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 03/22/2018

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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		4/17/18

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

Electronically Signed | 04/06/2018

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to implement the intervention of the comprehensive person - centered care plan to perform quarterly Braden Scale assessments for two of two residents reviewed for comprehensive care plans (Resident # 3 and Resident # 4). Findings included: 1. Resident # 3 was admitted 03/20/2015 and readmitted 12/14/2017 with diagnoses that included left below the knee amputation (LBKA), end stage renal disease (ESRD), diabetes mellitus type 2 (DM2) and muscle weakness. The quarterly Minimum Data Set (MDS) dated 01/12/2018 assessed Resident # 3 to be cognitively intact, and to be at risk for the development of a pressure ulcer. A review of a care plan updated 02/15/2018 revealed a care plan that read in part that Resident # 3 was at risk for further skin breakdown due to frequent incontinence and impaired mobility. The care plan goal was that Resident # 3 would have no further skin breakdown through the next review. An intervention was to perform a Braden scale (a scale used to predict pressure sore risk) quarterly. A chart review revealed a Braden scale was completed for Resident # 3 on 05/05/2016 and there had been no Braden scale completed since	F 656	Preparation and/or execution of this plan does not constitute agreement or admission by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Root Cause Completed 1) Resident #3 and #4's quarterly Braden Scale Assessment updated 3/21/18. Resident #3 and #4's care plans amended 4/5/18 to reflect comprehensive person centered information. Braden scale completion upon admission/readmission to be validated by Director of Nurses (DON)/Unit Manager (UM)/Designee during Morning Clinical Meeting. Quarterly Braden Scale Assessment completion to be validated by UM/Designee during quarterly care plan/Minimum Data Set (MDS)update. 2) Director of Nursing (DON)/designee conducted a Quality Review of current residents for updated quarterly Braden Scale Assessments on 3/21/18. DON/MDS Coordinator/Designee conducted a Quality Review of current resident's care plans for person centered interventions on 4/10/18. Follow up based on findings.	

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F 656	Continued From page 2 that date. 2. Resident # 4 was admitted on 04/30/2015 with diagnoses that included osteoarthritis, chronic pain, anemia and a chronic non- pressure ulcer of the foot. The quarterly MDS dated 01/08/2018 assessed Resident # 4 with significant cognitive impairment and had an infection of the foot. A review of a care plan for Resident # 4 that was most recently updated on 03/07/2018 included that Resident # 4 had the potential for further skin integrity issues related to incontinence and impaired mobility. The goal was that Resident # 4 would not develop any new skin breakdown through the next review with an intervention to perform a Braden scale assessment quarterly. A chart review revealed a Braden scale was completed for Resident # 4, the Braden scale was not dated. An interview was conducted on 03/21/2018 at 11:13 AM with the wound nurse that revealed that the unit nurses were responsible for completing the quarterly Braden scales. On 03/22/2017 at 1:39 PM with the Unit Manager revealed that the electronic record system had started in October of 2017 and that the Braden scale assessments had not ben input yet to trigger the unit nurses to complete the quarterly Braden scale assessments. The Unit Manager revealed the unit nurses were responsible for completing the quarterly Braden scale assessments and it was the expectation that the interventions on the care plans be followed as written.	F 656	3) Minimum Data Set (MDS) department received re-education by Regional MDS Coordinator regarding regulation and developing person centered care plans on 4/6/18. DON re-educated licensed nurses regarding person centered care plans and completion of Braden Scale Assessments on 4/6/18. 4) DON/Designee to conduct Quality Improvement Monitoring of Care plans for person centered interventions utilizing the Morning Clinical Meeting Process daily x 5 days, weekly x 4 weeks then monthly x 9 months and prn (as needed). Regional MDS Coordinator to conduct quality improvement monitoring of care plans quarterly and prn. DON/Unit Manager (UM)/Designee to conduct Quality Improvement Monitoring of new admissions/re-admission records for completion of Braden scale assessment utilizing the Morning Clinical Meeting process daily x 5 days, weekly x 4 weeks, monthly x 9 months and prn. DON/UM/Designee to conduct Quality Improvement Monitoring of Braden Scale Assessment for timely completion monthly x 2 months then quarterly and as needed. Findings to be reviewed at monthly Quality Assurance Performance Improvement Committee Meeting. (QAPI)Monitoring schedule to be modified based on findings.	

