STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	03/07/2013

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

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F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES			

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:

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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.

F156

1. No resident experienced harm as a result of the QIO's phone number missing from the Notice of Medicare Provider Non-coverage and reason for Medicare non coverage incomplete. Resident #212, #97, and #117 no longer resides in the facility. 4-4-2013

2. The Social Services Director reviewed the Notices issued to current residents the week of March 7, 2013.Four residents were noted. The Social Services Director revised two notices to include the QIO phone number and reason Medicare coverage ended. The remaining two letters had complete and accurate information. The letters were reissued to the residents. The Administrator educated 100% of the Social Services Staff regarding QIO contact information and completing reason Medicare coverage ended.

3. The Administrator/Director of Nursing/Social Services Director/Business Office Manager will conduct monitoring of Notice of Medicare Provider Non-coverage letters using an audit QI tool for to ensure QIO contact information is present and reason for non coverage is indicated three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks, then monthly x 9 months. The Administrator/Director of Nursing will re-educate Social Services Staff as indicated.

4. The Administrator/Director of Nursing/Social Services Director/Business Office Manager will report the results of the QI monitoring to the Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tanya Roquemore — TITLE: Executive Director — (X6) DATE: 3/25/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's

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policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interview, the facility failed to provide (1) the reason for Medicare non-coverage and (2) contact information for requesting an immediate appeal for 3 of 3 sampled residents (Residents #212, #97 and #117) who were issued notice of Medicare non-coverage.

The findings included:

1. Resident #212 was issued a "Notice of Medicare Provider Non-Coverage" on 10/5/12 that indicated Medicare coverage would end on 10/9/12. The notice did not include a reason for coverage to end, nor the name and telephone number of the Quality Improvement Organization (QIO) to contact for an immediate appeal.

During an interview on 3/7/13 at 3:30 PM, the Social Worker stated she issued the Medicare

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F 156	Continued From page 3 non-coverage notices. She indicated she did not consistently put the reason for the non-coverage in the notices and did not realize the QIO contact information was not specified in all the notices. 2. Resident #97 was issued a "Notice of Medicare Provider Non-Coverage" on 10/18/12 that indicated Medicare coverage would end on 10/23/12. The notice did not include a reason for coverage to end, nor the name and telephone number of the Quality Improvement Organization (QIO) to contact for an immediate appeal. During an interview on 3/7/13 at 3:30 PM, the Social Worker stated she issued the Medicare non-coverage notices. She indicated she did not consistently put the reason for the non-coverage in the notices and did not realize the QIO contact information was not specified in all the notices. 3. Resident #117 was issued a "Notice of Medicare Provider Non-Coverage" on 2/13/13 that indicated Medicare coverage would end on 2/15/13. The notice did not include a reason for coverage to end, nor the name and telephone number of the Quality Improvement Organization (QIO) to contact for an immediate appeal. During an interview on 3/7/13 at 3:30 PM, the Social Worker stated she issued the Medicare non-coverage notices. She indicated she did not consistently put the reason for the non-coverage in the notices and did not realize the QIO contact information was not specified in all the notices.	F 156		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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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 observation, record review and staff interview, the facility failed to care plan the securement of indwelling urinary catheters for 3 of 3 sampled residents with catheters (Residents #258, #184 and #216), and failed to care plan measures to prevent a decline in urinary continence for 2 of 3 sampled residents (Residents #146 and #7) reviewed for urinary incontinence.

The findings included:

1. Resident #184 was admitted to the facility on 12/27/11. Diagnoses included urinary retention and spinal stenosis.

F279

1. The Director of Nursing/Assistant Director of Nursing assessed residents #184, #258, and #216 for any trauma as a result of indwelling catheters not being secured on March 7, 2013. No trauma or harm was noted and documented accordingly. On March 7, 2013, The Director of Nursing/Assistant Director of Nursing/MDS coordinator reviewed the care plans for residents #184, #258, and #216 to ensure they were updated to include securement of indwelling catheters. The Assistant Director of Nursing/MDS coordinators reviewed and updated the care plans of residents #146 and #7 to include a goal to prevent urinary decline.
2. The Director of Nursing/Assistant Director of Nursing/MDS coordinators reviewed the care plans of all seven residents with indwelling catheters to ensure securement was noted on their care plans. Four residents care plans were updated to include securement of indwelling catheters. Three care plans were found to have securement of indwelling catheters noted on their care plans. The Director of Nursing/Assistant Director of Nursing/MDS coordinators assessed all current residents with a potential for bowel/bladder training score of 7-21. Forty-eight residents were identified for individualized training or toileting schedules. All 48 residents were initiated on the bowel/bladder program and care plans were updated to include prevent urinary decline. The Director of Nursing/Assistant Director of Nursing educated 100% of the MDS coordinators/Unit Managers on care planning the securement of indwelling catheters and preventing urinary decline. 4-4-2013
3. The Director of Nursing/Assistant Director of Nursing will conduct monitoring of care plans of residents with indwelling catheters and preventing urinary decline by assessing potential for bowel/bladder training programs of residents with scores of 7-21. A QI tool will be used for monitoring three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks, and then monthly x 9 months. The Director of Nursing/Assistant Director of Nursing will re-educate the staff as indicated.
4. The Director of Nursing/Assistant Director of Nursing will report results of QI monitoring to the Risk Management/Quality Improvement Committee monthly for 12 months for continued compliance and/or revision.

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A significant change Minimum Data Set (MDS) dated 4/25/12 indicated Resident #184 had an indwelling catheter. The Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter, dated 4/25/12, revealed Resident #184 had a suprapubic catheter placed due to urinary retention.

The care plan for the suprapubic catheter was last updated on 1/14/13. It did not address the need to secure the catheter.

Resident #184's catheter was observed on 3/7/13 at 11:30 AM in the presence of Nursing Assistant (NA) #2 while the resident was lying in bed. The catheter was attached to a leg bag. The catheter was pulling downward toward the leg bag with visible tension at the insertion site in the lower abdomen. The catheter was not secured in any fashion. NA#2 was interviewed at this time. She indicated she frequently took care of Resident #184 and had never seen the catheter secured. NA#2 added that the resident frequently manipulated the catheter and bag and pulled the catheter tight.

On 3/7/13 at 11:33 AM, catheter site care for Resident #184 was observed, provided by Nurse #4. The lower aspect of the site was pink. A small amount of crusty tan drainage was observed around the catheter. The Nurse #4 stated she provided daily catheter site care for the resident and the crusty drainage was usual for him. Nurse #4 indicated she had never seen the catheter secured.

During an interview on 3/7/13 at 2:45 PM, UM #1

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stated that the catheter should be secured to the abdomen at all times. UM #1 was not sure if securement had been tried in the past.

During an interview on 3/7/13 at 3:05 PM, Administrative Staff #2 stated that the resident's care plan should have included a means of securing the catheter.

