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 09/10/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 9/3-6/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GVW611.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and compliant survey were conducted from 9/3/2019 through 9/6/2019, event # GVW611. 7 of the 38 complaint allegations were substantiated resulting in deficiencies F561, F626, F693, F755, F759, and F842.	F 000		
F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561		10/8/19

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

Electronically Signed | 10/02/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 561	Continued From page 1 community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to honor a resident ' s choice to use the toilet instead of a bedpan for 1 of 1 resident reviewed for choices (Resident #181). The facility's failure to respect the resident's choice resulted in the resident utilizing Emergency Medical Services (EMS) for bathroom assistance and the resident experienced bladder pain lasting more than one day. Findings included: Review of the Level of care screening tool (FL2) completed by the primary physician and dated 9/28/2018 documented Resident #181 was alert, oriented and cognitively intact and without physical or verbal behaviors. A hospital physician discharge summery dated 9/27/2018 documented Resident #181 was alert and oriented. The hospital discharge instructions dated 9/27/2018 specified that Resident #181 was partial weight-bearing on her right leg with toe-touch weight-bearing and ordered a skilled nursing home physical therapy evaluation. Resident #181 was admitted to the facility on 9/29/2018 with diagnoses to include hypertension and revision of right hip replacement. Resident	F 561	F 561 1. There is no corrective action to perform at this time, resident #181 was admitted and discharged on 9/29/2018. 2. Residents admitted to facility who are in need of assistance for transfers for toileting have the potential to be affected by this practice. 3. Completed by 10-8-19 the Director of Nursing/Assistant Director of Nursing educated staff on the importance of giving all options for toileting, within safe and reasonable perimeters. Per education; Nursing will perform a transfer assessment ,notify Medical Director and offer resident appropriate options. (Bed pan, Bed side commode, Wheelchair) 4. DON/Designee will audit new residents who need transfer assistance for toileting regarding preferences 3 x weeks for 4 weeks, then 1 x week for 2 months and then 1 x monthly for 3 months. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee will meet monthly and as	

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F 561	Continued From page 2	F 561		

#181 was discharged on 9/29/2018. The admission Minimum Data Set (MDS) assessment was not completed. A nursing admission assessment was not completed.

The discharge MDS dated 9/30/2018 noted Resident #181 was discharged to the hospital.

A nursing note written by Nurse #14 and dated 9/30/2018 at 12:43 AM noted Resident #181 requested to use the toilet on 9/29/2018 at 3:45 PM. The note documented the nursing assistant (NA) had instructed Resident #181 she could not be transferred from the bed to walk to the toilet without a physical therapy evaluation and Resident #181 was offered the use of a bedpan. The nursing note documented Resident #181 was upset and she refused to use the bedpan and Resident #181 called "911" to request transfer from the facility to the hospital at 8:20 PM on 9/29/2018.

Resident #181 was interviewed by phone on 9/3/2019 at 5:30 PM and she reported she had been able to ambulate to the bathroom while hospitalized with one-person assistance and the use of a walker. Resident #181 explained she felt confident she could ambulate to the bathroom with assistance and explained to Nurse #14 that was her choice. Resident #181 reported she had a lot of pain from her surgery and that using a bedpan was too uncomfortable for her and she tried to explain to Nurse #14, but he would not allow her to get up to the toilet. The resident explained she had not been able to void her bladder until after she had called 911 and the emergency medical transporters assisted her to ambulate to the bathroom. Resident #181 reported called 911 for transport back to the

needed.
Date of Compliance Oct 8, 2019

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F 561	Continued From page 3	F 561		

hospital because she was not provided with the assistance she felt was necessary. Resident #181 reported she had bladder pain for several days after leaving that facility because she was unable to void her bladder when she first had the urge. Resident #181 reported she was readmitted to the hospital.

Nurse #14 was interviewed by phone on 9/6/2019 at 1:57 PM. He reported he remembered Resident #181 and she had requested to use the toilet after she was admitted to the facility. Nurse #14 reported he had instructed her to use the bedpan and he would assist her, but she refused. The nurse reported he had attempted to explain to Resident #181 he did not want her to fall and she needed to wait for the physical therapist to evaluate her before she got out of bed to ambulate. Nurse #14 explained he had not offered to transfer Resident #181 to the toilet by a wheelchair or use of a bed-side commode because Resident #181 would have had to bear weight on her right leg to transfer. The nurse stated he had not called the physician to get activity orders clarified for Resident #181 and he had not assisted her to the toilet.

Nurse #12 was interviewed on 9/6/2019 at 10:18 AM and she reported when a resident was admitted to the facility with orthopedic diagnoses, the staff usually waited until physical therapy evaluated their activity level before they were gotten out of bed. Nurse #12 further explained if a resident had discharge orders from the hospital that specified they were able to ambulate with assistance, she followed those orders until physical therapy was able to complete the evaluation.

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F 561	Continued From page 4 The Rehabilitation Director (RD) was interviewed on 9/6/2019 at 10:33 AM and she reported that new admissions to the facility were evaluated by physical therapy within 24 hours of admission, but if a resident wanted to get out of bed and the hospital discharge orders stated they could get out of bed with equipment and physical assistance, the resident should be gotten up by nursing staff. The RD reported that the physical therapist on duty on 9/29/2018 had left for the day when Resident #181 was admitted and the physical therapy staff had planned to perform her assessment in the morning on 9/30/2018. The Director of Nursing (DON) was interviewed on 9/6/2019 at 12:44 PM and she reported she expected nursing staff to read the discharge orders given for a resident. The DON further explained she expected the nursing staff to offer a bedpan to new admissions who had not had a physical therapy evaluation, but if the resident refused to use the bedpan, she expected staff to read the discharge orders and transfer the resident to the toilet based on those orders. The Administrator was interviewed on 9/6/2019 at 3:07 PM and she reported it was her expectation that nursing staff would call the facility physician for mobility orders if needed on a new admission and provide them with their toileting preference.	F 561		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		10/8/19

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F 584	Continued From page 5 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to (1) repair walls in resident rooms to prevent areas of exposed plaster for 3 of 15	F 584	F 584 1. Residents in rooms 303, 304, 310 have had exposed plaster repaired.	