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F 656	Continued From page 3 The Division Director of Clinical Services was interviewed at 2:00 PM on 03/22/2018 and revealed that the facility was currently scheduling all Braden scale assessments for all residents into the electronic record system so that the assessment would trigger quarterly for each resident.	F 656		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		4/17/18

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F 842	Continued From page 4 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 842	Root Cause Completed	

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F 842	Continued From page 5 facility failed to document a physical assessment for 1 of 1 residents (resident #10) who had a Clysis IV (subcutaneous intravenous devise placed in the residents abdomen) over a 5 day period and the facility failed to document a physical assessment for 1 of 1 residents (resident #1) following an unwitnessed fall in her room. Findings included: 1: Resident #10 was admitted to the facility on 8-25-17 with an initial admission date of 8-15-2007 with multiple diagnoses which included muscle weakness, dementia, feeding difficulties, dysphagia and cognitive communication deficit. The Minimum Data Set (MDS) dated 3-8-18 revealed that the resident was severely cognitively impaired and coded as needing extensive assistance with 2 people for bed mobility, extensive assistance with one person for transfers, dressing, toileting and personal hygiene and supervision with set up help only for eating. Resident #10's care plan dated 2-8-18 revealed a goal that the resident would be free from impaired skin integrity. The interventions for this goal were as follows; check for incontinence and provide incontinence care after each episode, notify physician of change in condition, offer and encourage fluid intake. A review of resident #10's labs dated 3-16-18 revealed that she had a high sodium reading of 150. The normal lab values for sodium are 135 to 146. The physician orders dated 3-16-18 revealed that the physician ordered 0.45% normal saline to run	F 842	1) Physical Assessment of resident #10 and #1 completed on 4/5/18. Documentation of residents physical assessment post fall and when receiving IV fluids to be validated by Director of Nursing (DON) /UM/Designee utilizing the Morning Clinical Meeting process. 2.) Quality Review of resident experiencing a fall within the last 30 days completed by the Director of Nursing (DON)/Unit Manager (UM)/ Designee 3/22/18, to ensure physical evaluation/assessment completed. Quality Review of current residents receiving IV fluids utilizing a subcutaneous device completed by the DON/UM/Designee to ensure a physical evaluation / assessment completed on 3/21/18. Follow up based on findings. 3) Licensed nurses re-educated on 4/6/18 by the Regional Director of Clinical Services (RDCS)/UM/designee regarding performing a physical evaluation/assessment of residents post fall. Licensed nurses re-educated on 4/6/18 by the RDCS/UM/designee performing a physical evaluation/assessment of residents receiving IV fluid utilizing a subcutaneous intravenous device. 4) DON/UM/Designee to conduct Quality Improvement Monitoring utilizing the Morning Clinical Meeting Process of residents experiencing a fall receiving a physical evaluation/assessment 5 x	