During an interview on 3/7/13 at 5:42 PM, Administrative Staff #1 indicated catheters should be secured at all times.

2. Resident #216 was admitted to the facility on 11/23/12. Diagnoses included status post surgical repair of a hip fracture and urinary retention.

The admission Minimum Data Set (MDS) dated 11/30/13 indicated that Resident #216 had an indwelling catheter.

The care plan of 11/30/12 listed urinary retention with catheter placement as a problem. The care plan did not address the need to secure the catheter.

On 3/7/13 at 11:50 AM, Resident #216's catheter was observed in the presence of NA#3. The catheter was not secured. NA #3 said this was the first day she had provided care to Resident #216 and thought if the catheter was supposed to have been secured, a leg strap would have been in place.

During an interview on 3/7/13 at 2:45 PM, UM#1 said catheters should be anchored at all times.

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During an interview on 3/7/13 at 3:05 PM, Administrative Staff #2 stated that the resident's care plan should have included a means of securing the catheter.

During an interview on 3/7/13 at 5:42 PM, Administrative Staff #1 indicated catheters should be secured at all times.

3. Resident # 258 was admitted to the facility 2/23/13. Cumulative diagnoses included: urinary retention. Resident #258 had an indwelling urinary catheter. Resident # 258 was cognitively intact.

A Minimum Data Set (MDS) had not been completed for Resident # 258.

An Admission care plan dated 2/23/13 indicated Resident #258 had an indwelling urinary catheter and was at risk for urinary tract infection. The care plan did not include Securement of the urinary catheter.

During an interview on 10:25 AM., NA #1 stated Resident # 258 used a leg bag during the day and a urinary catheter bag at the bedside at night. She stated there were two bands on the leg bag that was used to secure the leg bag to Resident #258's leg. She indicated there were no other bands used to secure the catheter tubing.

During an interview on 11:15 AM, Nurse #2 stated the urinary catheter tubing was secured with the leg straps on the urinary leg bag. If it was a urinary drainage bag attached to the bed frame, the catheter tubing was secured with a Velcro band that was secured on the thigh.

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During an interview on 3/7/13 at 11:20 AM., Resident # 258 stated he had a urinary leg bag that was secured with two straps. He said he did not have a strap at the top of his thigh to secure the catheter tubing itself and stated the catheter pulled at times especially if the leg bag became full of urine.

During an interview on 3/7/13 at 3:05 PM, Administrative Staff #2 stated that the resident's care plan should have included a means of securing the catheter.

During an interview on 3/7/13 at 5:42 PM, Administrative Staff #1 indicated catheters should be secured at all times.

4. Resident #7 was admitted to the facility on 2/5/13 with multiple diagnoses including Congestive Heart Failure (CHF) and Lower Extremity edema. The admission Minimum Data Set (MDS) assessment dated 2/12/13 indicated that Resident #7 had moderate impairment in cognitive status, was frequently incontinent of bladder and needed assist with transfer and toileting. The Care Area Assessments (CAAs) revealed " resident is incontinent of bladder and frequently incontinent of bowel. Nursing admission data collection, he is usually continent, staff to respond promptly to toileting requests. Checked for soiling frequently with pericare provided as needed. Receives diuretic therapy which could increase the urge to void. Incontinence increases the risk for skin breakdown. "

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The care plan was reviewed. The care plan did not have a specific problem and goal to address care to prevent decline in urinary continence and/or to improve as much bladder function as possible.

The admission Data Collection Form was reviewed. The form included an assessment for potential for bowel/bladder training. The assessment indicated that Resident #7 had a score of 12 which indicated that he was a candidate for toileting schedule.

The bladder record for Resident #7 from February 27 - March 5, 2013 was reviewed. The record revealed that Resident #7 was mostly incontinent of bladder.

On 3/5/13 at 8:45 AM, Resident #7 was interviewed. He stated that staff did not take him to the bathroom. He had to call and wait for the staff to come to toilet him. He further stated that at times he could not wait for so long because he was taking a fluid pill.

On 3/5/13 at 8:47 AM, administrative staff #2 was interviewed. She stated that the care plan for urinary incontinence was incorporated to the care plan for potential for skin breakdown. She revealed that the facility had no toileting program in place.

5. Resident # 146 was admitted to the facility on 12/12/12 with multiple diagnoses including Hypertension, Parkinson's disease and Diabetes Mellitus. The admission MDS assessment dated 12/17/13 indicated that Resident #146's cognition

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was intact, was frequently incontinent of bladder and needed assist with transfer and toileting. . The Care Area Assessments (CAAs) for urinary continence indicated " 74 year old with Dementia, decline in physical functioning, recently treated for urinary tract infection (UTI) during hospitalization. Has a diagnosis of Diabetes Mellitus, poorly controlled, received daily diuretic and had Benign Prostatic Hypertrophy (BPH). He is frequently incontinent of bowel and bladder. Assisted by staff for toileting. He is provided with adult brief for incontinent episodes to provided maximum dryness and protection. "

The care plan was reviewed. The care plan did not have a specific problem and goal to address care to prevent decline in urinary continence and/or to improve as much bladder function as possible.

The admission Data Collection Form was reviewed. The form included an assessment for potential for bowel/bladder training. The assessment indicated that Resident #146 had a score of 13 which indicated that he was a candidate for toileting schedule.

The bladder record for Resident #146 from February 27 - March 5, 2013 was reviewed. The record revealed that Resident #146 was mostly incontinent of bladder.

On 3/5/13 at 8:45 AM, Resident #146 was interviewed. He stated that staff did not take him to the bathroom.

On 3/5/13 at 8:47 AM, administrative staff #2 was interviewed. She stated that the care plan for

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urinary incontinence was incorporated to the care plan for potential for skin breakdown. She revealed that the facility had no toileting program in place.

F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and staff interview, the facility failed to follow physician's orders for 2 (Resident # 7 & # 44) of 10 sampled residents reviewed for unnecessary medications. The findings included:

1. Resident #7 was admitted to the facility on 2/5/13 with multiple diagnoses including Congestive Heart Failure (CHF) and Hypertension. The admission Minimum Data Set (MDS) assessment dated 2/12/13 indicated that Resident #7 had moderate cognitive impairment and had received a diuretic drug.

The doctor's progress notes were reviewed. The notes dated 2/27/13 revealed that Resident #7 had 4 plus edema on lower extremities. New orders were written for extra Lasix (diuretic) 40 mgs (milligrams), to increase Lasix to 80 mgs twice a day and to start Norvasc (antihypertensive drug) 5 mgs by mouth daily.