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F 584	Continued From page 6 rooms (rooms 303, 304 and 310), (2) repair/replace resident doors that were chipped and splintered for 3 of 15 rooms (rooms 303, 309 and 310), (3) maintain air/heat wall units for 2 of 15 rooms (rooms 304 and 310), (4) repair residents built in closets from chipping paint for 4 of 15 rooms (rooms 304, 305, 314 and 316), (5) repair/replace loose faucet in residents bathroom for 1 of 15 rooms (room 309), (6) repair loose air vent in residents bathroom for 1 of 15 rooms (room 309) and (7) provide a proper fitting toilet tank cover for 1 of 15 resident rooms (room 309). Findings included: 1a. Room 303 was observed on 9-3-19 at 1:12pm with paint chipping off the wall above the heat/air vent wall unit and by the bathroom. Room 303 was observed again on 9-6-19 at 9:50am with paint chipping off the wall above the heat/air vent wall unit and by the bathroom. 1b. The walls located in room 304 were observed on 9-3-19 at 9:44am. The walls were noted to have areas of paint chipped away exposing the plaster by the bathroom and the main entrance into the room. Room 304 was observed again on 9-6-19 at 9:52am where the walls were noted to have areas of paint chipped away exposing the plaster by the bathroom and the main entrance into the room. 1c. Room 310 was observed on 9-3-19 at 9:47am. The wall in the bathroom was noted to have chipped paint exposing the plaster. Another observation of room 310 was made on 9-6-19 at 9:54am. The wall in the bathroom was noted to have chipped paint exposing the plaster.	F 584	Rooms 303 and 310 have had chipped doors repaired. The bathroom door in Room 309 was repaired to close properly. The rusted bathroom door frame in Room 310 has been repaired. The missing unit□s control covers on the air/heat units in rooms 304, 310 will be replaced. Built in closets have been painted in rooms 304, 305, 314, 316. Loose faucet was repaired in room 309. Repaired loose air vent in room 309. Replaced toilet tank cover in room 309. These repairs were completed on 9-10-19. 2. Center residents have the potential to be affected by this deficient practice. The center was reviewed for repairs to plaster, doors, door closures, bathroom frames for rust, control covers on air and heat units, built in closets for paint, loose faucets, loose air vents, and toilet tank covers. Areas were addressed at the time of the review on 9-10-19 on going for additional 2 weeks. 3. The Executive Director/ designee educated staff on the importance of CFR(s) 483.10(i)(1)-(7) Safe/ Clean/ Comfortable/ Homelike Environment specific to submitting maintenance repair requests according to facility procedures 9-16-19 and 9-25-19. Line items have been added to TELS to monitor exposed plaster, chipped doors, check on air/heat units, built in closets for chipped paint, loose facets, loose air vents and toilets in proper order. Mock Survey Round sheets have had line items added to ensure that all areas of repair are noted daily for	

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F 584	Continued From page 7 During an interview with the maintenance supervisor on 9-6-19 at 9:55am, the maintenance supervisor stated he was aware the rooms needed painted and that he did not have a time frame or plan in place to have the rooms repaired. 2a. Room 303 was observed on 9-3-19 at 1:12pm. The resident's main door leading into their room was noted to have wood chipped off along the sides of the door. Room 303 was observed again on 9-6-19 at 9:50am. The resident's main door leading into their room was noted to have wood chipped off along the sides of the door. 2b. Room 309 was observed on 9-3-19 at 2:49pm and revealed the resident's bathroom door would not close all the way. Room 309 was observed again on 9-6-19 at 9:56am. The resident's bathroom door was noted to be hitting the door frame preventing the door from shutting all the way. 2c. Room 310 was observed on 9-3-19 at 9:47am. The bathroom door frame was noted to be rusted and paint was chipped off both sides of the door. Another observation of room 310 was made on 9-6-19 at 9:54am. The bathroom door frame was noted to be rusted and paint was chipped off both sides of the door. The maintenance supervisor was interviewed on 9-6-19 at 10:00am. The supervisor stated he was aware of the issues with the resident doors and he had started in August 2019 on the 400-hall repairing the wooden doors with wood putty and re-staining and did not have a plan or set goal on	F 584	ongoing maintenance awareness on 9-25-19. 4. Maintenance Director will bring Line items report from TELS to morning meeting for Executive Directors monitoring 3 x weeks for 4 weeks, then 1x week for 2 months and then 1x monthly for 3 months. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 584	Continued From page 8	F 584		

when the other halls maybe started.

3a. Room 304 was observed on 9-3-19 at 9:44am. The heat/air wall unit was noted to be missing the cover for the unit's controls. Room 304 was observed again on 9-6-19 at 9:52am. The heat/air wall unit was noted to be missing the cover for the unit's controls.

3b. Room 310 was observed on 9-3-19 at 9:47am. The heat/air wall unit was noted to be missing the cover for the unit's controls. Another observation of room 310 was made on 9-6-19 at 9:54am. The heat/air wall unit was noted to be missing the cover for the unit's controls.

During an interview with the maintenance supervisor on 9-6-19 at 9:55am, the maintenance supervisor stated he was not made aware of the covers missing for the controls on the heat/air vent unit. He stated staff could put a work order in the computer or hand write a work order and place it in the maintenance box in the lobby. He stated work orders are picked up 2 times a day and that he had not seen a work order for the missing covers.

4a. The built-in closets located in room 304 were observed on 9-3-19 at 9:44am. The drawers on the bottom of the closets were noted to be missing paint exposing the wood underneath. Room 304 was observed again on 9-6-19 at 9:52am. The drawers on the bottom of the closets were noted to be missing paint exposing the wood underneath.

4b. Room 305 was observed on 9-3-19 at 1:48pm and was noted to have paint chipped off exposing

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F 584	Continued From page 9	F 584		

the wood underneath of the built-in closets.
Room 305 was observed again on 9-6-19 at 10:02am and was found to have paint chipped off exposing the wood underneath of the built-in closets.

4c. During an observation of room 314 on 9-3-19 at 10:01am it was noted that the built-in closets had paint missing exposing the wood underneath.
Room 314 was observed again on 9-6-19 at 10:04am with the built-in closets paint missing exposing the wood underneath.

4d. Room 316 was observed on 9-3-19 at 10:04am. The built-in wall closets were noted to have missing paint exposing the wood underneath.
During another observation of room 316 on 9-6-19 at 10:06am it was noted that the built-in closets were missing paint exposing the wood underneath.

The maintenance supervisor was interviewed on 9-6-19 at 10:06am. The supervisor stated he was aware that painting was needed in the resident rooms and did not have a plan or time frame on when the painting would be completed.

5a. Room 309 was observed on 9-3-19 at 2:49pm. The resident's bathroom faucet was noted to be loose making it difficult to turn the faucet on/off.
Room 309 was observed again on 9-6-19 at 9:56am. The resident's bathroom faucet was noted to be loose making it difficult to turn the faucet on/off.

The maintenance supervisor was interviewed on 9-6-19 at 10:00am. The maintenance supervisor

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F 584	Continued From page 10	F 584		

stated he was not made aware of the loose faucet. He stated staff could put a work order in the computer or hand write a work order and place it in the maintenance box in the lobby. He stated work orders are picked up 2 times a day and that he had not seen a work order for the loose faucet.

6a. Room 309 was observed on 9-3-19 at 2:49pm. The resident's bathroom ceiling air vent was noted to have several missing screws causing it to hang from the ceiling.
Room 309 was observed again on 9-6-19 at 9:56am. The resident's bathroom ceiling air vent was noted to have several missing screws causing it to hang from the ceiling.

The maintenance supervisor was interviewed on 9-6-19 at 10:00am. The maintenance supervisor stated he was not made aware of the loose air vent in the bathroom and stated, "it's missing a few screws". He stated, staff could put a work order in the computer or hand write a work order and place it in the maintenance box in the lobby. He stated work orders are picked up 2 times a day and that he had not seen a work order for the loose air vent in the bathroom.

7a. Room 309 was observed on 9-3-19 at 2:49pm. The back of the resident's toilet tank did not have a cover that fit. The toilet tank was oval and had a square cover.
Room 309 was observed again on 9-6-19 at 9:56am. The back of the resident's toilet tank did not have a cover that fit. The toilet tank was oval and had a square cover.

