice a week x 4 weeks, then weekly x 4 weeks, and then monthly x 9 months. 4. The DON/ADON will report results of QI monitoring to Risk Management/Quality Improvement Committee monthly for continued compliance and/or revision. 	2-9-12	

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 314	<p>Continued From page 13</p> <p>dated 08/15/11 at 4 PM included " open area to coccyx ". There was no documentation of the size or condition of the open area, nor was there any further documentation about the blood blisters on the heels.</p> <p>A form entitled " Admission/Readmission Data Collection & Initial Plan of Care " included under Interventions, " Change dressings to coccyx and hip daily. Keep sites clean and dry. Initiated 08/15/11. "</p> <p>Physician Orders dated 08/15/11 included " hydrogel dressing to coccyx. Change daily. Cleanse with NS (normal saline). "</p> <p>The " Skin Sweep " form dated 08/16/11 - 08/31/11: no concerns were indicated about the coccyx. The body diagrams on the form were marked with circles on 08/16/11-08/18/11. No further indication of concerns with Resident #168's heels was documented on this form.</p> <p>Weekly " Care Management Summary Notes " revealed the following: 08/16/11: " treatment to coccyx "; 08/23/11: " hydrogel dressing to coccyx, skin prep to heels twice a day, float heels"; 08/30/11: " skin checks daily " .</p> <p>Physician Orders dated 08/18/11 included Skin Prep twice a day to bilateral heel blood blisters, and float heels to off load pressure.</p> <p>Nurse's notes dated 08/18/11, written by the wound care nurse, included " Large blood blisters to left lateral heel and right medial heel. Skin prep applied. Heel off loading on pillows. "</p>	F 314			

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 314	<p>Continued From page 14</p> <p>The admission Minimum Data Set (MDS) dated 08/22/11 indicated that Resident #168 had memory problems, was severely impaired in daily decision making; required extensive assistance with bed mobility and transfers; had three (3) stage 4 pressure ulcers, the longest length being 5.0 cm (centimeters), the widest width being 5.1 cm, no depth; and the tissue type for the most advanced stage ulcer was necrotic. The Care Area Assessment (CAA) for pressure ulcers was triggered but was not developed.</p> <p>An additional form with a hand-written title " Initial Care Plan " , dated 08/23/11, included a problem of risk for skin breakdown. The goal was for Resident #168 to remain free of new skin breakdown. Approaches included encourage/assist resident to change position frequently, report new/suspicious areas to wound nurse/doctor. The care plan did not specify the areas of actual breakdown, nor any specific interventions for the areas of breakdown documented on the admission assessment.</p> <p>The August 2011 Treatment Record (TR) revealed that on 08/22/11 the treatment to the coccyx was discontinued. No corresponding physician order was found on the record, or any documentation explaining why the treatment was stopped. The TR also revealed on 08/22/11 daily Skin Prep was initiated for a blood blister of the left 5th toe. No corresponding physician order was found on the record.</p> <p>During an interview on 01/11/12 at 3:37 PM, the Wound Nurse (WN) acknowledged that she could find no documentation to show that she had assessed the wounds on an ongoing basis or</p>	F 314			

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 314	Continued From page 15 performed wound measurements or staging. The WN indicated she had a notebook where she recorded measurements, and showed where the measurements were recorded in the notebook for the data on the admission MDS. The notebook had no other measurements for Resident #168 and did not specify the location of the wound that was measured. The WN said she did not recall looking at the coccyx wound, nor did she recall notifying the physician of the new blister on the resident's toe. After reviewing the TR, the WN stated that she had provided the treatments to the heels and toe on 08/26/11 and 08/29/11. The WN indicated she should have initiated a form on which to record weekly assessments. During an interview on 01/12/12 at 9:45 AM, the Director of Nursing (DON) indicated that the WN should have done a thorough wound assessment as soon as possible after admission and then continue with weekly assessments. The WN should have notified the physician when the resident developed a new wound.	F 314			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329	F329 1. The DON updated Resident #242 MARs on 1-11-2012 to allow for documentation of blood pressure and pulse prior to administering antihypertensive.		

