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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	**1810 CONCORD LAKE ROAD 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 000	INITIAL COMMENTS A complaint investigation was conducted from 03/01/17 through 03/03/17. Immediate Jeopardy was identified at: CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.75 at tag F520 at a scope and severity (J) Immediate Jeopardy began on 02/26/17 and was removed on 03/03/17. An extended survey was conducted.	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309		4/3/17

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

Electronically Signed | 03/21/2017

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 309	Continued From page 1 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to assess and recognize pain for 1 of 4 sampled residents reviewed for pain. (Resident # 4). The findings are: Resident #4 was admitted to the facility on 07/29/16 at 4:00 PM with diagnoses which included: primary lateral sclerosis, cervical myelopathy, neurogenic bladder, and chronic pain. The Admission Data Collection Form dated 07/29/16 assessed the resident as being alert and oriented to person, place and time and revealed the resident was cognitively intact. Record review revealed resident #4 was discharged from the facility on 07/30/16 at approximately 7:00 AM. Admission/Readmission Data Collection Nurse's Notes (not dated but attached to the Admission Documents dated 07/29/16), revealed Resident #4 had been prescribed scheduled and "as needed" (PRN) medications. The medications	F 309	F309- QOC-Pain assessment/interventions 1.)Resident #4 discharged from the facility AMA (Against Medical Advice) on 7/30/16. 2.)By 3/14/17, licensed nurses completed a "Pain Evaluation" of current residents to assess residents current pain score, acceptable level of pain, pain description including; quality, frequency, onset, pattern, contributing factors, alleviating factors, effects and current pain treatment. Treatments and comprehensive care plans for pain management were also updated as appropriate. 3.)By 3/15/17, the DCS (Director of Clinical Services) and registered nurse supervisors reeducated licensed nurses on Policy N-855 "Pain Assessment" and Policy N-860 "Pain Management" regarding the assessment of residents	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 309	Continued From page 2 were: Oxycodone 20 mg oral tablet, extended release - 3 tablets oral every 12 hours and Oxycodone 20 mg oral tablet - 1 tablet oral every 4 hours PRN Pain, Moderate (4-7). The medications were ordered on 07/29/16 and were to be started on 07/29/16. Nurse's Notes written on 07/29/16 at time of resident's admission to the facility indicated the medications had been ordered from the pharmacy. However, no pain assessment had been completed by the facility upon admission of the resident. The Pain Assessment document had been included with the resident's admission packet, but had not been completed (was blank). A pain medication monitoring flow sheet had been completed on 07/30/16. The flow sheet indicated the resident had been experiencing aching pain "all over" and had reported the pain as being a level #7 on a pain scale of 1 to 10, with #10 being the worst pain. Resident #4 had received PRN Oxycodone HCL 20 mg just prior to his discharge and departure from the facility on 07/30/16 at 6:10 AM. An interview conducted with nurse #5 on 03/03/17 revealed she was not sure (and could not recall) why a pain assessment had not been completed for the resident when he was admitted. Nurse #5 stated at the time of the resident's admission, there was a lot going on. She stated resident #4's medications had to be verified, "written up", and had to be faxed to the pharmacy.	F 309	pain upon admission (CNS-030 Admission Data Collection), quarterly (CNS-031 Quarterly Data Collection) and with significant change in condition (CNS-019 Pain Evaluation) to evaluate residents pain score, acceptable level of pain, pain description including; location, quality, frequency, onset, pattern, precipitating/aggravating factors, side effects and current pain treatment, as well as, implementing and revising non-pharmacologic and pharmacologic interventions to manage residents pain per their comprehensive plan of care. Additional education to licensed nurses included the use of CNS-020 “Pain Flow Record” to assess and document new or worsening pain and the implementation of interventions to alleviate pain per the residents’ comprehensive plan of care. By 3/15/17, the DCS and registered nurse supervisors reeducated CNA’s (Certified Nursing Assistants) on utilizing the Interact “Stop and Watch” tool to communicate a residents new or worsening pain to the licensed nurse for further assessment and implementation of interventions to alleviate residents’ pain. The licensed nurse will assess residents for pain upon admission (CNS-030 Admission Data Collection), quarterly (CNS-031 Quarterly Data Collection) and with significant change in condition (CNS-019 Pain Evaluation) to evaluate residents pain score, acceptable level of pain, pain description including; location, quality, frequency, onset, pattern,	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 309	Continued From page 3	F 309	precipitating/aggravating factors, side effects and current pain treatment, as well as, implementing and revising non-pharmacologic and pharmacologic interventions to manage residents pain per their comprehensive plan of care. The licensed nurse will also utilize CNS-020 “Pain Flow Record” to assess and document new or worsening pain and the implementation of interventions to alleviate residents’ pain per the residents’ comprehensive plan of care. The CNA to utilize the Interact “Stop and Watch” tool to communicate a residents new or worsening pain to the licensed nurse for further assessment and implementation of interventions to alleviate residents pain. 4.)The DCS/Registered Nurse Supervisor will conduct Quality Assurance Monitoring of 5 random residents for pain assessment and interventions of pain 3 times a week for 4 weeks, 1 time a week for 8 weeks, then monthly. Schedule for QI monitoring will be modified based on findings. The results of QI monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or designee. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action if necessary to maintain substantial	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 309	Continued From page 4	F 309	compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director, and at least three other members. AOC Date- 4/3/17	
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323		4/3/17