The maintenance supervisor was interviewed on 9-6-19 at 10:00am. The maintenance supervisor

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F 584	Continued From page 11 stated he was not made aware of the toilet tank cover and after he examined the cover, he stated "this is not the right cover". He stated staff could put a work order in the computer or hand write a work order and place it in the maintenance box in the lobby. He stated work orders are picked up 2 times a day and that he had not seen a work order for the toilet tank cover. The Administrator was interviewed on 9-6-19 at 12:20pm. The Administrator stated the maintenance supervisor completed "room sweeps" weekly to monitor and assess any work that needed to be completed. The Administrator also stated she expected the environment to be comfortable and homelike for the residents.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		10/8/19

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 09/10/2019

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 623	Continued From page 12	F 623		

(c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

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F 623	Continued From page 13 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews, family interview, and staff interviews, the facility failed to notify the resident's responsible party in writing of the	F 623	F623 Notice Requirements Before Transfer/Discharge 1) Resident #183 no longer resides in	

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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F 623	Continued From page 14 residents' discharge from the facility to the hospital for 1 of 3 residents reviewed for discharge (Resident #183). Findings included: A review of the medical record revealed Resident #183 was admitted to the facility on 11/23/18 with diagnoses which included: Altered Mental Status, difficulty swallowing, generalized weakness, inhalation pneumonia, debility, and infection. Review Resident #183's Minimum Data Set (MDS) revealed a discharge return not anticipated (DRNA) assessment with an Assessment Reference Date (ARD) of 11/30/18. Review of the assessment revealed the resident was coded as having been discharged to another nursing home as an unplanned discharge. A cognitive assessment was not completed, and the resident was coded as having been rarely or never understood. A review of a nurses' note completed by Nurse #1, dated 11/30/18 and timed 8:50 PM, revealed Resident #183 had been discharged to the hospital via Emergency Medical Services (EMS) at 4:00 PM on 11/30/18. The resident was documented as having been had a critically low hemoglobin (HGB) (the part of the blood which carries oxygen) of 6.2 (normal HGB is 13.5 to 17.5) and when the doctor was made aware an order was obtained to send the resident to the Emergency Room (ER). Further review of the documentation revealed the resident's responsible party had been notified via a message about the resident being sent to the ER. The resident was documented as having been alert, verbal, vital signs stable at the time of the	F 623	the facility. Resident #183 was transfer/discharged to acute setting on 11/30/18. 2) Current residents have the potential to be affected. Audit completed on 9/25/19 of residents who have transfer/discharged in the past 30 days from the facility to the hospital. 4 residents were identified to had not received the Transfer/Discharge letter ; the facility sent certified letters regarding said Transfer/Discharge for all 4. 3) The Assistant Director of Nursing/Nurse Management will educate licensed nurses and social workers on Family Notification by 10/8/19. The education will be included in Orientation for new hires. Nurses are responsible for notifying the family by verbal exchange when family member is present in the facility or by telephone calls. If the nurse is unable to contact the family, the social worker will initiate a written letter and mail to family. 4) Executive Director/ Designee will audit all transfers/discharges to hospital to ensure notification to families in writing 3xweek for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months. Nurses are responsible for notifying the family by verbal exchange when family member is present in the facility or by telephone calls. If the nurse is unable to contact the family, the social worker will initiate a written letter and mail to family. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality	

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F 623	Continued From page 15 transfer and did not appear to have been in any acute distress. An interview was conducted with Nurse #1 on 9/6/19 at 10:28 AM. Nurse #1 stated she was the nurse who was assigned to Resident #183 on 11/30/18 on the date of his discharge to the hospital. She stated she called the resident's responsible party and notified them via a message on an answering machine the resident was being discharged to the hospital. An interview was conducted on 9/6/19 at 1:36 PM with Resident #183's responsible party. The responsible party stated she had not received written notification from the facility regarding the resident's discharge to the hospital. She stated she had not signed nor received paperwork regarding the resident's discharge to the hospital.	F 623	Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F 625		10/8/19

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F 625	Continued From page 16 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, family interview, and staff interviews, the facility failed to provide written notification to the resident's responsible party regarding bed hold when the resident was hospitalized for 1 of 3 residents reviewed for discharge (Resident #183). Findings included: A review of the medical record revealed Resident #183 was admitted to the facility on 11/23/18 with diagnoses which included: Altered Mental Status, difficulty swallowing, generalized weakness, inhalation pneumonia, debility, and infection. Review Resident #183's Minimum Data Set (MDS) revealed a discharge return not anticipated (DRNA) assessment with an Assessment Reference Date (ARD) of 11/30/18. Review of the assessment revealed the resident was coded as having been discharged to another nursing home as an unplanned discharge. A cognitive assessment was not completed, and the resident was coded as having been rarely or never understood.	F 625	F 625 1. There is no corrective action to perform at this time this resident (who was in facility from 11/23/18 through 11/30/18) is no longer in facility. However, upon admission the Bed Hold Policy and the Admission packet was discussed with resident's wife. 2. Residents sent out to the hospital has the potential to be affected by this practice. A 100% audit was completed on all resident sent out within the past 30 days; 3 were identified and Bed Holds were sent certified mail to the families with the Bed Hold Policy and Procedure. 3. Executive Director/ designee educated Department Heads on the importance of F625 Notice of Bed Hold Policy before/Upon Transfer. A line item was added to the Stand Up template monitor any resident sent out to hospital; Verifying that Bed Hold was sent and the documentation of this action was done. In-servicing by ADON will be done for	

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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F 625	Continued From page 17 A review of a nurses' note completed by Nurse #1, dated 11/30/18 and timed 8:50 PM, revealed Resident #183 had been discharged to the hospital via Emergency Medical Services (EMS) at 4:00 PM on 11/30/18. The resident was documented as having been had a critically low hemoglobin (HGB) (the part of the blood which carries oxygen) of 6.2 (normal HGB is 13.5 to 17.5) and when the doctor was made aware an order was obtained to send the resident to the Emergency Room (ER). Further review of the documentation revealed the resident's responsible party had been notified via a message about the resident being sent to the ER. The resident was documented as having been alert, verbal, vital signs stable at the time of the transfer and did not appear to have been in any acute distress. Review of a second nurses' note completed by Nurse #1, dated 12/1/18 and timed 7:41 PM, revealed resident #183's responsible party had called the facility and spoke to the nurse on 11/30/18. The family member was documented as having informed the staff member she did not want to give up the resident's bed at the facility. An interview was conducted with Nurse #1 on 9/6/19 at 10:28 AM. Nurse #1 stated she did not discuss the possibility of a bed hold with the responsible party during the phone conversation. An interview was conducted on 9/6/19 at 11:09 AM with the Administrator. She stated she was not aware if the resident's responsible party received or was made aware of the possibility of a bed hold. She stated typically when a resident is discharged to the hospital, the responsible	F 625	100% of the Nursing staff to ensure that Bed Hold and Documentation process is followed. 4. Executive Director/Designee will monitor and reviewed in the daily Interdisciplinary Team Meeting for Bed Hold 3 x weeks for 4 weeks, then 1x week for 2 months and then 1x monthly for 3 months. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. Date of Compliance Oct 8, 2019	