The February and March, 2013 Medication Administration Records (MARs) were reviewed. Norvasc was not transcribed to the MARs for

F 281

1. On March 6, 2013, The Assistant Director of Nursing assessed resident #7, and no harm was noted as a result of not receiving Norvasc. The Director of Nursing assessed resident #44 and no harm was noted as a result of receiving potassium capsules. The Director of Nursing/Assistant Director of Nursing conducted a review of all physicians' orders. One correction was made to Medication Administration Record for orders sent to pharmacy and not on the MAR. The Assistant Director of Nursing/Unit Managers notified the responsible party and Family Nurse Practitioner on March 7, 2013. 4-4-2013
2. The Director of Nursing/Assistant Director of Nursing/Unit Managers reviewed all physician orders for accuracy on March 8, 2013. The Director of Nursing/Assistant Director of Nursing will educate all licensed nurses on processing physician's orders with 80% staff education complete. The Director of Nursing will have 100% of licensed nurses to include prn and weekend staff educated by April 4, 2013.
3. The Director of Nursing/Assistant Director of Nursing/Unit Managers will monitor physician orders transcribed to the Medication Administration Records and Treatment Administration Records using a QI audit tool three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks, and then monthly x 9 months. The Director of Nursing/Assistant Director of Nursing/Unit Managers will re-educate the licensed staff as indicated. The pharmacy consultant will continue monthly Quality Assurance monitoring as well.
4. The Director of Nursing/Assistant Director of Nursing/Unit Managers will report results of QI monitoring to the Risk Management/Quality Improvement Committee monthly for 12 months for continued compliance and/or revision.

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February and March, 2013 and therefore was not administered to Resident #7.

On 3/5/13 at 4:50 PM, Nurse #3 was interviewed. She looked at the MARs for February and March, 2013 and verified that Norvasc was not transcribed.

On 3/6/13 at 3:30 PM, Nurse # 4 was interviewed. She acknowledged that she was the nurse who transcribed the orders for Resident #7. She stated that she overlooked the order for Norvasc and failed to transcribe it to the MAR.

On 3/6/13 at 3:35 PM, the medication cart was observed with Nurse #4. There was no Norvasc available for Resident #7.

2. Resident #44 was re-admitted to the facility on 1/12/13 with multiple diagnoses including Hypertension. The significant change in status MDS assessment dated 2/16/13 indicated that Resident # 44 had memory and decision making problems and had received a diuretic drug.

The physician's orders were reviewed.

On 2/1/13, there was an order to change K-dur (potassium supplement) to equivalent in liquid form for easier consumption - 30 ml (milliliter) three times a day due to potassium level of 3.3. The normal range for potassium level was 3.5 - 5.1. Review of the MAR revealed that Potassium was administered in liquid form from 2/1/13 to 2/13/13. On 2/5/13, the potassium level was 4.0 (normal range).

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On 2/13/13, there was a physician's order to please change potassium to liquid formulary, give 40 meq (milliequivalent) by mouth x 1 dose and then 20 meq 3 times a day. The potassium level on 2/12/13 was 2.5. The MAR indicated that potassium was administered in liquid form from 2/13/13 - 2/16/13.

On 2/16/13, there was an order to discontinue potassium 20 meq 3 times a day and to give potassium 40 meq twice a day due to potassium level of 2.7. On 2/18/13, the potassium level was 3.0 and the physician had ordered to recheck potassium level in 2 weeks.

The MAR for February, 2013 was reviewed. The potassium was transcribed from 2/16/13 - 2/28/13 to give KCL (potassium chloride) 40 meq by mouth twice a day. It was not specified to give liquid form.

On 3/4/13, there was a doctor's order for potassium 40 meq x 1 now due to potassium level of 2.6 and to recheck the level on 3/7/13. On 3/7/13, the potassium level was 2.6.

The MAR for March, 2013 was reviewed. The potassium was transcribed as K-dur 20 meq tablet -take 2 (40 meq) tablets by mouth twice daily.

On 3/7/13 at 4:05 PM, the medication cart was observed. In the cart, there were 2 bottles of KCL labeled for Resident #44 that were sent from the pharmacy on 2/2/13. One bottle was opened and the other bottle was sealed. There were also 4 cards of K-dur (30 capsule each card) labeled for Resident #44 that were sent from the pharmacy

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F 281	Continued From page 14 on 2/18/13. One card had 1 capsule left and the 3 cards were full. This indicated that there were 29 capsules administered to Resident #44 from 2/18/13 to 3/7/13. On 3/7/13 at 4:53 PM, Nurse # 7 was interviewed. He stated that he normally dissolved the potassium capsule in water and administered it with apple sauce. He added that most of the time Resident #44 refused to take her medications.	F 281		
F 283 SS=C	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that the discharge summaries which included recapitulation of the resident's stay and the final summary of the resident's status were complete for 3 (Residents # 232, #74,& #208)of 3 sampled residents who were discharged to home. The findings included: 1. Resident # 232 was admitted to the facility on 11/14/12 with multiple diagnoses including tremors. She was discharged to home on 11/30/12.	F 283		

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F 283	Continued From page 15 Review of the resident's records revealed that a discharge summary was not completed for Resident # 232. On 3/6/13 at 10:25 AM, administrative staff #1 was interviewed. She stated that with the new company the discharge summary forms were eliminated. 2. Resident # 74 was admitted to the facility on 12/13/12 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Hypertension. He was discharged to home on 1/22/13. Review of the resident's records revealed that the discharge summary was incomplete for Resident # 74. The social services, dietary services, activities and rehab services were not completed. On 3/6/13 at 10:25 AM, administrative staff #1 was interviewed. She stated that with the new company the discharge summary forms were eliminated. 3. Resident # 208 was admitted to the facility on 9/17/12 with multiple diagnoses including C2-C4 fusion segmental decompression of occipital to C4 and hypertension. He was discharged to home on 10/5/12. Review of the resident's records revealed that the discharge summary was incomplete for Resident # 208. The social services, dietary services, activities and rehab services were not completed.	F283 F 283	1. Residents #232, #74, and #208 no longer reside in the facility. The Director of Nursing/Assistant Director of Nursing had the interdisciplinary team complete the recapulation of services for residents #232, #74, and #208. 2. The Administrator/Social Services Director/Medical Records Coordinator conducted a review of the recapulation of services for the ten residents discharged the week of March 4, 2013. Five residents interdisciplinary recapulation of services was completed in its entirety and the interdisciplinary team completed the remaining five on March 8, 2013. Two forms were initiated for residents discharging on March 9, 2013.The Social Services Director will initiate the form for residents with active discharge plans and place in the front of the chart for the interdisciplinary team to complete within seven days of discharge. The Administrator/Director of Nursing/Assistant Director of Nursing will educate the interdisciplinary team regarding completing the interdisciplinary recapulation of services with 100% education completed. 3. The Administrator/Director of Nursing/Assistant Director of Nursing/Medical Records Coordinator will monitor the interdisciplinary recapulation of services using a QI audit tool by day seven of a residents discharge three times a week x 4 weeks , twice a week x 4 weeks, weekly x 4 weeks, and then monthly x 9 months. The Administrator/Director of Nursing/Assistant Director of Nursing will re-educate interdisciplinary team as indicated. 4. The Administrator/Director of Nursing/Assistant Director of Nursing/Medical Records Coordinator will report the results of QI monitoring to the Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	4-4-2013