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 5 by: Based on record review, resident interview, family interview, nurse practitioner interview and staff interviews the facility failed to implement interventions for a resident with cognitive impairment (Resident #1), to prevent an elopement on 2/26/17 out a facility bedroom window for one of one sampled residents with exit seeking behavior Resident #1 exited the window, walked 111 feet, going up a steep incline and fell down the incline. Resident #1 sustained a fracture of the left forearm. Immediate jeopardy began on 2/26/17 at 10:21 AM when facility staff failed to monitor Resident #1's whereabouts after exit seeking behavior had been demonstrated. Immediate jeopardy was lifted on 3/3/17 when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedures for identifying residents with elopement behaviors and providing immediate interventions. The findings included: Resident #1 was admitted to the facility on 9/14/2016 with diagnoses including stroke, Alzheimer's Dementia and expressive aphasia. Admission Data Collection Mood and Behaviors dated 9/14/16 indicated Resident #1 was withdrawn and sometimes refused medications. Admission Nurse's Notes indicated the resident was alert and oriented. A cerebrovascular accident resulted in expressive aphasia. The resident ambulated with a cane and	F 323	F323- Safety to Prevent Accidents. 1.)To remove immediate jeopardy for F323 on 3/3/17 THC of Kannapolis has initiated and/or completed the following: On 2/26/17 at 10:05am, Resident #1 was observed leaving church service and walking towards the front door and was then redirected by the certified nursing assistant to her room for distraction. On 2/26/17 at 10:10am, the licensed nurse observed the certified nursing assistant with Resident #1 in her room offering to take resident outside for a walk in an attempt to reduce her agitation however, resident refused. And at 10:15am, the licensed nurse administered Ativan 0.5mg orally x 1 dose for agitation with intentions of reassessing effectiveness. On 2/26/17 at 10:21am, Resident #1 was observed walking outside the rear parking lot by another residents family member who then called out to alert the licensed nurse. The licensed nurses immediately ran outside where they found her on the grassy surface just beyond the parking area. The licensed nurse physically assessed Resident #1 and due to residents complaint of ankle pain, she did not move resident and another licensed nurse received an order and called EMS at approximately 10:45am for transfer to hospital for further evaluation. Licensed	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 6 independently repositioned herself in bed without difficulty. An Elopement Risk Assessment was not available for review in the medical record after admission. Review of the initial care plan for a problem of mood/behavior (no initial date, but an update of 12/15/16) included impaired or inappropriate behaviors, ineffective coping skills, violence to others, wandering and exit seeking behavior. The approaches for exit seeking behavior included to anticipate and address resident needs, psychiatry consult as needed, and safety checks as indicated. Review of the Admission Minimum Data Set (MDS) dated 9/21/16 indicated Resident #1 had short and long term memory problems, no behaviors were exhibited or assessed and she required limited assistance of one staff for activities of daily living. Review of a nurse's note dated 11/5/16 on the "3-11 pm" shift revealed the resident was walking with a cane, was concerned about seeing her sister. She was outside and the aides were assisting her back in the facility. A wanderguard in place. Review of a telephone order dated 11/5/16 at 4:30 PM indicated a wanderguard was to be placed on the resident. A communication form (SBAR) dated 11/5/16 at 6:15 PM, used to notify the physician, indicated the resident was observed outside without staff. The intervention documented as used was	F 323	nurses remained with Resident #1 until EMS arrived and transported her to the hospital at approximately 11:00am. Upon Resident #1's return to facility on 2/26/17 at 5:10pm, Resident #1's window was properly secured by the Maintenance Director to allow only a 4 inch opening and continuous 1:1 supervision was immediately provided by certified nursing assistants until her discharge on 3/1/17 at approximately 1:15pm as mutually agreed by the facility and residents family. On 2/27/17, the Interdisciplinary Team (IDT), consisting of the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, MDS licensed nurses, Social Services, Activities Director, Admissions Director, Human Resources, Dietary Manager and Environmental Services Director, met to review and revise Resident #1's plan of care and additional interventions were initiated to maintain safety, to include 1.) updated "Elopement Risk Assessment" completed , 2.) residents room moved closer to nurses station with bed away from secured window, 3.) non-skid footwear applied and 3.) Social Services initiated transfer to a facility with a secured unit. 2.)On 2/26/17, the Maintenance Director visually and manually inspected facility exit doors and 17 wander guards utilizing the wander guard monitoring system to ensure proper placement and functioning.	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 7 "wanderguard." An Elopement Risk Assessment was not available for review in the medical record after this incident. Review of a nurse's note dated 11/27/16 indicated Resident #1 was agitated around 3:00 PM and tried to go out the front door. The note documented "wants to find her sister." The resident was redirected and had increased agitation. Staff redirected Resident #1 to her room. Around 3:00PM the "C N A (aide) hollers for nurse. And res (resident) was found to be climbing out of window. Staff redirect and res states she wants to go for a walk outside. Staff take res outside and walk with her .... 1 on 1 staff with res this shift." Review of the communication form dated 11/27/16 to the physician indicated the resident attempted to go out bedroom window. Interventions initiated included 1 on 1 for one shift, then every 30 minute checks. The unit manager and maintenance supervisor were notified. An Elopement Risk Assessment was not available for review in the medical record after this incident. Review of the updated care plan of 12/15/16 included impaired or inappropriate behaviors, ineffective coping skills, violence to others, wandering and exit seeking behavior. The approaches for exit seeking behavior included to anticipate and address resident needs, psychiatry consult as needed, and safety checks as indicated.	F 323	On 2/26/17- 2/27/17, the Maintenance Director manually secured all facility windows that open to only allow a 4 inch opening to ensure resident safety. On 2/28/17, licensed nurses completed an “Elopement Risk Assessment” of a census of 85 residents to identify residents currently at risk for eloping and validated appropriate interventions are in place. On 2/28/17, the IDT completed a quality monitoring of residents footwear by visual inspection to validate safe footwear was in place i.e; wander guards, redirection, psychological services, 1:1 supervision and rooms near nurses station for closer visualization and monitoring. On 3/2/17, the IDT conducted a Quality Assurance Performance Improvement (QAPI) Meeting to review, investigate and initiate a Root Cause Analysis (RCA). Root Cause Analysis determined 1.) Windows were not properly secured to prevent elopement and 2.) residents exhibiting exit-seeking behaviors were not properly reassessed and reviewed for additional safety interventions as indicated to prevent elopement and maintain resident safety. On 3/2/17, MDS and social services reviewed and/or revised safety care plans for 11 identified residents at risk for elopement to ensure the plan reflected appropriate interventions to maintain resident safety. Identified changes were	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 8 Review of the Nurse Practitioner's initial visit dated 1/16/17 indicated her group of physicians was assuming care of the resident from another physician's group. The "Assessment and Plan" included in part "1. Vascular Dementia-pt (patient) is at increased risk for eloping. Continue monitoring and ensure wanderguard is in place. Defer to MH (mental health) ..." A nurse's note dated 1/17/17 at 4:20 PM indicated Resident#1 was reviewed by the care plan team. The resident continued to have exit seeking behaviors and was easily redirected by staff. A nurse's note dated 1/19/17 at 2:00 PM documented "Alarm sounding upon entering hallway. Staff inform(ed) this nurse that resident had walked out the door. Staff members outside trying to redirect resident without success. Staff was able to redirect resident and escort her back into facility. Resident was upset, wanted to talk to her friend. Allowed resident to talk to friend at another facility via telephone. After conversing with friend, resident calm down with no further exit seeking noted. NP (nurse practitioner) in facility and informed." A nurse's note dated 1/19/17 at 6:00 PM "RP (Responsible Party) in facility, informed RP of resident elopement attempt. RP inquired again about placement to unit that's secured. Informed RP that SW was working on placing resident to a memory care facility." The care plan had updates of 1/19/17 regarding the resident attempts to exit the building. Approaches included wanderguard alarm and to check placement every shift and function. There	F 323	documented in the medical record and updated on the TAR, Care Plan and Kardex. On 3/2/17, the DCS reviewed residents currently receiving psychological services and on 3/3/17 psychological evaluation orders were received by the physician to ensure residents at risk for elopement are being evaluated for the need of additional services to maintain the well-being and safety of residents. On 3/2/17, the Licensed Nurse/Activities Coordinator/Human Resources Coordinator and Medical Records completed an audit of 87 residents' physician orders from 1/1/17-3/2/17 to validate that 1.) physician orders for psychological evaluations were completed timely as indicated and 2.) physicians' orders for wander guards were in place and transcribed onto the Treatment Administration Record (TAR) with Q shift monitoring for placement and daily function by licensed nurses. On 3/2/17, Elopement Books were verified by the DCS to validate that current assessments, face sheets, demographics and photographs were available for quick reference. 