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F 625	Continued From page 18 party and physician are made aware, a packet of information about the resident with bed hold information is sent out with the resident, a staff member will follow up with the hospital to clarify if the resident was going to be admitted, and they contact the resident's responsible party to discuss a bed hold. An interview was conducted on 9/6/19 at 1:36 PM with Resident #183's responsible party. The responsible party stated she had not received written notification from the facility regarding the bed hold information. She stated she had not received paperwork regarding the resident's bed hold. The responsible party stated the possibility of a bed hold was not discussed with any staff members from the facility nor did she received any written information regarding the possibility of a bed hold from the facility.	F 625		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility	F 626		10/8/19

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F 626	Continued From page 19 services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record reviews, family interview, and staff interviews, the facility failed to permit a resident to return to the facility from the hospital for 1 of 3 residents reviewed for discharge (Resident #183). Findings included: A review of the medical record revealed Resident #183 was admitted to the facility on 11/23/18 with diagnoses which included: Altered Mental Status, difficulty swallowing, generalized weakness, inhalation pneumonia, debility, and infection. Review Resident #183's Minimum Data Set (MDS) revealed a discharge return not anticipated (DRNA) assessment with an Assessment Reference Date (ARD) of 11/30/18.	F 626	F 626 1. There is no corrective action to perform at this time; this resident (who was in the facility from 11/23/18 through 11/30/2018) is no longer in facility. However, upon admission the Bed Hold Policy was discussed with wife. 2. Residents sent out to the hospital have the potential to be affected by this practice. Audit of all residents sent out to hospital in the past 30 days; 2 residents identified and certified notification was sent to families, Bed Hold Policy/Readmission was provided at this time. 3. Executive Director/ designee educated Department Heads on the importance of F	

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F 626	Continued From page 20 Review of the assessment revealed the resident was coded as having been discharged to another nursing home as an unplanned discharge. A cognitive assessment was not completed, and the resident was coded as having been rarely or never understood. A review of a nurses' note completed by Nurse #1, dated 11/30/18 and timed 8:50 PM, revealed Resident #183 had been discharged to the hospital via Emergency Medical Services (EMS) at 4:00 PM on 11/30/18. The resident was documented as having been had a critically low hemoglobin (HGB) (the part of the blood which carries oxygen) of 6.2 (normal HGB is 13.5 to 17.5) and when the doctor was made aware an order was obtained to send the resident to the Emergency Room (ER). Further review of the documentation revealed the resident's responsible party had been notified via a message about the resident being sent to the ER. The resident was documented as having been alert, verbal, vital signs stable at the time of the transfer and did not appear to have been in any acute distress. Review of a second nurses' note completed by Nurse #1, dated 12/1/18 and timed 7:41 PM, revealed resident #183's responsible party had called the facility and spoke to the nurse on 11/30/18. The nurse documented the responsible party informed the nurse the resident would be ready to be readmitted to the facility on 12/1/18. The nurse further documented she discussed with the responsible party the resident would not be returning to the nursing home due to arrangements having been made for the resident to be admitted to a different nursing home. The responsible party was documented as having	F 626	626 Notice of Bed Hold Policy before/Upon Transfer. A line item was added to the Stand Up template monitor any resident sent out to hospital; Verifying that Bed Hold was sent and the documentation of this action was done. Per the North Carolina Bed Hold Policy “if applicable regarding the duration State bed Hold Policy during which the resident is permitted to return and resume residence in the nursing facility and the reserve Bed Payment Policy in the State Plan”. In-servicing by ADON will be done for 100% of the Nursing staff to ensure that Bed Hold and Documentation process is followed and residents are appropriately returning from the hospital. 4. Executive Director /Designee will monitor the readmissions per the Bed Hold/Readmission Policy. The facility will follow the North Carolina Bed Hold Policy in accordance to each residents payer source (Private Pay, Medicare and Medicaid) Residents will be reviewed in the daily Interdisciplinary Team Meeting for Bed Hold/Readmission 3 x weeks for 4 weeks, then 1x week for 2 months and then 1x monthly for 3 months. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 626	Continued From page 21	F 626		

informed the staff member she did not want to give up the resident's bed at the facility.

A Hospital Discharge Summary dated 12/11/18 revealed Resident #183 was seen in the Emergency Room (ER) on 11/30/18 and remained in the ER until he was admitted to the hospital on 12/2/18 with a principal diagnosis of Anemia. A narrative note by the Registered Nurse (RN) of the Emergency Room (ER) dated 12/1/18 and timed 6:26 PM documented per nursing report from the facility the resident was not allowed to return to the facility. Review of a narrative note by an RN dated 12/3/18 and timed 1:13 PM revealed the RN had discussed the resident with a staff member at the facility and she confirmed the patient was not going to return to the facility. The resident died at the hospital on 12/11/18.

Review of a Social Service Progress note dated 12/4/18 and timed 10:03 AM revealed documentation of a conversation between the Social Worker (SW) and an employee of the Department of Social Services (DSS). The SW documented she informed the DSS employee Resident #183 was not going to be allowed to be readmitted to the facility per the Administrator.

An interview was conducted with the Director of Nursing (DON) on 9/5/19 at 4:26 PM. The DON stated the facility was able to provide care and services for Resident #183, but the resident's responsible party had been noncompliant with aspects of the resident's care.

An interview was conducted with Nurse #1 on 9/6/19 at 10:28 AM. Nurse #1 stated she was the nurse who was assigned to Resident #183 on

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F 626	Continued From page 22	F 626		

11/30/18 on the date of his discharge to the hospital. She stated she called the resident's family and notified them via a message on an answering machine the resident was being discharged to the hospital. She stated the resident was being sent to the ER due to having had a critical lab value and she was instructed to send him out to the ER. The nurse stated she told the responsible party the resident was going to be admitted to a different facility from the hospital and would not be returning to the facility.

An interview was conducted on 9/6/19 at 11:09 AM with the Administrator. The Administrator stated Resident #183 did not receive a 30-day discharge notice. She stated a referral had been sent to other facilities about the resident, but the other facilities did not accept the resident. She stated the facility had not told the hospital they would not readmit the resident. She stated typically when a resident is discharged to the hospital, the family and physician are made aware, a packet of information about the resident with bed hold information is sent out with the resident, a staff member will follow up with the hospital to clarify if the resident was going to be admitted, and they contact the resident's family to discuss a bed hold.

An interview was conducted on 9/6/19 at 1:36 PM with Resident #183's family. The responsible party stated someone from the facility had called her and told her the resident was not going to be readmitted to the facility. The responsible party further stated she had expected the resident to have been readmitted to the facility, but she had been told during phone conversations the resident would not be able to be readmitted to the facility.