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F 283	Continued From page 16 On 3/6/13 at 10:25 AM, administrative staff #1 was interviewed. She stated that with the new company the discharge summary forms were eliminated.	F 283		
F 284 SS=C	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to address in the discharge plan the necessary post discharge care for 3 (Residents # 232, #74, & #208) of 3 sampled residents who were discharged to home. The findings included: 1. Resident # 232 was admitted to the facility on 11/14/12 with multiple diagnoses including tremors. He was seen by the neurologist for the tremors and the follow up visit was scheduled on 1/30/13 at 11:00 AM. Resident #232 had a doctor's order to discharge home with home care on 11/30/12. Review of the discharge summary and guide revealed that the follow up appointment with the neurologist was not addressed. Resident #232 was also discharged on Coumadin (anticoagulant) and Lovenox (anticoagulant) and	F 284		

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the discharge summary did not address instruction to monitor the side effects of the drugs such as bleeding

On 3/6/13 at 9:15 AM, administrative staff #1 was interviewed. She stated that she was aware that the discharge plan of care was incomplete and did not address all the necessary post discharge care for Resident # 232.

2. Resident # 74 was admitted to the facility on 12/13/12 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Hypertension.

Review of the physician's order for December, 2012 revealed that Resident #74 had a follow up visit scheduled on 2/26/13 at 2:45 PM from the rheumatology clinic and the resident's diet was no added salt (NAS).

Resident #74 had a doctor's order to discharge to home on 1/22/13.

Review of the discharge summary and guide revealed that the follow up visit to the rheumatology clinic and the diet were not addressed in the post discharge plan of care.

On 3/6/13 at 9:15 AM, administrative staff #1 was interviewed. She stated that she was aware that the discharge plan of care was incomplete and did not address all the necessary post discharge care for Resident # 74.

3. Resident # 208 was admitted to the facility on

1. Resident #232, #74, and #208 no longer reside in the facility. 4-4-2013
2. The Director of Nursing/Assistant Director of Nursing reviewed the post discharged plan of care for the ten residents identified as discharged home the week of March 4, 2013. Missing information was noted for one resident indicating the date health home was to be initiated and equipment needs. All residents discharged home with home health are evaluated by the home health agency prior to discharging. The customer service liaison conducts follow up discharge surveys every weekend on all residents discharged home during the week. No issues were identified. The Director of Nursing/Assistant Director of Nursing/Unit Managers educated 80% of licensed personnel regarding completing post discharge plan of care in its entirety. 100% of staff education will be completed by April 4, 2013. On March 7, 2013, The Director of Nursing reviewed the charts of two residents with active discharge plans on March 9, 2013. The plan of care was completed in its entirety to include follow up appointments, date home health services to be initiated, equipment needs, and medication administration instructions.
3.The Administrator/Director of Nursing/ Assistant Director of Nursing/Unit Managers/Social Services Director will monitor the post discharge plan of care using a QI audit tool three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks, and then monthly x 9 months. The Director of Nursing/Assistant Director of Nursing/Unit Managers will re-educate licensed personnel as indicated.
4. The Administrator/Director of Nursing/Assistant Director of Nursing/Unit Managers/Social Services Director will report the results of QI monitoring to the Risk management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.

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9/17/12 with multiple diagnoses including C2-C4 fusion segmental decompression of occipital to C4 and hypertension. The admission orders included Toprol (anti hypertensive) 25 mgs -take ½ tablet (12.5 mgs) by mouth daily for hypertension and a follow up appointment with the neurology on 10/23/12 at 10:30 AM.

The physician's orders were reviewed. On 9/25/12, there was an order to " cleanse daily around halo pin sites with 50:50 mixture of normal saline and hydrogen peroxide. " On 10/1/12, there was an order for " dry dressing to back of head daily until healed. " On 10/3/12, there was an order to monitor incision site back of head and halo pin sites for signs/symptoms of infection, redness, warmth, swelling, drainage.

On 10/5/12, there was an order to discharge Resident #208 to home.

Review of the discharge summary and guide revealed that Toprol was written to give 25 mgs tablet by mouth daily instead of ½ tab (12.5 mgs.) as ordered. The discharge summary also did not address the treatment to the back of the head and halo pin sites and the follow up appointment with the neurology clinic.

On 3/6/13 at 9:15 AM, administrative staff #1 was interviewed. She stated that she was aware that the discharge plan of care was incomplete and did not address all the necessary post discharge care for Resident # 208.

F 315 SS=E 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER — F 315

Based on the resident's comprehensive

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assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to secure the indwelling urinary catheters for 3 of 3 sampled residents with catheters (Residents #258, #184 and #216), and failed to put measures in place to prevent a decline in urinary continence for 2 of 3 sampled residents (Residents #146 and #7) reviewed for urinary incontinence.

The findings included:

1. Resident #184 was admitted to the facility on 12/27/11. Diagnoses included urinary retention and spinal stenosis.

A significant change Minimum Data Set (MDS) dated 4/25/12 indicated Resident #184 had an indwelling catheter. The Care Area Assessment (CAA) for Urinary Incontinence and Indwelling Catheter, dated 4/25/12, revealed Resident #184 had a suprapubic catheter placed due to urinary retention.

The care plan for the suprapubic catheter was last updated on 1/14/13. It did not address the

F315

1. The Director of Nursing/Assistant Director of Nursing assessed residents #184, #258, and #216 for any trauma as a result of indwelling catheters not being secured on March 7, 2013. No trauma or harm was noted and documented accordingly. On March 7, 2013, The Assistant Director of Nursing/Unit Managers secured the indwelling catheters for residents #184, #258, and #216. The Director of Nursing assessed residents #146 and #7 for potential for bowel and bladder training and both residents were initiated on the bowel/bladder program to prevent urinary decline. 4-4-2013
2. The Director of Nursing/Assistant Director of Nursing assessed the additional seven residents identified with indwelling catheters to ensure securement of indwelling catheter. The Director of Nursing/Assistant Director of Nursing assessed all current residents with a potential for bowel/bladder training score of 7-21. Forty-eight residents were identified for individualized training or toileting schedules. All 48 residents were initiated on a bowel/bladder program to prevent urinary decline. The Director of Nursing/Assistant Director of Nursing educated staff on securing indwelling catheters and assessing potential for bowel/bladder training and initiation on the program.
3. The Director of Nursing/Assistant Director of Nursing will conduct monitoring of residents for securement of indwelling catheters and assessing potential for bowel/bladder training programs of residents with scores of 7-21. A QI tool will be used for monitoring three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks, and then monthly x 9 months. The Director of Nursing/Assistant Director of Nursing will re-educate the staff as indicated.
4. The Director of Nursing/Assistant Director of Nursing will report results of QI monitoring to the Risk Management/Quality Improvement Committee monthly for 12 months for continued compliance and/or revision.