3.)On 3/2/17, the RN supervisor completed an Elopement drill with all department staff in the facility including licensed nurses, certified nursing assistants, dietary staff, maintenance staff, activities staff, laundry staff, MDS	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 9 were no new interventions. The care plan had a problem of "Exit seeking behavior" with the one approach to "Anticipate and address resident needs." The pre-printed approaches for this problem were not identified as an approach, which included "Elopement risk assessment, increase 1:1 monitoring as needed, personal wander prevention device check for placement each shift and function daily, remove the resident from the area and Establish behavior management program Specify___(blank)." Review of the Quarterly Minimum Data Set dated 2/9/17 indicated Resident #1 had long and short term memory impairment, with a Brief Interview for Mental Status (BIMS) of 3. She was required supervision of one person for activities of daily living. The MDS assessed Resident #1 with verbal behaviors towards others and no wandering behavior or rejection of care. Review of the care plan dated 2/9/17 revealed no changes in the problems or approaches for falls or elopement risk. Review of the telephone orders revealed mental health orders were made on 1/7/17, 1/16/17 and again on 2/8/17. Resident #1 was seen by mental health on 2/21/17 and on 2/27/17. Review of their progress notes revealed Resident #1 was seen by a psychologist for mental health assessment/diagnostic interview. Visits were requested by staff due to depression, agitation, wandering and use of psychiatric medications. The safety evaluation included "The patient is at risk for elopement." There were no changes made to medications, and no plan provided to the	F 323	and department heads on 2nd and 3rd shift and again on 1st first shift on 3/3/17 to ensure facility staff were educated on the elopement procedure in the event of a resident elopement. On 2/27/17, the DCS reeducated the IDT including certified nursing assistants on the Elopement Guideline, Missing Resident Search, identifying and responding to residents with exit-seeking behaviors and interventions for residents at risk for elopement which may include but, is not limited to 1:1 supervision, providing activities, back bub or exercise, music, snacks, repositioning, medication review and relaxation techniques to include utilizing the Interact “Stop and Watch” tool to communicate changes in residents behaviors to the nurse supervisor for further assessment. Residents at risk for elopement will be supervised by licensed nurses and certified nursing assistants Q 15 minutes and documented on the “Resident Safety Check” form to monitor and supervise residents for exit seeking behaviors and to identify and implement appropriate interventions to maintain safety. All other present department staff including certified nursing assistants were educated by 3/3/17. Employees will not be permitted to work until education requirement is met. Newly hired staff will be educated upon hire. On 2/27/17, the DCS and RN Supervisor began reeducation to licensed nurses and completed by 3/3/17 on completing	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 10 facility on behavior management for Resident #1. Review of a nurse's note dated 2/26/17 at 11:30 AM revealed Resident #1 was found outside on 2/26/17. The documentation included "Prior to being found, was at church services and left services headed to front redirected to 400 hall. Aide observed resident agitated offered to walk with resident, she refused. Wanted to find pocket (sic) was going on about missing money/and pocketbook. Never seen resident with pocketbook. Administered Ativan at 10:15 (AM) of .5mg x1 po (half a milligram one time orally). Resident's family reported resident outside. She immediately ran outside. Resident on ground in behind oxygen tank outside. Asked what happen Speech unclear pointing to top of hill 'walked up and I fell down.' Unable to measure pain but screaming and cursing when moving left arm and left leg. Notified all transferred via ambulance. Observed window open and screen on ground of resident room." Review of an emergency room report dated 2/26/17 indicated she had fall with a forearm fracture of the radius. A cast was applied to the arm and she was discharged back to the facility. An "Elopement Risk Evaluation" was completed on 2/28/17 with a determination Resident #1 was at risk for elopement. Review of the Social Worker's notes dated 2/27/17 indicated she had called several facilities looking for a memory care bed. The Social Worker note dated 2/28/17 indicated placement was found and the resident was transferred to another facility at 1:30 PM on 2/28/17. The family had previously requested placement in a secure facility.	F 323	"Elopement Risk Assessments", implementation and validation of appropriate interventions to prevent elopement i.e; wander guards, redirection, psychological services, 1:1 supervision and rooms near nurses station for closer visualization and monitoring., obtaining and transcribing timely psychological evaluations orders, wander guard placement with Q shift monitoring orders and updating the residents plan of care to maintain safety. Newly hired licensed nurses will not be permitted to work until education requirement is met. In addition to shift-to-shift visual inspections of wander guard for proper placement and functioning by licensed nurses, the Maintenance Director or trained designee will also inspect that doors remain properly secured and windows remain properly secured allowing only a 4 inch for residents' safety. 4.)The Administrator and/or Registered Nurse designee will conduct Quality Assurance Monitoring of 5 cognitively impaired residents to ensure appropriate interventions are in place to prevent elopement 5 times a week for 4 weeks, 2 times a week for 8 weeks, then monthly. Schedule for QI monitoring will be modified based on findings. The results of QI monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 11 Interview with aide #1, on 3/1/17 at 4:15 PM revealed Resident #1 was usually calm, and she remembered the resident had a wander guard bracelet. Aide #1 explained the resident usually was in her room, but could go about the facility. Aide #1 added the resident would get agitated, and staff would try to calm her down. Aide #1 knew the resident had a wander guard by the aide care plan. When asked how she would monitor those residents with exit seeking behavior, aide #1 explained she would check on them frequently and their whereabouts. Interview with Administrator 3/1/17 at 5:00 PM revealed the book with pictures of residents that were at risk for elopement was not correct. Interview with the Director of Nursing (DON) on 3/1/17 at 5:05 PM revealed an action plan had been started on 2/26/17 due to Resident #1 getting out the window. Their plan had not been completed at this time. The inservices were being presented with the last one on 3/2/17 during staff meeting. A drill for missing resident had been conducted by maintenance. Interview with Nurse #3 on 3/2/17 at 10:35 AM revealed the Elopement Risk Assessment would be completed on a quarterly basis by the nurses on the floor. She did the assessment after the incident on 2/26/17 for Resident #1. Interview with aide #2 on 3/2/17 at 11:29 AM revealed she worked on the 7-3 shift on 2/26/17 and was assigned to Resident #1. She explained the resident could dress herself, she walked with a cane and went to the dining room for meals. On 2/26/17, she was assisted to the church	F 323	designee. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for making changes to the corrective action if necessary to maintain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director, and at least three other members. AOC Date- 4/3/17	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 12	F 323		