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 329	<p>Continued From page 16</p> <p>who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor the pulse and the blood pressure for 1 (Resident # 242) of 8 sampled residents. The finding includes:</p> <p>Resident # 242 was admitted to the facility on 12/22/11 with multiple diagnoses including Hypertension.</p> <p>The admission MDS assessment dated 01/10/12 indicated that Resident #242 had no memory and decision making problems.</p> <p>Review of the January 2012 physician's orders revealed that Resident #242 had an order dated 12/22/11 for " Atenolol 50 mgs (milligram) 1 tablet by mouth twice a day - hold for HR (heart rate) less than 55 and SBP (systolic blood pressure) of less than 100 " .</p> <p>Review of the December, 2011 and January, 2012 MARs (Medication Administration Record)</p>	F 329	<p>Continued from page 16</p> <p>2. The DON, ADON and Unit Manager reviewed and updated MARs for current residents on antihypertensives with specified parameters to ensure documentation as per physician orders. The DON contacted the pharmacy to ensure MARs allocate space for documentation of parameters as indicated. The DON and ADON educated current licensed nurses documenting vital signs as indicated on the MAR and the policy and procedure for medication administration.</p> <p>3. The DON/ADON will conduct QI monitoring for antihypertensive medication administration to ensure blood pressure and pulse are checked and documented as indicated three x a week x 4 weeks, then twice a week x 4 weeks, then weekly x 4 weeks, then monthly x 9 months.</p> <p>4. The DON/ADON will report results of QI monitoring to the Risk Management/Quality Improvement Committee for continued compliance and/or revision.</p>	2-9-12	

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 329	Continued From page 17 revealed no HR and SBP recorded on the MAR. On 01/11/12 at 3:50 PM, Nurse #1 was interviewed. She stated that the HR and BP (blood pressure) were recorded on the care track notes by the nurses. She further stated that there was no exact time as to when the HR and the blood pressure were taken. Nurse #1 indicated that the HR and the BP should have been documented on the MAR and should have been checked prior to administering the medication. The care track notes for December, 2011 and January, 2012 were reviewed. The daily notes did not have HR and BP consistently recorded on a daily basis. On some days when HR and BP recorded, there were no exact times as to when they were taken. On 01/11/12 at 4:19 PM, the DON was interviewed. She stated that the HR and the BP should have been checked and documented on the MAR prior to administering the medication.	F 329			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that medication error rate was 5% or below by not following the doctor's orders and the manufacturer's specification. There were 3 errors	F 332	F332 1. Resident # 159, #71 and #100 were placed on acute monitoring for 72 hours to ensure no signs of discomfort were noted. The DON updated Resident #159 MARs to include "do not crush" for the ferrous sulfate on 1-10-2012. Resident #159 did not experience GI discomfort as a result of ingesting crushed ferrous sulfate. Resident #71 did not experience GI discomfort as a result of ingesting senna S. Resident # 100 did not experience increased dryness as a result of administering one artificial tear. The DON completed medication error reports for resident #159, #71, and #100.		