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need to secure the catheter.

Resident #184's catheter was observed on 3/7/13 at 11:30 AM in the presence of Nursing Assistant (NA) #2 while the resident was lying in bed. The catheter was attached to a leg bag. The catheter was pulling downward toward the leg bag with visible tension at the insertion site in the lower abdomen. The catheter was not secured in any fashion. NA#2 was interviewed at this time. She indicated she frequently took care of Resident #184 and had never seen the catheter secured. NA#2 added that the resident frequently manipulated the catheter and bag and pulled the catheter tight.

On 3/7/13 at 11:33 AM, catheter site care for Resident #184 was observed, provided by Nurse #4. The lower aspect of the site was pink. A small amount of crusty tan drainage was observed around the catheter. The Nurse #4 stated she provided daily catheter site care for the resident and the crusty drainage was usual for him. Nurse #4 indicated she had never seen the catheter secured.

During an interview on 3/7/13 at 2:45 PM, UM #1 stated that the catheter should be secured to the abdomen at all times. UM #1 was not sure if securement had been tried in the past.

During an interview on 3/7/13 at 3:05 PM, Administrative Staff #2 stated that the resident ' s care plan should have included a means of securing the catheter.

During an interview on 3/7/13 at 5:42 PM, Administrative Staff #1 indicated catheters should

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be secured at all times.

2. Resident #216 was admitted to the facility on 11/23/12. Diagnoses included status post surgical repair of a hip fracture and urinary retention.

The admission Minimum Data Set (MDS) dated 11/30/13 indicated that Resident #216 had an indwelling catheter.

The care plan of 11/30/12 listed urinary retention with catheter placement as a problem. The care plan did not address the need to secure the catheter.

On 3/7/13 at 11:50 AM, Resident #216 ' s catheter was observed in the presence of NA#3. The catheter was not secured. NA #3 said this was the first day she had provided care to Resident #216 and thought if the catheter was supposed to have been secured, a leg strap would have been in place.

During an interview on 3/7/13 at 2:45 PM, UM#1 said catheters should be anchored at all times.

During an interview on 3/7/13 at 3:05 PM, Administrative Staff #2 stated that the resident ' s care plan should have included a means of securing the catheter.

During an interview on 3/7/13 at 5:42 PM, Administrative Staff #1 indicated catheters should be secured at all times.

3. Resident # 258 was admitted to the facility 2/23/13. Cumulative diagnoses included: urinary

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retention. Resident #258 had an indwelling urinary catheter. Resident # 258 was cognitively intact.

A Minimum Data Set (MDS) had not been completed for Resident # 258.

An Admission care plan dated 2/23/13 indicated Resident #258 had an indwelling urinary catheter and was at risk for urinary tract infection. The care plan did not include Securement of the urinary catheter.

During an interview on 10:25 AM., NA #1 stated Resident # 258 used a leg bag during the day and a urinary catheter bag at the bedside at night. She stated there were two bands on the leg bag that was used to secure the leg bag to Resident #258's leg. She indicated there were no other bands used to secure the catheter tubing.

During an interview on 11:15 AM, Nurse #2 stated the urinary catheter tubing was secured with the leg straps on the urinary leg bag. If it was a urinary drainage bag attached to the bed frame, the catheter tubing was secured with a Velcro band that was secured on the thigh.

During an interview on 3/7/13 at 11:20 AM., Resident # 258 stated he had a urinary leg bag that was secured with two straps. He said he did not have a strap at the top of his thigh to secure the catheter tubing itself and stated the catheter pulled at times especially if the leg bag became full of urine.

During an interview on 3/7/13 at 3:05 PM,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Administrative Staff #2 stated that the resident's care plan should have included a means of securing the catheter.

During an interview on 3/7/13 at 5:42 PM, Administrative Staff #1 indicated catheters should be secured at all times.

4. Resident #7 was admitted to the facility on 2/5/13 with multiple diagnoses including Congestive Heart Failure (CHF) and Lower Extremity edema. The admission Minimum Data Set (MDS) assessment dated 2/12/13 indicated that Resident #7 had moderate impairment in cognitive status, was frequently incontinent of bladder and needed assist with transfer and toileting. The Care Area Assessments (CAAs) revealed " resident is incontinent of bladder and frequently incontinent of bowel. Nursing admission data collection, he is usually continent, staff to respond promptly to toileting requests. Checked for soiling frequently with pericare provided as needed. Receives diuretic therapy which could increase the urge to void. Incontinence increases the risk for skin breakdown. "

The care plan was reviewed. The care plan did not have a specific problem and goal to address care to prevent decline in urinary continence and/or to improve as much bladder function as possible.

The admission Data Collection Form was reviewed. The form included an assessment for potential for bowel/bladder training. The assessment indicated that Resident #7 had a score of 12 which indicated that he was a

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candidate for toileting schedule.

The bladder record for Resident #7 from February 27 - March 5, 2013 was reviewed. The record revealed that Resident #7 was mostly incontinent of bladder.

Review of the Physical Therapy (PT) notes dated 2/28/13 revealed that Resident #7 was able to ambulate with the use of the rolling walker and with contact guard assist.

On 3/5/13 at 8:45 AM, Resident #7 was interviewed. He stated that staff did not take him to the bathroom. He had to call and wait for the staff to come to toilet him. He further stated that at times he could not wait for so long because he was taking a fluid pill.

On 3/5/13 at 8:46 AM, NA #2 was interviewed. NA #2 was assigned to Resident #7. She stated that Resident #7 was able to walk, was incontinent of bladder and was using a disposable brief. She further stated that Resident #7 was not on any toileting program but he was checked every 2 hours for incontinence.

On 3/5/13 at 8:47 AM, administrative staff #2 was interviewed. She stated that a toileting program was not tried or attempted for Resident #7. She revealed that the facility had no toileting program in place.

On 3/6/13 at 11:57 AM, administrative staff #3 was interviewed. She stated that the facility had no bladder program at this time.

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5. Resident # 146 was admitted to the facility on 12/12/12 with multiple diagnoses including Hypertension, Parkinson's disease and Diabetes Mellitus. The admission MDS assessment dated 12/17/13 indicated that Resident #146's cognition was intact, was frequently incontinent of bladder and needed assist with transfer and toileting. . The Care Area Assessments (CAAs) for urinary continence indicated " 74 year old with Dementia, decline in physical functioning, recently treated for urinary tract infection (UTI) during hospitalization. Has a diagnosis of Diabetes Mellitus, poorly controlled, received daily diuretic and had Benign Prostatic Hypertrophy (BPH). He is frequently incontinent of bowel and bladder. Assisted by staff for toileting. He is provided with adult brief for incontinent episodes to provided maximum dryness and protection. "

The care plan was reviewed. The care plan did not have a specific problem and goal to address care to prevent decline in urinary continence and/or to improve as much bladder function as possible.