activity by aide #2 at 10:00 AM. The resident did not stay in the activity and was coming down the hall. She was stopped by nurse #2. Aide #2 assisted the resident to her room and informed nurse #3 that Resident #1 was going to the front of the building. The aide further explained she stayed with Resident #1 for a while and calmed the resident down. Resident #1 was looking for her pocket book and aide #2 assisted in looking for the item. After a few minutes, aide #2 left Resident #1 and went down the hall to document on the hall computer. She explained it may have been 10 minutes later, a family member was telling a nurse a resident was walking outside the building and was unsteady. Aide #2 went outside and heard yelling. Nurses #2 and #3 went outside with her. They found Resident #1 outside on the ground and was yelling. Resident #1 was found behind the oxygen storage tank that was fenced in, lying on her left side face down. Resident #1 was asked by aide #2 what was she doing and she replied "Looking for my pocketbook." Aide #2 further explained the resident then said she went up the hill to see "up there." The resident was assessed for injuries by the nurses. Resident #1 attempted to stand up, and would grab her left arm. EMS arrived and assessed the resident. They (EMS) said she could not move her fingers and her wrist was swelling.

Interview with nurse #3 on 3/2/17 at 12:00 PM revealed a family member told them a resident was outside. She and aide #2 went out to the back of the facility and found Resident #1 lying on the ground around 10:23 AM. Nurse #4 came outside and called 911 from her phone. The resident was not moved and complained of arm pain when she sat up independently. The EMT

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 13	F 323		

(Emergency Medical Technician) arrived and checked the resident. Nurse #3 gave the time frames of when she saw the resident as: Resident #1 was at church at 10:00 AM, she was at her room and received an Ativan at 10:15 AM.

Continued interview on 3/2/17 at 12:05 PM revealed Nurse #3 explained she saw the window screen "pushed out" and the window was open. A pad was across the window track ledge. Resident #1 informed her she had gone out the window.

Interview with Resident #7 on 3/2/17 at 1:45 PM revealed he was looking out his window and saw a woman walking back and forth on the driveway pavement. He then saw her walk "cross ways" up the hill above the tank (oxygen). The woman then fell and rolled down the hill. His family member left to let the nurses know someone may be hurt outside. He did not know what time this occurred, he stated "It was before lunch."

Interview with Resident #7's family member on 3/2/17 at 1:47 PM revealed she saw the woman outside and walking unsteady. She saw the woman try to climb the hill and fall down. She was only able to see her feet at that point because she was behind the fenced in tank. She did not know the time she was outside, it might have been 10:30 going on 11:00 AM.

Interview with the DON on 3/2/17 at 2:00 PM revealed she would expect the nurses to do an elopement risk assessment if a resident was outside the facility and they had not had "eyes on them." When asked if a risk assessment would have been done for the event on 11/5/16 and 11/27/16 she stated "Yes." No explanation was

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 14	F 323		

provided as to why the assessment was not available in the medical record. The DON explained interventions should be implemented after each incident.

Interview with the maintenance assistant staff on 3/2/17 at 3:00 PM revealed he had not received notification Resident #1 had attempted to exit her bedroom window on 11/27/16.

Interview on 3/3/17 at 10:55 AM with the nurse practitioner (NP) revealed the physician group she works with began care for Resident #1 in January 2017. She was familiar with Resident #1, and had been notified regarding the fall on 2/26/17. She had not been notified of any other behavior issues, or exit seeking behavior prior to 2/26/17. The physician on-call was notified at the time of the incident and she saw the resident on 2/27/17. At the time of that visit, she ordered more x-rays. A visit was made by her on 1/16/17 with a note indicating the resident had vascular dementia and was at increased risk for eloping. Staff were to continue monitoring and ensure wander guard was in place. Her plan was to "Defer to MH." The resident was referred to mental health. The NP explained the resident stayed/associated with the staff more so than with other residents. The staff usually were able to monitor her due to their close association with the resident.

The area behind the facility from the resident's window, across the parking lot, up the hill behind the oxygen storage tank was measured on 3/3/16 at 3:00 PM by a therapy staff member using their rolling distance calculator and measured 111 feet. The dimensions of the opened window was measured using a tape measure on 3/3/17 at

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 15	F 323		

3:10 PM. The window measured 41 inches in width and 44 inches in height. The window ledge was at waist height or about 36 inches from the ground.

On 3/2/17 the Administrator was notified of Immediate Jeopardy at 5:50 PM. The Administrator provided the following credible allegation of compliance on 3/3/17 at 6:00 PM:

To remove immediacy, THC of Kannapolis has initiated and/or completed the following:
On 2/26/17 at 10:05am, Resident #1 was observed leaving church service and walking towards the front door and was then redirected by the certified nursing assistant to her room for distraction.