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 09/10/2019

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 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews, the facility failed to complete a significant change of status Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for significant changes (Resident #1). Findings included: Resident #1 was admitted to the facility on 12/22/2016. The annual MDS dated 5/19/2019 noted Resident #1 to eat a mechanically altered diet and she did not have a gastrostomy tube in place. The MDS assessed Resident #1 to require extensive one-person assistance with bed mobility, transfers, and dressing and supervision for eating. Resident #1 was readmitted on 8/14/2019 with diagnoses to include cerebral vascular accident (stroke), atrial fibrillation and gastrostomy tube.	F 637	F637 1. On 9/6/19 resident #1□s Significant Change Assessment dated 8/19/19 was completed by Dietary and the Minimum Data Set nurse signed and completed the assessment for transmission. The assessment was transmitted and accepted on 9/9/19. 2. On 10/2/19, the Regional Minimum Data Assessment Nurse performed Quality Improvement monitoring for all current residents with assessments in progress to identify any late assessments. Any issues identified were addressed. 3. On 10/2/19, the Interdisciplinary Team was re-educated by the Regional Minimum Data Set nurse on timeliness of Significant Change assessment completion. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS	10/8/19

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 09/10/2019

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

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F 637	Continued From page 24 The significant change MDS dated 8/19/2019 was in progress and not completed. The MDS noted the insertion of a gastronomy tube for feeding and hydration. The MDS assessed Resident #1 to require total two-person assistance for bed mobility and transfers, one-person total assistance for eating and dressing. A care area summery from the significant change MDS dated 8/19/2019 was reviewed and the summery noted Resident #1 was readmitted to the facility with a gastrostomy tube due to dysphagia (difficulty swallowing) after a cerebral vascular accident on 8/4/2019. Resident #1 was observed on 9/3/2019 at 3:21 PM with a tube feeding infusing via a gastrostomy tube. Resident #1 was non-verbal and unable to be interviewed. MDS Nurse #2 was interviewed on 9/6/2019 at 12:32 PM and she reported the Significant Change MDS with a date of 8/19/2019 should have the completed by 9/2/2019. MDS Nurse #2 was not aware the assessment had not been completed and reported the former MDS coordinator had moved into a different position and she initiated the assessment but did not complete the assessment. MDS Nurse #1 was interviewed on 9/6/2019 at 12:32 PM and she reported she was not aware the significant change assessment had not been completed. MDS Nurse #1 concluded by reporting the assessment needed corrections from another department and that was why the assessment was not completed.	F 637	assessments for timeliness of completion by reviewing the In Progress MDS list daily for two weeks, then twice weekly for two weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 10/3/19. 4. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	

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F 637	Continued From page 25 The former MDS coordinator was not available for interview. The Administrator was interviewed on 9/6/2019 at 3:07 PM and she reported she expected the MDS to be completed in a timely manner. The Administrator went on to explain the MDS coordinator had moved on to a corporate position and had not submitted the significant change MDS.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to code the Minimum Data Set (MDS) accurately in the areas of oxygen (Resident #30), discharge (Resident #81) and bowel and bladder (Resident #80) for 3 of 24 residents reviewed for MDS accuracy. Findings included: 1.Resident #30 was admitted to the facility on 7-18-18 with multiple diagnosis that included pneumonia, chronic obstructive pulmonary disease, shortness of breath and pulmonary hypertension. The quarterly Minimum Data Set (MDS) dated 7-13-19 revealed Resident #30 was severely cognitively impaired. The MDS also revealed the resident was coded for shortness of breath but not her use of oxygen.	F 641	F641 1. On 10/2/19, resident #30□s MDS was updated to accurately reflect the residents MDS Assessment for Oxygen by the Minimum Data Set nurse. On 7/19/19, resident #81□s MDS was updated to accurately reflect the residents MDS Assessment for Discharge by the Minimum Data Set nurse. On 10/2/19, resident #80□s MDS was updated to accurately reflect the residents MDS Assessment for Indwelling Catheter by the Minimum Data Set nurse. 2. On 10/2/19, the Minimum Data Set nurses and the Regional Minimum Data Assessment nurse performed Quality Improvement monitoring of all assessments with an ARD of 9/10/19 and forward that were completed, transmitted and accepted for accurate coding. Any	10/8/19

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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

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F 641	Continued From page 26 Resident #30's care plan dated 7-15-19 revealed a goal that Resident #30 would display comfort while breathing during activity. The interventions listed for that goal in part included; assessing and reporting respiratory rate and administering oxygen as ordered. A review of the physician orders dated 11-19-18 revealed an ongoing order for Resident #30 to have oxygen administered at 2 liters per minute. During an observation of Resident #30 on 9-4-19 at 4:15pm, the resident was noted to be laying in bed with oxygen being administered via nasal canula at 2 liters per minute. Nurse #3 was interviewed on 9-5-19 at 8:45am. The nurse stated she had been working with Resident #30 since the first of July 2019 and she had not seen the resident without her oxygen. She also stated Resident #30 would use her portable oxygen when she attended activities or the oxygen concentrator in her room if she was laying down. A review of the nursing notes dated 7-10-19 revealed Resident #30 was being administered oxygen via nasal canula using her oxygen concentrator. During an interview with MDS nurse #1 on 9-5-19 at 10:35am, the MDS nurse stated she retrieves her information from the resident's medication and treatment administration records, staff and progress notes. She reviewed Resident #30's medication and treatment administration record for July 2019 and noted the resident was provided oxygen daily and then she reviewed the quarterly	F 641	issues identified were addressed. 3. On 10/2/19, the Interdisciplinary Team was re-educated by the Regional Minimum Data Set nurse on: a. O0100 □ Special Treatments, Procedures, and Programs □ specifically O0100C □ Oxygen Therapy, b. A2100 □ OBRA Discharge Status, and c. H0100 □ Appliances The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of MDS assessments for Accuracy of MDS Assessments □ to include Oxygen, Discharge and Indwelling Catheters □ on five random MDS assessments three times per week for four weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 10/3/19. 4. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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

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F 641	Continued From page 27	F 641		

MDS dated 7-13-19 and did not see oxygen coded. MDS nurse #1 stated she did not know why she had not coded oxygen use on the MDS "I guess I just missed it."

The Administrator was interviewed on 9-6-19 at 12:20pm. The Administrator stated she expected the MDS to paint a picture of the resident and their care needs.

2. Resident #81 was admitted to the facility on 6-20-19 with multiple diagnosis that included cerebral infarction, diabetes and chronic obstructive pulmonary disease.

A review of the social work notes dated 7-11-19 revealed Resident #81 was to be discharged home with home health.

The discharge Minimum Data Set (MDS) dated 7-12-19 revealed the resident was discharged to an acute care hospital.
The progress notes dated 7-12-19 were reviewed and revealed Resident #81 was discharged home with family.

During an interview with MDS nurse #2 on 9-6-19 at 11:35am, the MDS nurse stated she obtained information from the nursing notes, talking with staff and medical record review. She reviewed the nursing note written 7-12-19 and then reviewed the discharge MDS and stated, "How did I get that all mixed up." The MDS nurse stated she had "just made a mistake."