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083	
(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 332	<p>Continued From page 18 (Resident #159, #71 & #100) of 51 opportunities resulting to a 5.88 % error rate. The findings include:</p> <p>1. Resident # 159 was admitted to the facility on 11/18/11 with multiple diagnoses including Anemia. On 11/18/11, the physician had ordered Ferrous Sulfate 325 mgs by mouth twice a day for Anemia.</p> <p>On 01/10/12 at 4:10 PM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare Resident #159's medications including Ferrous Sulfate film coated (f/c) 325 mgs tablet. She was observed to crush the medications and administered them with apple sauce.</p> <p>On 01/10/12 at 5:25 PM, Nurse #2 was interviewed. He acknowledged that he had crushed the Ferrous Sulfate tablet. He stated that he would check the list of medications not to be crushed and would get back with me. At 5:35 PM, Nurse #2 indicated that Ferrous Sulfate was one of those medications listed not to be crushed.</p> <p>2. Resident # 71 was admitted to the facility on 01/16/06 with multiple diagnoses including constipation. On 12/16/11, the physician had ordered Senna (a laxative) 2 tablets by mouth twice a day for constipation.</p> <p>On 01/10/12 at 4:33 PM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare and to administer Resident # 71's medications including Senna S (a stool softener and a laxative) 2 tablets.</p>	F 332	<p>Continued from page 18</p> <p>2. The DON and ADON reviewed and updated current resident MARs to indicate "do not crush" for medications from the do not crush list. The DON contacted the pharmacy to ensure MARs are preprinted with "do not crush" as reconciled with the list. The DON and ADON educated current licensed nurses on policy and procedure for medication administration and a list of "do not crust meds". DON, ADON, Unit Manager, Nurse Supervisor and Pharmacy Consultant conducted medication administration observations of 28 licensed nurses.</p> <p>3. The DON/ADON will conduct QI monitoring of medication administration observation of licensed nurses on all shifts and weekends to include 4 nurses a week x 4 weeks, then 3 nurses a week x 4 weeks, then 2 nurse a week x 4 weeks, then 1 nurse monthly x 9 months.</p> <p>4. The DON/ADON will report results of QI monitoring to the Risk Management/Quality Improvement Committee monthly for continued compliance and/or revision.</p>	2-9-12

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

PRINTED: 01/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2012
NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083		
(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 332	Continued From page 19 On 01/10/12 at 5:25 PM, Nurse #2 was interviewed. He acknowledged that he had administered Senna S tablet to Resident #71 instead of Senna tablet as ordered. Nurse #2 looked at his medication cart drawer and did not find a bottle of Senna tablet. 3. Resident # 100 was admitted to the facility on 11/04/11. On 12/09/11, the physician had ordered for Artificial Tears - instill 2 drops each eye twice a day for dry eyes. On 01/10/12 at 4:43 PM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to administer 1 drop of Artificial Tears to each eye. On 01/10/12 at 5:25 PM, Nurse #2 was interviewed. He stated that he had instilled 1 drop of Artificial Tears to each eye of Resident #100.	F 332			

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

PRINTED: 02/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345258	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE RD KANNAPOLIS, NC 28083
--	---

(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
K 076 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on the observations on February 2, 2012 the following items were observed as noncompliant with the bulk oxygen storage at the liquid oxygen farm, specific findings include:</p> <p>(1) The area around the cylinders was not protected on three sides to protect against cylinder valves getting exposed to the weather</p> <p>(2) The cylinders were touching the concrete pad without having another surface to protect the bottom of the cylinders from being exposed to water.</p> <p>(3) The cylinders were gang chained and not individually chained.</p>	K 076	<p>A Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law.</p> <p>K076</p> <p>1. The Maintenance Director will enclose the area around the cylinders on three sides to protect the cylinder valves from exposure to weather. The cylinders will be placed on a rubber mat to protect the bottom surface from exposure to water. The cylinders will be chained individually.</p> <p>2. The Maintenance Director inspected the cylinder valves to ensure damage has not occurred due to weather exposure. The Maintenance Director inspected the bottom surface of the cylinders to ensure water has not pooled around the base. The Maintenance Director inspected the cylinders to ensure positioning of the cylinders was maintained as a result of being chain ganged. No damage noted to the cylinder valves. No water noted around the bases of the cylinders. Positioning of the cylinders has been maintained.</p> <p>3. The Maintenance Director will conduct will conduct QI monitoring of the cylinders and surrounding area three times a week x 4 weeks, then twice a week x 4 weeks, then weekly x 4 weeks, and then monthly x 9 months.</p> <p>4. The Maintenance Director will report results of QI monitoring to the Risk Management/Quality Monitoring Committee monthly x 12 months for continued compliance and/or revision.</p>	3-18-2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Laura Proquemo NHA* TITLE: *Administrator* (X6) DATE: *2-16-2012*

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.