On 2/26/17 at 10:10am, the licensed nurse observed the certified nursing assistant with Resident #1 in her room offering to take resident outside for a walk in an attempt to reduce her agitation however, resident refused. And at 10:15am, the licensed nurse administered Ativan 0.5mg orally x 1 dose for agitation with intentions of reassessing effectiveness.

On 2/26/17 at 10:21 am, Resident #1 was observed walking outside the rear parking lot by another resident's family member who then called out to alert the licensed nurse. The licensed nurses immediately ran outside where they found her on the grassy surface just beyond the parking area. The licensed nurse physically assessed Resident #1 and due to resident's complaint of ankle pain, she did not move resident and another licensed nurse received an order and called EMS at approximately 10:45am for transfer to hospital for further evaluation. Licensed nurses

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 16	F 323		

remained with Resident #1 until EMS arrived and transported her to the hospital at approximately 11:00am.
Upon Resident #1's return to the facility on 2/26/17 at 5:10pm, Resident #1's window was properly secured by the Maintenance Director to allow only a 4 inch opening and continuous 1:1 supervision was immediately provided by certified nursing assistants until her discharge on 3/1/17 at approximately 1:15pm as mutually agreed by the facility and residents family.

On 2/27/17, the Interdisciplinary Team (IDT), consisting of the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, MDS licensed nurses, Social Services, Activities Director, Admissions Director, Human Resources, Dietary Manager and Environmental Services Director, met to review and revise Resident #1's plan of care and additional interventions were initiated to maintain safety, to include 1.) updated "Elopement Risk Assessment" completed , 2.) residents room moved closer to nurses station with bed away from secured window, 3.) non-skid footwear applied and 3.) Social Services initiated transfer to a facility with a secured unit.
On 2/26/17, the Maintenance Director visually and manually inspected facility exit doors and 17 wander guards utilizing the wander guard monitoring system to ensure proper placement and functioning.

On 2/26/17- 2/27/17, the Maintenance Director manually secured all facility windows that open to only allow a 4 inch opening to ensure resident safety.
On 2/28/17, licensed nurses completed an "Elopement Risk Assessment" of a census of 85

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 17	F 323		

residents to identify residents currently at risk for eloping and validated appropriate interventions are in place.

On 2/28/17, the IDT completed a quality monitoring of residents footwear by visual inspection to validate safe footwear was in place i.e.; wanderguards, redirection, psychological services, 1:1 supervision and rooms near nurse's station for closer visualization and monitoring.
On 3/2/17, the IDT conducted a Quality Assurance Performance Improvement (QAPI) Meeting to review, investigate and initiate a Root Cause Analysis (RCA). Root Cause Analysis determined 1.) windows were not properly secured to prevent elopement and 2.) residents exhibiting exit-seeking behaviors were not properly reassessed and reviewed for additional safety interventions as indicated to prevent elopement and maintain resident safety.

On 3/2/17, MDS and social services reviewed and/or revised safety care plans for 11 identified residents at risk for elopement to ensure the plan reflected appropriate interventions to maintain resident safety. Identified changes were documented in the medical record and updated on the Treatment Administration Record (TAR), Care Plan and Kardex.

On 3/2/17, the DCS reviewed residents currently receiving psychological services and on 3/3/17 psychological evaluation orders were received by the physician to ensure residents at risk for elopement are being evaluated for the need of additional services to maintain the well-being and safety of residents.

On 3/2/17, the Licensed Nurse/Activities

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 18	F 323		

Coordinator/Human Resources Coordinator and Medical Records completed an audit of 87 residents' physician orders from 1/1/17-3/2/17 to validate that 1.) physician orders for psychological evaluations were completed timely as indicated and 2.) physicians' orders for wanderguards were in place and transcribed onto the Treatment Administration Record (TAR) with Q (every) shift monitoring by licensed nurses for proper placement and functioning.
On 3/2/17, Elopement Books were verified by the DCS to validate that current assessments, face sheets, demographics and photographs were available for quick reference.

On 3/2/17, the RN supervisor completed an Elopement drill with all department staff in the facility including licensed nurses, certified nursing assistants, dietary staff, maintenance staff, activities staff, laundry staff, MDS and department heads on 2nd and 3rd shift and again on 1st first shift on 3/3/17 to ensure facility staff were educated on the elopement procedure in the event of a resident elopement.
On 2/27/17, the DCS reeducated the IDT including certified nursing assistants on the Elopement Guideline, Missing Resident Search, identifying and responding to residents with exit-seeking behaviors and interventions for residents at risk for elopement which may include but, is not limited to 1:1 supervision, providing activities, back rub or exercise, music, snacks, repositioning, medication review and relaxation techniques to include utilizing the Interact "Stop and Watch" tool to communicate changes in residents behaviors to the nurse supervisor for further assessment. Residents at risk for elopement will be supervised by licensed nurses and certified nursing assistants Q 15 minutes and

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 19	F 323		

documented on the "Resident Safety Check" form to monitor and supervise residents for exit seeking behaviors and to identify and implement appropriate interventions to maintain safety. All other present department staff including certified nursing assistants were educated by 3/3/17. Employees will not be permitted to work until education requirement is met. Newly hired staff will be educated upon hire.

On 2/27/17, the DCS and RN Supervisor began reeducation to licensed nurses on completing "Elopement Risk Assessments", implementation and validation of appropriate interventions to prevent elopement i.e; wanderguards, redirection, psychological services, 1:1 supervision and rooms near nurses station for closer visualization and monitoring., obtaining and transcribing timely psychological evaluations orders, wanderguard placement with Q shift monitoring orders and updating the residents plan of care to maintain safety. Newly hired licensed nurses will not be permitted to work until education requirement is met.
In addition to shift-to-shift visual inspections of wanderguard for proper placement and functioning by licensed nurses, the Maintenance Director or trained designee will also inspect that doors remain properly secured and windows remain properly secured allowing only a 4 inch for residents' safety.