The Administrator was interviewed on 9-6-19 at 12:20pm. The Administrator stated she expected the MDS to paint a picture of the resident and their care needs. She also stated she felt 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 09/10/2019

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

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F 641	Continued From page 28 miscoding was a "human error" by marking the wrong box. 3) Resident #80 was admitted to the facility on 7/28/19 with diagnoses that included retention of urine and neuromuscular disorder of the bladder. A physician's order dated 7/28/19 revealed an order for Resident #80 to have a urinary catheter. Review of the baseline care plan dated 7/28/19 revealed the resident had a urinary catheter. Nursing notes dated 7/28/19 through 8/4/19 specified Resident #80 had a urinary catheter in place. The admission Minimum Data Set (MDS) dated 8/4/19 revealed the resident had moderately impaired cognition. Resident #80 was coded as always incontinent of bladder and as not having an indwelling catheter. During an interview with the MDS Nurse #3 on 9/6/19 at 11:02am, she confirmed the resident had an indwelling urinary catheter when the 08/04/19 MDS was completed and it was an error the MDS did not reflect the resident had an indwelling catheter. An interview was conducted on 9/6/19 at 11:45am with the Director of Nursing. She indicated it was her expectation for the MDS to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		10/8/19

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 09/10/2019

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

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F 656	Continued From page 29 §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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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

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F 656	Continued From page 30 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and implement a person-centered comprehensive care plan to address residents' behaviors and diagnosis for 1 of 5 residents reviewed for unnecessary psychotropic medications (Resident #36). Findings included: Resident #36 was admitted to the facility on 4-2-19 with multiple diagnosis that included cellulitis of the left lower limb, atrial fibrillation, dementia, major depressive disorder psychotic disorder with delusions and anxiety disorder. The quarterly Minimum Data Set (MDS) dated 7-10-19 revealed Resident #36 was severely cognitively impaired and received antipsychotic medication 7 out of 7 days, antianxiety medication 7 out of 7 days and antidepressant medication 7 out of 7 days. The MDS also revealed Resident #36 did not have any mood or behaviors exhibited. Resident #36's care plan dated 8-14-19, that was initiated on 6-12-19 did not reveal any goals or interventions for the resident's mental health diagnosis or behaviors. Resident #36 was observed on 9-3-19 at 12:00pm sitting in her wheelchair in the dinning room. She was noted to be alert, looking around the room but not conversing with her peers. Nurse #1 was interviewed on 9-4-19 at 2:35pm. The nurse stated Resident #36 had been	F 656	F656 On 10/2/19, resident #36□s Care Plan was updated to accurately reflect the residents Care Plan for active diagnoses and behaviors by the Minimum Data Set nurse and Social Worker. On 10/2/19, the Minimum Data Set nurses and the Regional Minimum Data Assessment nurse performed Quality Improvement monitoring of all assessments with an ARD of 9/10/19 and forward that were completed, transmitted and accepted for Care Plan accuracy. Any issues identified were addressed. On 10/2/19, the Interdisciplinary Team was re-educated by the Regional Minimum Data Set nurse on Care Planning of active Diagnoses and behaviors to accurately reflect the resident. 3. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of Care Plans for active diagnoses and resident behaviors on five random MDS assessments three times per week for four weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 10/3/19. 4. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality	

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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

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F 656	Continued From page 31 combative, confused and refusing her medication at times. She also stated she did not know what interventions were on the resident's care plan to help aide with the behaviors but that she would walk away from the resident and return 5-10 minutes later. When Nurse #1 reviewed Resident #36's care plan she could not find any interventions to help aide with the resident's behaviors. During an interview with Social Worker #1 on 9-4-19 at 2:40pm, the Social Worker reviewed Resident #36's care plan and stated he did not know why there were no goals or interventions for her diagnosis or behaviors. The Social Worker stated he would have to "look into" the resident's diagnosis and her behaviors. He also stated he would have been the Social Worker who should have developed the goals and interventions for Resident #36. The Director of Nursing was interviewed on 9-4-19 at 4:30pm. The Director of Nursing stated the facility had changed social work staff "about 6 months ago" and felt Social Worker #1 had "just over looked care planning the resident for her behaviors". She was also able to state Resident #36 exhibited confusion, combativeness and refused her medication at times. The Administrator was interviewed on 9-6-19 at 12:20pm. The Administrator stated she expected the care plan to paint a picture of the resident and their needs.	F 656	Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		10/8/19

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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

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F 657	Continued From page 32 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interviews, the facility failed to review and revise the care plan for one of twenty-four care plans reviewed for care plan revisions (Resident #67). The findings included: Resident #67 was admitted to the facility 1/31/19. The resident's cumulative diagnoses included: Chronic pain syndrome, contracture, dementia,	F 657	F657 1. On 9/17/19, resident #67□s Care Plan was updated to accurately reflect the residents Care Plan for hallucinations by the Social Worker. On 10/2/19, resident #67□s MDS was updated to accurately reflect the residents MDS Assessment for hallucinations by the Social Worker. 2. On 10/2/19, the Minimum Data Set nurses and the Regional Minimum Data Assessment nurse performed Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

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F 657	Continued From page 33 heart failure, adjustment disorder, anxiety, depression, and psychosis. A review completed of the Minimum Data Set (MDS) assessments for Resident #67 revealed the most recent completed assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 8/10/19. Review of the assessment revealed the resident was coded as having had no cognitive loss. The resident was coded as not having hallucinations or delusions during the assessment period. A review was completed of Resident #67's care plan. The review revealed the care plan had been last reviewed on 8/22/19, revealed there was no care plan to address hallucinations. The progress notes for Resident #67 had a Nursing Progress Note dated 3/5/19 and timed 2:36 PM which documented the resident stated during the night she saw a man with a dog in the hallway close to her door. The resident's door was documented as having been closed. The nurse documented she was unable to corroborate the resident's story through interviews with other residents. The progress notes for Resident #67 had a Nursing Progress Note dated 3/25/19 and timed 5:06 AM which documented the resident thought there was someone playing instruments just to annoy her, and reorientation was ineffective. Further review of Resident #67's physician progress notes revealed delusions and hallucinations were documented on 3/8/19, 3/21/19, 3/26/19, 4/5/19, 4/9/19, and 4/15/19.	F 657	Improvement monitoring of all assessments with an ARD of 9/10/19 and forward that were completed, transmitted and accepted for MDS assessment and Care Plan accuracy. Any issues identified were addressed. 3. On 10/2/19, the Interdisciplinary Team was re-educated by the Regional Minimum Data Set nurse on Care Planning and coding of hallucinations and delusions to accurately reflect the resident. The Director of Nursing and/or Regional Minimum Data Assessment Nurse will perform Quality Improvement Monitoring of Care Plans for active diagnoses and resident behaviors on five random MDS assessments three times per week for four weeks, then one time per week for two months and then one time monthly for three months. Audits will begin 10/3/19. 4. The Director of Nursing will report on the results of the Quality Monitoring (Audits) to the Quality Assurance Performance Improvement Committee. Findings will be reviewed by QAPI Committee monthly and Quality Monitoring (Audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.	

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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

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F 657	Continued From page 34	F 657		

Review of the progress notes for Resident #67 revealed a Nursing Progress Note dated 6/30/19 and timed 6:41 AM which documented the resident rang multiple times through the night hallucinating with complaints of a dog barking and seeing a man. The resident was documented as having had a history of hallucinating.