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F 842	Continued From page 6 at 75cc/hour (75 cubic centimeters per hour) and that resident #10 was to receive 2 liters by a Peripheral or Clysis intravenous devise. When reviewing the electronic and hard chart medical record there was a late entry on 3-21-18 at 10:00pm explaining that the IV was started on second shift on 3-16-18 and that the Clysis IV was placed into resident #10's abdomen without any difficulties and that the IV was infusing without any complications. A further review of the medical record revealed that there was no assessment of the IV site or the resident from 3-16-18 to 3-21-18. The nurse case manager was interviewed on 3-22-18 at 11:00am and he stated that the Clysis IV was removed on 3-21-18 from resident #10's abdomen after he had spoken with the Nurse Practitioner. An interview with the nurse weekend supervisor occurred on 3-22-18 at 11:15am. The nurse stated she believed the other nurse who was working with her was going to document the IV procedure and the infusion of the saline solution and then stated she was not familiar with the electronic medical record and did not know how to enter a nursing note into the system. An attempt was made to speak with the other nurse present for the IV procedure however she no longer had worked for the facility and was not able to be reached. The Nurse Practitioner was interviewed on 3-22-18 at 12:15pm. She stated that the Clysis IV was to remain in place till further labs were	F 842	weekly x 4 weeks, 3 x weekly x 4 weeks, weekly x 4 weeks, then monthly x 9 months and as needed. DON/UM/Designee to conduct Quality Improvement Monitoring utilizing Morning Clinical Meeting Process of residents receiving IV fluid with a subcutaneous intravenous device receive physical evaluation/assessment 5 x weekly x 4 weeks, 3 x weekly x 4 weeks, weekly x 4 weeks, then monthly x 9 months and as needed. Findings to be reviewed at monthly Quality Assurance Performance Improvement (QAPI) Committee meeting. Monitoring schedule modified based on findings.	

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F 842	Continued From page 7	F 842		

collected and reviewed and that she would expect to see documentation from the nursing staff related to how the IV site looked each day it was in place and how the resident was tolerating having the IV in place.

An attempt was made to interview resident #10 but the resident asked to be left alone as she was not feeling well.

The Administrator was interviewed on 3-22-18 at 1:30pm. The Administrator stated she expected her staff to follow the company's policies and procedures regarding documentation and assessment of IV sites.

2: Resident #1 was admitted to the facility on 8-4-17 with multiple diagnoses that included major depression, anxiety, muscle weakness and dementia.

The Minimum Data Set (MDS) dated 2-6-18 revealed that resident #1 was severely cognitively impaired and was independent with needing no assistance for bed mobility, transfers, walking in or out of her room, locomotion on or off the unit and toileting. Resident #1 was coded as independent with set up help only for eating and supervision with set up help only for personal hygiene. The MDS revealed that the resident was coded for falls.

Resident #1's care plan dated 3-1-18 revealed a goal that the resident would not injure themselves in a fall. The interventions for this goal were as follows; provide a safe environment, use adaptive equipment if needed, encourage the resident to wear her glasses, provide appropriate foot wear, follow facilities fall protocol and maintain a clear

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F 842	Continued From page 8	F 842		

pathway.

A review of the incident reports revealed that resident #1 had an unwitnessed fall on 1-9-18 and that she was found in her room on the floor beside her bed. The documentation in the report documented that the resident did not have any injury related to that fall and that an assessment was completed and documented in the medical record.

A review of the electronic and hard copy of the medical record revealed that there was no physical assessment documented of resident #1 after her fall.

An interview with resident #10 occurred on 3-20-18 at 2:00pm. The resident was unable to remember if she had any falls in January. The resident stated she does fall sometimes because "I shake all over and I can't stop it."

The Unit Manager was interviewed on 3-21-18 at 9:30am and she stated that after a resident had a fall the nurse was required to complete an S-Bar form (the facilities physical assessment form), fall assessment, pain assessment and neurological checks if indicated. She went on to state that she did not know why there was not a note or S-Bar form completed after resident #1's fall on 1-9-18.

An interview with the nurse who wrote the incident report occurred on 3-21-18 at 9:49am. The nurse stated she remembered resident #1 falling on 1-9-18 and doing the incident report but that she could not remember any specifics. She stated "all the information should be in my note or on the S-Bar form". The nurse stated she did not know what happened to the note or S-Bar form

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F 842	Continued From page 9 because she did complete one. The Administrator was interviewed on 3-22-18 at 1:30pm. The Administrator stated that she expected that her staff would complete an S-Bar form and a note following each fall.	F 842		