The validation of the credible allegation was completed on 3/3/17 at 7:30 PM by the following: A review of the audits of all residents for the need of a wander guard, review of the list of residents with wanderguards was reviewed for completion of the elopement risk assessment, orders for wander guards and the shift checks by nursing on

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 323	Continued From page 20 the MARs, and care plan updates. Review of the inservice information and staff signature sheets and interviews were conducted with staff from all three shifts on the information. The elopement notebook was reviewed for current residents on the wanderguard list. Random windows were checked on each hall for the placement of the screw to allow a 4 inch gap. After these reviews and interviews were conducted, the facility had implemented their credible allegation of compliance.	F 323		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to obtain a newly ordered medication for pain management for 1 of 4 sampled residents on a pain management program (Resident #4). The findings included: Resident #4 was admitted to the facility on Friday, 07/29/16 at 4:00 PM with diagnoses which	F 425	F425- Pharmaceutical Services 1.)Resident #4 discharged from the facility AMA (Against Medical Advice) on 7/30/16. 2.)By 3/14/17, licensed nurses reviewed current residents with orders for pain medication to ensure medication availability by physical observation of medication in medication cart per physicians' orders. No discrepancies were	4/3/17

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 425	Continued From page 21	F 425		

included primary lateral sclerosis, cervical myelopathy, neurogenic bladder, urinary retention, chronic pain and depression. The Admission Data Collection Form dated 07/29/16 assessed the resident as being alert and oriented to person, place and time and revealed resident could understand others and others could understand resident. The Admission Data Collection Form revealed resident #4 was on a scheduled and "as needed" (PRN) pain regimen, however, no pain assessment had been completed by the facility upon admission.

Hospital discharge medications included orders for scheduled Oxycodone 20 mg ER (extended release) to be given by mouth three times a day every 12 hours to start on 07/29/16. Orders for "as needed" (PRN) pain medication of Oxycodone 20 mg had also been prescribed. Resident was to receive 1 tablet by mouth every 4 hours as needed for moderate pain on a pain scale of 4 to 7, with 7 being the more severe pain. The PRN pain medication was also to be started on 07/29/16.

The facility's Medication Administration Record (MAR) dated 07/29/16 through 07/30/16 indicated no Oxycodone pain medication had been administered to the resident on 07/29/16 as ordered. Medical records revealed the Oxycodone medication was unavailable until the morning of 07/30/16. Resident #4 did not receive the PRN medication ordered until 07/30/16 at 6:10 AM, just prior to the resident leaving the facility against medical advice.

Interview on 03/03/17 (3:20 PM) with nurse #4 revealed the facility received their medications from the contract pharmacy. She stated if a

identified.

3.) By 3/15/17, the DCS or RN Supervisor reeducated licensed nurses on the policies and procedures for ordering, administering and documenting pain medications. Education included the process for faxing routine orders and calling in STAT orders to pharmacy, as well as, the use of back-up Emergency Kit medications and the use of the back-up after hours pharmacy to ensure timely administration of pain medication for residents on a pain management program.

The licensed nurse will be responsible for ordering pain medications timely per physicians orders by faxing routine orders and calling in STAT orders to pharmacy, as well as, using back-up Emergency Kit medications and the using back-up after hours pharmacy to ensure timely administration of pain medication for residents on a pain management program.

In the event that the medication is not available timely from the back-up pharmacy or back-up E-kit for administration, the nurse will notify the physician for additional treatment orders to alleviate pain until medication becomes available.

4.)The DCS or Registered Nurse designee will conduct Quality Assurance Monitoring of 5 random residents to ensure timely processing and

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 425	Continued From page 22 resident was coming from a hospital, the facility would receive a copy of the resident ' s discharge summary which contained medication orders and the unit coordinator would then begin the process of obtaining the resident ' s medications. The nurse stated the unit coordinator would work on the admission packet (paperwork) while the floor nurses usually worked on the floor assisting residents with their needs. She relayed that nurses did not order medications for new residents until the residents had arrived at the facility. She mentioned the facility had a lock box where backup bags of narcotics were stored and stated the narcotics were "double-locked". Nurses were told to try and obtain controlled medications from the narcotic backup boxes first if the medication(s) were in stock. The nurse explained if the facility did not have the proper medications in stock for the resident, the nurses would contact the pharmacy and have them send the medication(s) to them. She stated nurses could also call the "Smart pager" which went directly to the physician on call. That way, the physician could order a similar medication that may be in stock until the originally ordered medication arrived from the pharmacy. She stated if the medications were ordered from the pharmacy before 5:00 PM, the medications would usually arrive on the first run from the pharmacy (11:30 PM or 12:00 AM). She mentioned if a medication had been ordered from the pharmacy and did not arrive with the other medications ordered, the nurse would call the pharmacy back and "stat the medication out" (re-order the medications immediately). She stated if that happened, it would probably take another 2 or 3 hours to get the medications. The nurse stated she had worked at the facility since August of 2016 and was not aware of any problems concerning a	F 425	administration of pain medications as ordered 3 times a week for 4 weeks, 1 time a week for 8 weeks, then monthly . Schedule for QI monitoring will be modified based on findings. The results of QI monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or designee. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for making changes to the corrective action if necessary to maintain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director, and at least three other members. AOC- 4/3/17	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 425	Continued From page 23	F 425		

resident not getting their medications on time. Nurse #4 explained that unit nurses often assisted with new admissions and ordered resident ' s medications, but stated any of the nurses could order the medications.

An interview on 03/03/17 at 4:45 PM with nurse #1 revealed when nurses processed medications for an emergency order, nurses had to call the "on-call" physician and then had to communicate with the pharmacy. Staff would just have to wait until the medication arrived. Nurse stated she was not aware of any newly admitted residents that were not able to get their medications on time.
Nurse #1 revealed she often carried the keys for the backup narcotic medications and stated the facility now had an agreement with a local backup pharmacy. She stated the new system for obtaining medications had been put in place around February of 2017, about the same time the physicians employed at the facility changed. The nurse stated they can now use the local pharmacy for 72 hour/emergency medication orders instead of having to wait to get them from the primary pharmacy. To begin the process, the nurse would contact the primary pharmacy. The primary pharmacy would then contact the backup pharmacy and arrange to have the medication picked up or delivered to the facility.