During an interview conducted with Resident #67 on 9/3/19 at 11:39 AM the resident stated there had been a resident, a man, at the facility who played a flute or a recorder at night. The resident further stated the resident had a dog with him while he was at the facility. The resident stated the man returned to the facility at night with his dog and played the flute or recorder at the back door of the facility.

An interview was conducted on 9/4/19 at 12:05 PM with Nursing Assistant (NA) #5. She stated Resident #67 did have hallucinations including there was a dog who slept under the facility in an area which had been cleared out.

An interview was conducted on 9/4/19 at 2:53 PM with Nurse #5. She stated Resident #67 did have hallucinations including there was a person at the facility whose name was Kevin, who plays the flute, and he had a dog.

An interview was conducted on 9/5/19 at 11:21 AM with Nurse #11. She stated she was the Unit Manager and she was aware of Resident #67's hallucinations. She stated psychiatric services was working with the resident.

An interview was conducted on 9/5/19 at 11:21 AM with MDS Nurse #1. The MDS Nurse stated there was no information in the resident's care

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 09/10/2019

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

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F 657	Continued From page 35 plan about hallucinations and she had not heard of the resident having hallucinations. An interview was conducted on 9/5/19 at 11:49 AM with Social Worker (SW) #1. He stated Resident #67 was followed by psychiatric services and he was aware she had hallucinations such as a boy playing a flute and who had a dog. He stated he did not put the information regarding the hallucinations in the resident's care plan because the resident's hallucinations had been occurring prior to him having started to work at the facility. An interview was conducted on 9/5/19 at 4:41 PM with the Director of Nursing (DON). The DON stated she was aware Resident #67 had hallucinations. She stated the resident having hallucinations is a behavior which should be addressed on the Care Plan. An interview was conducted on 9/6/19 at 11:43 AM with the Administrator. The Administrator stated it was her expectation for behaviors such as hallucinations to be in the resident's care plan.	F 657		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by	F 693		10/8/19

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F 693	Continued From page 36 enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer tube feeding according to the physician orders for 1 of 2 residents reviewed for tube feeding (Resident #196). The tube feeding was administered during the daytime 12-hour period instead of nighttime 12 hour period and the hourly water flush was not administered manually by a nurse. Findings included: Resident #196 was admitted to the facility on 8/23/2019 with diagnoses to include encephalopathy, dysphagia (difficulty swallowing) and diabetes. The admission Minimum Data Set (MDS) assessment dated 8/30/2019 was not completed. The MDS assessed Resident #196 to be severely cognitively impaired without behaviors. The MDS documented Resident #196 received more than 51% of her calories by gastrostomy tube (G-tube) feeding and more than 501 milliliters (ml) of fluid per day. A physician order with a start date 9/2/2019 Jevity 1.5 @ 80 ml/hour continuous for 12 hours from	F 693	F693 Tube feeding Mgmt/Restore Eating Skills 1) On 9/6/19 once staff was made aware tube feeding for resident #196 was stopped, no concerns noted. Nurse Practitioner and Registered Dietician both in facility at the time and were made aware. No new orders received however orders were updated to include: “on” and “off” on medication administration record. 2) Current residents who receive enteral feeding have the potential to be affected. On 9/25/19 an audit on all 3 residents receiving tube feeding was completed to ensure tube feeding and water flushes are being administered according to physician orders. All 3 residents were found to need zero adjustments for their orders for tube feeding. 3) The Assistant Director of Nursing/Nurse Management will reeducate licensed nurses on enteral feeding management by 10/8/19. The education will be included in Orientation for new hires.	

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F 693	Continued From page 37 8:00 PM to 8:00 AM and water flush of 60 ml/hour for 12 hours every shift for hydration from 8:00 AM until 8:00 PM. Resident #196 was observed on 9/3/2019 at 12:07 PM and the tube feeding Jevity was infusing via G-tube at 80 ml/hour. Resident #196 was not interviewable. A review of the medication administration record revealed that Nurse #11 had initialed the order "Jevity 1.5 80 ml/hour for 12 hours and water flush 60 ml/hour for 12 hours" on 9/3/2019, 9/4/2019 and 9/5/2019 indicating the task was completed. Resident #196 was observed on 9/6/2019 at 10:46 AM and the tube feeding Jevity was infusing via G-tube tube at 80 ml/hour. Nurse #11 was interviewed on 9/5/2019 at 10:30 AM and she reported she was not aware that Resident #196 had orders for Jevity G-tube feeding to infuse from 8:00 PM until 8:00 AM and water to be administered by G-tube from 8:00 AM until 8:00 PM. Nurse #11 reported the facility did not have a pump that could be programed to deliver water and the nurse would have to administer the water manually to Resident #196 by her G-tube. Nurse #11 reported she had not administered the water to Resident #196 but had administered water to her with her medication administration. Nurse #1 was interviewed on 9/6/2019 at 10:48 AM and she reported that the facility did not have a G-tube feeding pump that allowed for the administration of water flushes and if the order was to give water to a resident with a G-tube, the nurse would have to administer the water	F 693	4) Nurse Management/Administrative Nursing will audit residents receiving enteral feeding to ensure tube feeding and water flushes are being administered per physician orders 3x week for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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

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F 693	Continued From page 38 manually. Unit Manager (UM) #2 was interviewed on 9/6/2019 at 11:09 AM and she reported she was not aware the tube feeding for Resident #196 was to start at 8:00 PM and end at 8:00 AM with water flushes. UM #1 reported the order should be clarified by the facility dietician. The Director of Nurses (DON) was interviewed on 9/6/2019 at 12:44 PM and she reported the order for the Jevity G-tube feeding for Resident #196 was not correct and should have been clarified and corrected. The DON reported the facility dietician usually clarifies the physician orders for tube feeding and the order appeared to have been entered into the system incorrectly. The facility registered dietician (RD) was interviewed on 9/6/2019 at 1:36 PM and she reported her supervisor performed the admission assessment on Resident #196 and the documentation was not in the hard chart or the electronic chart. The RD reported the physician orders for Resident #196 were incorrect and should have been clarified by the nurse. The RD concluded by reporting that Resident #196 was receiving oral feedings of meals and this was why her tube feeding was to be stopped from 8:00 AM until 8:00 PM to allow her the opportunity to eat. The Administrator was interviewed on 9/6/2019 at 3:07 PM and she reported she expected the orders to be entered correctly for all resident with G-tube feedings and those residents to receive nutrition correctly.	F 693		
F 727 SS=B	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)	F 727		10/8/19

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 09/10/2019

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

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F 727	Continued From page 39 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to staff Registered Nurse (RN) coverage for 8 consecutive hours daily for 7 of 70 days reviewed for RN coverage (6/29/19, 6/30/19, 7/13/19, 7/20/19, 7/21/19, 7/27/19 and 7/28/19). The findings included: A review of the facility's daily schedule sheets from June 2019 to August 2019 indicated a RN was not scheduled for at least 8 consecutive hours a day on the following dates: 6/29/19, 6/30/19, 7/13/19, 7/20/19, 7/21/19, 7/27/19 and 7/28/19. An interview was conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 9/6/19 at 2:00pm. They both acknowledged there were some days when the facility had no hours of RN coverage and indicated the RN unit managers had recently started to rotate weekends (date unable to be	F 727	F727 1. The facility daily schedule sheets did no indicate RN hours for the following dates: 6/29/19, 6/30/19, 7/13/19, 7/20/19, 7/21/19, 7/27/19, and 7/28/19. 2. On 9/26/19, a review of RN coverage for the last 30 days was completed to verify RN coverage with no concerns noted. 3. On 9/25/19 Director of Nursing, Assistant Director of Nursing, Unit Managers, Executive Director, Scheduler, and Human Resource Coordinator reeducated by Regional Director of Clinical Services on RN Staffing Requirements. Beginning 9/30/19 the weekly schedule will be reviewed and approved by the facility Executive Director or Director of Nursing to ensure adequate RN coverage. Any RN calling out will be	