The admission Data Collection Form was reviewed. The form included an assessment for potential for bowel/bladder training. The assessment indicated that Resident #146 had a score of 13 which indicated that he was a candidate for toileting schedule.

The PT notes dated 1/24/13 indicated that Resident #146 was able to ambulate 175 feet with contact guard assist.

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F 315	Continued From page 26 The bladder record for Resident #146 from February 27 - March 5, 2013 was reviewed. The record revealed that Resident #146 was mostly incontinent of bladder. On 3/5/13 at 8:45 AM, Resident #146 was interviewed. He stated that staff did not take him to the bathroom. On 3/5/13 at 8:46 AM, NA #2 was interviewed. NA #2 was assigned to Resident #146. She stated that Resident #146 was able to walk, was incontinent of bladder and was using a disposable brief. She further stated that Resident #146 was not on any toileting program. On 3/5/13 at 8:47 AM, administrative staff #2 was interviewed. She stated that a toileting program was not tried or attempted for Resident #146. She revealed that the facility had no toileting program in place. On 3/5/13 at 9:11 AM, restorative aide #1 was interviewed. She stated that Resident #146 was able to ambulate using a rolling walker. She further revealed that she had nobody in the building for toileting program. On 3/6/13 at 11:57 AM, administrative staff #3 was interviewed. She stated that the facility had no bladder program at this time.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and resident and staff interview, the facility failed to secure the smoking materials for 3 (Residents #133, #178 & # 42) of 3 sampled residents who were smokers. The findings included:

The facility policy on smoking dated 3/12 was reviewed. The policy read in part " (name of company) will ensure that residents that smoke are evaluated to ensure that they are safe smokers." The procedure included " complete safe smoking evaluation and determine if resident is a safe smoker. If the resident is not a safe smoker, a care plan will be established identifying the needs of the resident in regards to smoking." The policy did not indicate that residents could keep smoking materials in their rooms.

1. Resident # 133 was admitted to the facility on 1/17/13 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, Hypertension, Obstructive Sleep Apnea and History of Alcohol abuse. The admission MDS assessment dated 1/22/13 indicated that Resident # 133 had memory and decision making problems, had physical behavioral symptoms directed towards others and rejection of care.

The care plan dated 1/17/13 was reviewed. One of the problems was " resident is an active

1. No residents experienced harm as a result of failing to secure smoking material. The Director of Nursing/Assistant Director of Nursing identified the five residents who currently smoke and their smoking and incendiary materials were removed from their persons/rooms and secured by the nursing staff. Individual containers for smoking materials were labeled with the residents names and placed in the medication room for access by the licensed personnel staff. The Director of Nursing/Assistant Director of Nursing educated all five residents on the smoking policy and obtained signatures for the new smoking agreement. All residents were voiced understanding. The Social Services Director conducted new smoking assessments on all five residents and their care plans were updated to indicate nursing would secure smoking materials. The Admissions Coordinator was given a copy of the smoking agreement to review with all newly admitted residents/families identified as smokers upon admission.
2. The Administrator/Director of Nursing/Assistant Director of Nursing/Unit Managers will educate all licensed staff on the smoking policy and smoking contract to be reviewed with residents identified as smokers. 80% of licensed staff education completed. 100% of all licensed staff education will be conducted by April 4, 2013. 4-4-2013
3. The Administrator/Director of Nursing/Assistant Director of Nursing/Unit Managers/Social Services Director will conduct monitoring using a QI audit tool of residents who smoke to ensure they are assessed accurately and deemed safe versus unsafe smokers. Smoking aids including smoking aprons and/or supervised smoking will be implemented based on assessment. Residents care plans will be updated accordingly based on individual needs. Residents will be assessed to ensure smoking and incendiary materials are not kept on persons and/or resident's rooms. The QI monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks, and then monthly x 9 months. The QI monitoring will include newly admitted residents identified as smokers. The Administrator/Director of Nursing/Assistant Director of Nursing/Unit Managers/Social Services Director will re-educate staff and residents as indicated.

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F 323	Continued From page 28 smoker " and the goal was " resident will adhere to facility smoking policy times 90 days. " The approaches were smoking assessment will be completed, all smoking materials will be kept on the nurse's cart, this includes cigarettes, lighters and matches, resident will return all smoking material to the nurse following each time the resident goes outside to smoke, resident will be allowed to smoke in the designated smoking area only and resident is compliant with smoking policy without use of oxygen. On 3/5/13 at 10:42 AM and 3:40 PM and 3/6/13 at 9:10 AM, Resident #44 was observed in bed with oxygen on at 2 liters per minute. There were 2 oxygen concentrators in the room. There were 2 lighters and a pack of cigarettes observed at the over the bed table. On 3/5/13 at 4:40 PM, NA #5 was interviewed. She stated that residents can smoke anytime but the smoking materials were kept by the nurses in the cart. NA #5 indicated that she was not aware that Resident #133 had lighters and cigarettes at bedside. On 3/6/13 at 9:15 AM, administrative staff #1 was interviewed. She stated that residents who were assessed as safe smokers can keep the smoking materials in their room because of residents rights. She added that the facility had not talked to residents how to safeguard their smoking materials. She also indicated that residents who were alert but confused should not have the smoking materials in their rooms. Administrative staff #1 was observed to remove 2 lighters and a pack of cigarette from Resident #133's room and stated that he should not have the smoking	F 323	F323 Continued 4. The Administrator/Director of Nursing/Assistant Director of Nursing/Unit Managers/Social Services Director will report the results of the QI monitoring to Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	

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materials at all. She stated that the social worker does the smoking evaluation.

On 3/6/13 at 10:24 AM, administrative staff #4 was interviewed. She stated that she assessed residents for smoking by observing them smoke in the smoking area. She agreed that Resident #133 was confused and was unable to safeguard the smoking materials and should have been assessed as unsafe smoker. She further stated that the policy had changed and she just updated the care plan that residents could keep their smoking materials if he/she was safe to smoke.

2. Resident # 178 was admitted to the facility on 2/20/13 with multiple diagnoses including Anxiety, Depression, Diabetes Mellitus and Hypertension. The admission MDS assessment dated 2/27/13 indicated that Resident #178's cognition was intact.

On 3/4/13 at 5:00 PM, Resident #178 was observed in his room. There was a pack of cigarette observed on top of the over the bed table. He stated that he had a lighter and cigarettes with him and he can go out to smoke anytime he wants.

On 3/5/13 at 9:05 AM, Resident #178 was observed. He was in his room sleeping. There were 2 packs of cigarettes and a lighter on top of the over the bed table.

On 3/5/13 at 9:10 AM, Nurse # 8 was interviewed. She stated that the smoking materials should be kept in the cart and not in the resident's rooms. She stated that she was not aware that Resident

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#178 was keeping his smoking materials.

On 3/6/13 at 9:15 AM, administrative staff #1 was interviewed. She stated that residents who were assessed as safe smokers can keep the smoking materials in their room because of residents rights. She added that the facility had not talked to residents how to safeguard their smoking materials. She indicated that she would get the smokers a box to put their smoking materials and to store the box inside the drawers. She stated that the social worker does the smoking evaluation.