An interview conducted with the director of nursing (DON) on 03/03/17 at 4:30 PM revealed she expected medication orders to be processed in a timely manner as soon as the orders had been verified by the physician. She expected the nurses to have the medications verified and faxed to the pharmacy as soon as possible. The DON stated when medications were ordered from the

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 425	Continued From page 24 pharmacy, she expected it to take 3 or 4 hours to receive the medications. If the facility ordered something the facility or resident needed right away, she stated it could still take about 3 or 4 hours. Medications for stat orders were not delivered on a normal route. The DON stated she did not recall a time when a resident did not get their medication(s) on time or when it took an extended amount of time to get the medications. An observation of the backup narcotics box on 03/03/17 at 4:55 PM revealed the facility did not stock the Oxycodone 20 mg medication(s) ordered for resident #4.	F 425		
F 520 SS=J	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as	F 520		4/3/17

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 520	Continued From page 25 identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place. This was for one recited deficiency that was cited on 6/12/15, 5/19/16 on recertification surveys and subsequently recited in February 2017 on a complaint survey. The deficiency was in the area of supervision to prevent accidents (F323). The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. Resident #1 sustained a fracture of her left forearm (radial). Immediate jeopardy began on 2/26/17 at 10:21 AM when facility staff failed to monitor Resident #1's whereabouts after exit seeking behavior had	F 520	F520- QA 1.)To remove immediate jeopardy for F323 on 3/3/17, THC of Kannapolis has initiated and/or completed the following: On 2/26/17 at 10:05am, Resident #1 was observed leaving church service and walking towards the front door and was then redirected by the certified nursing assistant to her room for distraction. On 2/26/17 at 10:10am, the licensed nurse observed the certified nursing assistant with Resident #1 in her room offering to take resident outside for a walk in an attempt to reduce her agitation however, resident refused. And at 10:15am, the licensed nurse administered	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 520	Continued From page 26	F 520		

been demonstrated. Immediate jeopardy was lifted on 3/3/17 when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to allow the facility time to monitor and fully implement the new procedures for identifying residents with elopement behaviors and providing immediate interventions.

The findings included:
This tag is crossed referenced to F:323: Based on record review, resident interview, family interview, nurse practitioner interview and staff interviews the facility failed to implement interventions for resident #1, to prevent an elopement on 2/26/17 out a facility bedroom window for one of one sampled residents with exit seeking behavior. Resident #1 had attempted an elopement on 11/25/16 out the same window. Resident #1 exited the window, walked 111 feet, going up a steep incline and fell down the incline. Resident #1 sustained a fracture of the left forearm.

During the recertification of 5/19/16: Based on observations, record review and staff interviews the facility failed to supervise 1 of 3 residents assessed as an unsafe smoker.

During the recertification of 6/12/15: Based on record review, resident interview and staff interview the facility failed to manage inappropriate behaviors and implement effective interventions for 1 of 1 sampled residents (Resident #203) who exposed himself to a resident (Resident #59) and inappropriately touched residents

Ativan 0.5mg orally x 1 dose for agitation with intentions of reassessing effectiveness.

On 2/26/17 at 10:21am, Resident #1 was observed walking outside the rear parking lot by another residents family member who then called out to alert the licensed nurse. The licensed nurses immediately ran outside where they found her on the grassy surface just beyond the parking area. The licensed nurse physically assessed Resident #1 and due to residents complaint of ankle pain, she did not move resident and another licensed nurse received an order and called EMS at approximately 10:45am for transfer to hospital for further evaluation. Licensed nurses remained with Resident #1 until EMS arrived and transported her to the hospital at approximately 11:00am.

Upon Resident #1's return to facility on 2/26/17 at 5:10pm, Resident #1's window was properly secured by the Maintenance Director to allow only a 4 inch opening and continuous 1:1 supervision was immediately provided by certified nursing assistants until her discharge on 3/1/17 at approximately 1:15pm as mutually agreed by the facility and residents family.

On 2/27/17, the Interdisciplinary Team (IDT), consisting of the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, MDS licensed nurses, Social Services, Activities Director, Admissions Director, Human Resources, Dietary Manager and