On 3/6/13 at 10:24 AM, administrative staff #4 was interviewed. She stated that she assessed residents for smoking by observing them smoke in the smoking area. She added the policy had changed and she updated the care plan that residents could keep their smoking materials if he/she was assessed as safe smoker.

3. Resident # 42 was admitted to the facility on 10/19/13 with multiple diagnoses including Hypertension, Diabetes Mellitus, Seizure Disorder and Depression. The quarterly MDS assessment dated 1/16/13 indicated that Resident #42's cognition was intact.

The care plan dated 10/19/12 was reviewed. One of the problems was " resident is an active smoker " and the goal was " resident will adhere to facility smoking policy times 90 days. " The approaches were smoking assessment will be completed, all smoking materials will be kept on the nurse's cart, this includes cigarettes, lighters and matches, resident will return all smoking

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material to the nurse following each time the resident goes outside to smoke, resident will be allowed to smoke in the designated smoking area only.

On 3/4/13 at 4:50 PM, Resident #42 was observed. She was in bed and stated that her husband brings her cigarettes and lighter. She stated that she did not have a lighter or cigarette with her.

Review of the nurse's notes revealed that on 3/5/13 at 4:00 AM, Resident #42 was observed smoking in the hallway. The notes read in part " resident observed smoking in hallway near laundry room. Resident was asked to stop smoking in hallway. Redirected to designated smoking area, and then supervised by staff. "

On 3/6/13 at 9:15 AM, administrative staff #1 was interviewed. She stated that residents who were assessed as safe smokers can keep the smoking materials in their room because of residents rights. She added that the facility had not talked to residents how to safeguard their smoking materials. She indicated that she would get the smokers a box to put their smoking materials and to store the box inside the drawers. She stated that the social worker does the smoking evaluation.

On 3/6/13 at 10:24 AM, administrative staff #4 was interviewed. She stated that she assessed residents for smoking by observing them smoke in the smoking area. She added the policy had changed and she updated the care plan that residents could keep their smoking materials if he/she was assessed as a safe smoker.

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F 329 SS=D	483.25(l) 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 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow the physician's order for 1 (Resident #1)of 10 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident #1 was admitted to the facility on 12/7/12 with multiple diagnoses including Anemia. The annual MDS assessment dated 2/11/13	F329 F 329	1. The Assistant Director of Nursing assessed Resident #1 and no harm was incurred as a result of taking ferrous sulfate daily versus every other day. The Director of Nursing/Assistant Director of Nursing reviewed Physician orders and corrected the transcription error immediately. The Assistant Director of Nursing notified the resident's responsible party and Family Nurse Practitioner. A new team of Licensed Nurses has been devised to review physician orders daily and monthly to ensure consistency and accuracy of transcription. 2. The Director of Nursing/Assistant Director of Nursing/Unit Managers will educate all licensed personnel on transcribing Physician Orders. 80% licensed staff education complete. 100% licensed staff education will be complete by April 4, 2013. 3.The Director of Nursing/Assistant Director of Nursing/Unit Managers will monitor physician orders daily and a delegated team of Licensed Nurses will ensure accuracy of monthly Medication Administration Records and Treatment Administration Records. A QI audit tool has been devised for reviewing physician orders three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks, and then monthly x 9 months. The Director of Nursing/Assistant Director of Nursing/Unit Managers will re-educate the licensed personnel as indicated. The pharmacy consultant will continue monthly Quality Assurance monitoring as well. 4. The Director of Nursing/Assistant Director of Nursing/Unit Managers will report the results of monitoring to the Risk Management/Quality Improvement Committee monthly for 12 months for continued compliance and/or revision.	4-4-2013

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F 329	Continued From page 33 indicated that Resident #1 had moderate cognitive impairment. Review of the doctor's orders revealed that on 1/11/13, the physician had ordered Ferrous Sulfate 325 mgs.(milligram)1 tablet by mouth every other day for Anemia. The MARs for February and March, 2013 were reviewed. Ferrous Sulfate was transcribed to the MAR to be give every other day. The MAR was signed the nurses daily indicating that the Ferrous Sulfate was administered daily instead of every other day as ordered. On 3/7/13 at 10:35 AM, Nurse # 6 was interviewed. She indicated that the nurse who checked the MAR should have marked it as every other day. She agreed that it was a medication error and would inform the doctor.	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 observation, medical record review and staff interview, the facility failed to ensure that the medication error rate was 5% or below by not following physician's orders. There were three errors out of fifty-two opportunities resulting in a 5.76 % error rate (Resident #161, #216). The findings included:	F 332		

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1a. Resident #161 had a physician's order dated 12/12/12 and renewed for March, 2013 for Omeprazole 20 milligrams (mg.) capsule DR--take one cap by mouth every morning. The time of administration was documented as 6:00 AM. On 3/6/13 at 8:11 AM., Nurse # 1 was observed during medication pass. Nurse #1 was observed to prepare and to administer Prilosec 20 mg. one cap for Resident #161.

On 3/6/13 at 8:30 AM., a review of the Medication Administration Record for March 2013 revealed that the Prilosec had been initialed as given by the night nurse. When interviewed, Nurse #1 stated she did not think she had given a Prilosec capsule to Resident #161.

1b. Resident # 161 had a physician's order dated 12/12/12 and renewed for March, 2013 for Lutein softgel 6 mg. capsule-take one cap by mouth every day. The time of administration was documented as 8:00 AM. On 3/6/13 at 8:11 AM., Nurse # 1 was observed during medication pass. Nurse #1 was observed administering morning medications. She did not prepare and administer the Lutein softgel capsule.

On 3/6/13 at 8:30 AM., a review of the Medication Administration Record for March, 2013 revealed that Nurse #1 had initialed that she had administered the Lutein softgel capsule. When interviewed, Nurse #1 stated she had given the Lutein capsule during the observed medication pass.

2. Resident #216 was admitted to the facility on 11/23/12. Diagnoses included osteopenia, osteoporosis and hypocalcemia.

1. The Assistant Director of Nursing assessed residents #161 and no harm was experienced as a result of ingesting Prilosec or not receiving the Lutein. The resident's responsible party and physician were made aware. The Assistant Director of Nursing assessed resident #216 and no harm was experienced as a result of ingesting Calcium with Vitamin D. The resident's responsible party and physician were made aware. Both residents were placed on acute monitoring for 72 hours to ensure no signs of discomfort were noted. The Assistant Director of Nursing provided education to Nurse #1. The Director of Nursing of Nursing/Assistant Director of Nursing/Unit Managers conducted a review of all physician orders.