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 520	Continued From page 27 Interview with the Administrator on 3/2/17 at 2:05 pm revealed the facility had a QA and A program that met on a regular basis. The accident/incidents were reviewed Monday through Friday in their morning meeting. The facility had monitored accidents and incidents but did not have a QA plan in place for resident elopements. On 3/2/17 the Administrator was notified of Immediate Jeopardy at 5:50 PM. The Administrator provided the following credible allegation of compliance on 3/3/17 at 6:00 PM: On 2/26/17 at 10:21 am, Resident #1 was observed walking outside the rear parking lot by another resident's family member who then called out to alert the licensed nurse. The licensed nurses immediately ran outside where they found her on the grassy surface just beyond the parking area. The licensed nurse physically assessed Resident #1 and due to resident's complaint of ankle pain, she did not move resident and another licensed nurse received an order and called EMS at approximately 10:45am for transfer to hospital for further evaluation. Licensed nurses remained with Resident #1 until EMS arrived and transported her to the hospital at approximately 11:00am. Upon Resident #1's return to facility on 2/26/17 at 5:10pm, Resident #1's window was properly secured by the Maintenance Director to allow only a 4 inch opening and continuous 1:1 supervision was immediately provided by certified nursing assistants until her discharge on 3/1/17 at approximately 1:15pm as mutually agreed by the facility and residents family. On 2/27/17, the Interdisciplinary Team (IDT),	F 520	Environmental Services Director, met to review and revise Resident #1's plan of care and additional interventions were initiated to maintain safety, to include 1.) updated "Elopement Risk Assessment" completed , 2.) residents room moved closer to nurses station with bed away from secured window, 3.) non-skid footwear applied and 3.) Social Services initiated transfer to a facility with a secured unit. 2.)On 2/26/17, the Maintenance Director visually and manually inspected facility exit doors and 17 wander guards utilizing the wander guard monitoring system to ensure proper placement and functioning. On 2/26/17- 2/27/17, the Maintenance Director manually secured all facility windows that open to only allow a 4 inch opening to ensure resident safety. On 2/28/17, licensed nurses completed an "Elopement Risk Assessment" of a census of 85 residents to identify residents currently at risk for eloping and validated appropriate interventions are in place. On 2/28/17, the IDT completed a quality monitoring of residents footwear by visual inspection to validate safe footwear was in place i.e; wander guards, redirection, psychological services, 1:1 supervision and rooms near nurses station for closer visualization and monitoring. On 3/2/17, the IDT conducted a Quality	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 520	Continued From page 28 consisting of the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, MDS licensed nurses, Social Services, Activities Director, Admissions Director, Human Resources, Dietary Manager and Environmental Services Director, met to review and revise Resident #1's plan of care and additional interventions were initiated to maintain safety, to include 1.) updated "Elopement Risk Assessment" completed , 2.) residents room moved closer to nurses station with bed away from secured window, 3.) non-skid footwear applied and 3.) Social Services initiated transfer to a facility with a secured unit. The Regional Director of Clinical Services reeducated the IDT on 3/3/17 on Federal Regulation F 520 and Consulates QAPI Committee Policy regarding the expectations regarding maintaining an ongoing Quality Assurance and Performance Improvement (QAPI) program. The QAPI Committee consists of the Executive Director, Director of Clinical Services, Medical Director and at least 3 other members and meets at least monthly (Medical Director at least quarterly). Education also included the processes and procedures of implementing, reviewing and revising ongoing action plans for areas of deficiency that have been identified to attain and maintain substantial regulatory compliance and provide the highest level of care to residents. Newly hired IDT employees will be educated upon hire. The Regional Director of Clinical Services or the Regional Vice President of Operations will attend QAPI meetings at a minimum of quarterly to assure compliance with Federal Regulation F 520 to sustain and maintain compliance with Federal Regulation F 323-Resident Safety to include ongoing monitoring and revisions to the plan as	F 520	Assurance Performance Improvement (QAPI) Meeting to review, investigate and initiate a Root Cause Analysis (RCA). Root Cause Analysis determined 1.) windows were not properly secured to prevent elopement and 2.) residents exhibiting exit-seeking behaviors were not properly reassessed and reviewed for additional safety interventions as indicated to prevent elopement and maintain resident safety. On 3/2/17, MDS and social services reviewed and/or revised safety care plans for 11 identified residents at risk for elopement to ensure the plan reflected appropriate interventions to maintain resident safety. Identified changes were documented in the medical record and updated on the TAR, Care Plan and Kardex. On 3/2/17, the DCS reviewed residents currently receiving psychological services and on 3/3/17 psychological evaluation orders were received by the physician to ensure residents at risk for elopement are being evaluated for the need of additional services to maintain the well-being and safety of residents. On 3/2/17, the Licensed Nurse/Activities Coordinator/Human Resources Coordinator and Medical Records completed an audit of 87 residents' physician orders from 1/1/17-3/2/17 to validate that 1.) physician orders for psychological evaluations were completed timely as indicated and 2.)	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 520	Continued From page 29 necessary. The validation of the credible allegation was completed on 3/3/17 at 7:30 PM by the following: Review of the inservice information and staff signature sheets and interviews were conducted with Administrative staff on the information. Review of the audits for elopement assessments, and the QA minutes of 3/2/17 were completed.	F 520	physicians' orders for wander guards were in place and transcribed onto the Treatment Administration Record (TAR) with Q shift monitoring for placement and daily function by licensed nurses. On 3/2/17, Elopement Books were verified by the DCS to validate that current assessments, face sheets, demographics and photographs were available for quick reference. 3.)On 3/2/17, the RN supervisor completed an Elopement drill with all department staff in the facility including licensed nurses, certified nursing assistants, dietary staff, maintenance staff, activities staff, laundry staff, MDS and department heads on 2nd and 3rd shift and again on 1st first shift on 3/3/17 to ensure facility staff were educated on the elopement procedure in the event of a resident elopement. On 2/27/17, the DCS reeducated the IDT including certified nursing assistants on the Elopement Guideline, Missing Resident Search, identifying and responding to residents with exit-seeking behaviors and interventions for residents at risk for elopement which may include but, is not limited to 1:1 supervision, providing activities, back bub or exercise, music, snacks, repositioning, medication review and relaxation techniques to include utilizing the Interact "Stop and Watch" tool to communicate changes in residents behaviors to the nurse supervisor for further assessment. Residents at risk for elopement will be	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 520	Continued From page 30	F 520	supervised by licensed nurses and certified nursing assistants Q 15 minutes and documented on the “Resident Safety Check” form to monitor and supervise residents for exit seeking behaviors and to identify and implement appropriate interventions to maintain safety. All other present department staff including certified nursing assistants were educated by 3/3/17. Employees will not be permitted to work until education requirement is met. Newly hired staff will be educated upon hire. On 2/27/17, the DCS and RN Supervisor began reeducation to licensed nurses and completed by 3/3/17 on completing “Elopement Risk Assessments”, implementation and validation of appropriate interventions to prevent elopement i.e; wander guards, redirection, psychological services, 1:1 supervision and rooms near nurses station for closer visualization and monitoring., obtaining and transcribing timely psychological evaluations orders, wander guard placement with Q shift monitoring orders and updating the residents plan of care to maintain safety. Newly hired licensed nurses will not be permitted to work until education requirement is met. In addition to shift-to-shift visual inspections of wander guard for proper placement and functioning by licensed nurses, the Maintenance Director or trained designee will also inspect that doors remain properly secured and	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 520	Continued From page 31	F 520	windows remain properly secured allowing only a 4 inch for residents' safety. The Regional Director of Clinical Services reeducated the IDT on 3/3/17 on Federal Regulation F520 and Consulates QAPI Committee Policy regarding the expectations regarding maintaining an ongoing Quality Assurance and Performance Improvement (QAPI)program. The QAPI Committee consists of the Executive Director, Director of Clinical Services, Medical Director and at least 3 other members and meets at least monthly (Medical Director at least quarterly). Education also included the processes and procedures of implementing, reviewing and revising ongoing action plans for areas of deficiency that have been identified to attain and maintain substantial regulatory compliance and provide the highest level of care to residents. Newly hired IDT employees will be educated upon hire. 4.)The Administrator and/or Registered Nurse designee will conduct Quality Assurance Monitoring of 5 cognitively impaired residents to ensure appropriate interventions are in place to prevent elopement 5 times a week for 4 weeks, 2 times a week for 8 weeks, then 1 time a month for 9 months. Schedule for QI monitoring will be modified based on findings. The results of QI monitoring will be	

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 _____	C 03/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD 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 520	Continued From page 32	F 520	reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or designee. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for making changes to the corrective action if necessary to maintain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director, and at least three other members. The Regional Director of Clinical Services or the Regional Vice President of Operations will attend QAPI meetings at a minimum of quarterly to monitor and assure the facility's Quality Assessment and Assurance Committee maintains implemented procedures and monitors these interventions that the committee put into place. Ongoing monitoring, revisions to the plan of correction, reeducations and/or disciplinary action will be addressed as necessary. AOC- 4/3/17	