2. The Director of Nursing/Assistant Director of Nursing/Unit Managers will educate all licensed personnel on the six rights of medication administration. 80% of licensed staff education complete. 100% licensed staff education will be complete by April 4, 2013. 4-4-2013

3. The Director of Nursing/Assistant Director of Nursing/Unit Managers will conduct medication observations of all licensed nurses on all shifts and weekends using a QI audit tool to ensure error rate is <5% three time a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks, and then monthly x 9 months. The Director of Nursing/Assistant Director of Nursing/Unit Managers will re-educate the licensed nurses as indicated. The pharmacy consultant will continue monthly Quality Assurance monitoring as well.

4. The Director of Nursing/Assistant Director of Nursing/Unit Managers will report the results of QI monitoring to the Risk Management/Quality Improvement Committee monthly for 12 months for continued compliance and/or revision.

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TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	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 35	F 332		

March 2013 Physician Orders included Calcium 600 milligrams tablet three times daily.

On 3/6/13 at 12:08 PM, Nurse #9 was observed to administer a tablet of Calcium 600 milligrams with Vitamin D 400 milligrams to Resident #216.

During an interview on 3/6/13 at 2:37 PM, Nurse #9 indicated she was not aware the facility had plain tablets of Calcium 600 milligrams in stock so she gave the Calcium with Vitamin D.

F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS — F 431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked,

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	345258	A. BUILDING _____ B. WING _____	03/07/2013

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TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE RD KANNAPOLIS, NC 28083

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F 431	Continued From page 36 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on a review of facility policy, observation and staff interview, the facility failed to date opened multi dose medication on two (2) of five (5) medication carts (Med cart on 400 hall and lower 300 hall) and failed to discard expired medication on one (1) of five (5) medication carts (200 hall). Findings included: The facility policy, last revised 8/9/11, titled "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" read, in part, "4. Facility should ensure that medications and biologicals that (1) have an expired date on the label ...are stored separate from other medications until destroyed or returned to the supplier. 5. Once any medication or biological package is opened ...facility staff should record the date opened on the medication container when a medication has a shortened expiration date once opened." 1. An observation of the lower 300 medication cart on 3/7/2013 at 7:50 AM. revealed an open undated multidose vial of Lidocaine 1% solution. Nurse #1 stated multidose vial should have been	F 431	1. On March 7, 2013, The Assistant Director of Nursing ensured the licensed nurses disposed of the undated multi-dose vial and expired medications. Education was provided to Nurse #1 and Nurse #2. The Director of Nursing/Assistant Director of Nursing/Unit Managers conducted a review of all three medication rooms and six medication carts for opened undated multi-dose vials and expired medications. The findings were one opened undated bottle on the upper 300 mediation cart. The licensed nurse disposed of the medication vial immediately and education was conducted. 2. The Director of Nursing/Assistant Director of Nursing/Unit Managers will educate all licensed nurses on the proper dating of opened multi-dose vials and discarding of expired medications. 80% licensed staff education complete. 100% licensed staff education will be complete by April 4, 2013. 3. The Director of Nursing/Assistant Director of Nursing/Unit Managers will monitor dates for opened multi-dose vials and discarding of expired medications for three medication rooms and six medication carts using a QI audit tool three times a week x 4 weeks, twice a week x 4 weeks, weekly x 4 weeks, and then monthly x 9 months. The Director of Nursing/Assistant Director of Nursing/Unit Managers will re-educate the licensed nurses as indicated. The pharmacy consultant will continue monthly Quality Assurance monitoring as well. 4. The Director of Nursing/Assistant Director of Nursing/Unit Managers will report the results of QI monitoring to the Risk Management/Quality Improvement Committee monthly for 12 months for continued compliance and/or revision.	4-4-2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	03/07/2013

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

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F 431	Continued From page 37	F 431		

dated when opened.

On 3/7/13 at 11:34 AM., Administrative staff #1 stated she expected to have the vials dated when opened.

2. An observation of the 200 medication cart on 3/7/2013 at 11:10 AM. revealed a bottle of Simethicone tablets (antiflatulant medication) with an expiration date of 2/13. There was a remainder of sixty-six (66) tablets in the bottle. Nurse #2 stated the medication should have been discarded.

On 3/7/13 at 11:34 AM., Administrative staff #1 stated she expected the nursing staff to check medications for the expiration date before administration of medications.

3. On 3/6/13 at 2:45 PM, 2 vials of opened undated insulin were observed on the 400 hall medication cart. An interview was conducted with Unit Manager (UM) #1 at this time. UM#1 stated insulin vials should be dated when opened by the nurse opening the vial.

On 3/7/13 at 11:34 AM., Administrative staff #1 stated she expected to have the vials dated when opened.

APR 12 2013

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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/27/2013

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

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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 Existing Health Care section of the LSC and its referenced publications. This facility is Type III protected construction utilizing North Carolina Special locking arrangements, and is equipped with an automatic sprinkler system.	K 000	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.	
K 056 SS=E	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 3/27/2013 the following Life Safety item was observed as noncompliant, specific findings include: The overhangs from the hallway exits are greater than 4 feet and are not currently covered by the automatic sprinkler system.	K 056	K056 1. The Maintenance Director contacted Automatic Sprinkler Inspection Services, Inc. to install dry pendant sprinkler heads at the seven identified overhangs at the hallway exits greater than 4 feet. On April 9, 2013, the pipes have been run from each overhang and we are awaiting installation of the dry pendants ordered. The sprinkler system will be equipped with water flow and tamper switches which are electronically connected to the building fire systems. 2. The Maintenance Director will ensure any new construction with overhangs greater than 4 feet will have an automatic sprinkler system installed. 3. The Maintenance Director/Maintenance Assistant will conduct QI monitoring of the seven sprinkler heads to ensure they are dust free 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. The sprinkler system will continue to be tested quarterly. 4. The Maintenance Director will report results of the QI monitoring to the Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	5-11-2013

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

Tanya Roquemore RN CNHA — Executive Director — 4-11-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/27/2013

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K 056	Continued From page 1 NOTE: The facility does have a project for having the overhangs sprinklered. CFR#: 42 CFR 483.70 (a)	K 056	K147 1. The Maintenance Director contacted Kraftpower to service our generator. On March 28, 2013, Kraftpower adjusted the time delay on our generator panel. A transfer test was performed three times with the following results; Test 1: 7 seconds, Test 2: 6 seconds and Test 3: 6 seconds. 2. The Maintenance Director will have the generator checked every six months. 3. The Maintenance Director/Maintenance Assistant will conduct QI monitoring of the automatic transfer switch weekly x 4 weeks, then biweekly x 8 weeks, monthly times 9 months. 4. The Maintenance Director will report results of the QI monitoring to the Risk Management/Quality Improvement Committee monthly x 12 months for continued compliance and/or revision.	5-11-2013
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 3/27/2013 the following Life Safety item was observed as noncompliant, specific findings include: The emergency power system required approximately sixteen seconds to restore power during loss of normal power to the Life Safety automatic transfer switch. CFR#: 42 CFR 483.70 (a)	K 147		