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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

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F 727	Continued From page 40 stated) to provide 8 hours of RN coverage on Saturdays and Sundays. The DON indicated it was her expectation for a RN to be scheduled 8 hours per day, 7 days per week. On 9/6/19 at 3:05pm an interview was conducted with the facility's nursing staff scheduler. She stated the RN unit managers began rotating weekends on August 1, 2019 to provide 8 hours of RN coverage on weekends. She stated she was unaware of the RN daily requirement until the Executive Director and DON brought it to her attention at the end of July.	F 727	referred to Executive Director/Director of Nursing to ensure RN coverage is maintained. 4. Administrator and/or Human Resource Coordinator will audit schedules 3x week for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months to ensure RN coverage. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility	F 755		10/8/19

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 09/10/2019

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

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F 755	Continued From page 41 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to follow established procedures for acquiring and administering medications (including documentation) to meet the needs for 2 of 7 sampled residents (Resident #24 and Resident #282) observed during medication pass observations and for 1 of 7 residents reviewed for unnecessary medications (Resident #39). The findings included: 1) Resident #24 was initially admitted to the facility on 7/5/16 with re-entry from a hospital on 9/8/16. Her cumulative diagnoses included depression. A medication pass observation was conducted on 9/3/19 at 10:19 AM with Nurse #11 as she prepared medications for administration to Resident #24. The medications scheduled for administration to Resident #24 included 50	F 755	F755 1. Nurse #11 was educated by Director of Nursing 9/3/19 on checking emergency kit for resident #24 medication that was not available. Nurse #8 administered medications (Amlodipine and Losartan) late to resident #282 after emergency kit was brought to her attention. Nurse #8 is no longer employed at facility. Resident #39□s medication (Donepezil) was ordered from pharmacy and delivered. Medication Error Reports were completed for each incident with notification to Physician. 2. Medications carts audited to ensure medications are available for residents on 9/27/19. Issues identified were addressed. 3. The Assistant Director of Nursing/Nurse Management will reeducate licensed nurses on Medication Availability (Ordering/Reordering Process, Receiving	

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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

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F 755	Continued From page 42 milligrams (mg) sertraline (an antidepressant). The nurse reported this medication was not on the med cart and she would need to call the pharmacy to have it sent out. A review of Resident #24 ' s physician ' s orders included a current medication order for 50 mg sertraline to be given as one tablet by mouth one time a day. The medication was scheduled to be administered at 9:00 AM each day. An observation was conducted on 9/4/19 at 11:35 AM of the med cart used for Resident #24. The observation revealed there was no sertraline available on the med cart for administration to the resident. Review of the resident ' s Medication Administration Record (MAR revealed Resident #24 did not receive a dose of sertraline at any time on 9/3/19. An interview was conducted on 9/4/19 at 4:25 PM with Nurse #11. During the interview, the med pass administration from 9/3/19 was discussed further. Upon inquiry, Nurse #11 reported she did not think she had checked the facility ' s e-kit to obtain a dose of sertraline for Resident #24 on 9/3/19 and acknowledged she did not administer any sertraline doses to the resident on 9/3/19. When asked what the facility ' s procedure indicated she should do if a medication was not available to be administered to a resident at the time it was scheduled, Nurse #11 reported she should first go to the e-kit to see if the med was available. If the med was not there, she would go to the other med room to check if the medication was available in a second e-kit stored there. Nurse #11 stated she would also need to call the resident ' s physician to inform him/her if the medication was not currently available, then call	F 755	Medications in, Emergency Medication Kit, and Back-up Pharmacy) by 10/8/19. All new nurse hires will be educated during orientation by ADON. 4. Nurse Management/Administrative Nursing will audit medication carts, 2 carts 3 x weekly for 4 weeks, then 1 x weekly for 2 months and then 1x monthly for 3 months to ensure medications available. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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F 755	Continued From page 43	F 755		

the pharmacy to let them know the resident was out of the med. When asked if she had taken these steps, the nurse reported she had not. However, she also stated she understood the 2nd or 3rd shift nurses working on 9/3/19 and 9/4/19 had faxed the multiple requests for the sertraline refill because the pharmacy reported they couldn't read the refill request. She confirmed Resident #24 did not receive the sertraline as ordered on 9/3/19.

An observation and interview were conducted on 9/4/19 at 2:00 PM with Nurse #8. Nurse #8 was the 1st shift nurse assigned to Resident #24 ' s med cart. Upon request, the nurse reviewed the medications stored on the cart for Resident #24. Nurse #8 confirmed no sertraline was stored on the med cart for this resident. She reported the resident ' s electronic medical record indicated the medication was ordered from the pharmacy on 9/4/19 (this date). The nurse reported she administered Resident #24 ' s medications earlier that morning (which did not include sertraline). Upon further inquiry, Nurse #8 stated the facility had some back up medications in an emergency (ER) medication kit (known as an e-kit) stored in the medication room. However, the nurse reported she did not check the e-kit when Resident #24 ' s sertraline was scheduled for administration at 9:00 AM. Nurse #8 was accompanied as she went to the med room. A review of the itemized list of medications stored in the e-kit revealed it contained both 25 mg and 50 mg tablets of sertraline. The 50 mg sertraline tablets were observed to be stored in the e-kit at that time. The nurse double checked the medication dose ordered and was observed as she administered the prescribed sertraline to Resident #24.

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 09/10/2019

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

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F 755	Continued From page 44	F 755		

A telephone interview was conducted on 9/4/19 at 3:52 PM with a dispensing pharmacist who worked for the facility's contracted pharmacy. During the interview, the pharmacist reported a 30-day supply (30 tablets) of 50 mg sertraline was last dispensed from the pharmacy for Resident #24 on 7/19/19. She noted only one tablet of 50 mg sertraline was reported as having been taken from the facility ' s e-kit for this resident (on 9/4/19 at 2:20 PM) within the last two months. The pharmacist also reported a request was received on 9/4/19 for a refill of the resident ' s sertraline and stated the med would be shipped from the pharmacy around 9:00 PM that evening. When asked, the pharmacist reported deliveries were made to the facility twice daily; one left the pharmacy around 12:00 PM and the second delivery shipment left the pharmacy at 9:00 PM. Upon inquiry, the pharmacist reported if a resident ran out of a medication that was needed before a scheduled delivery, the facility could contact the pharmacy and they would arrange to obtain the medication from a back-up pharmacy (a local retail pharmacy).

An observation of Resident #24 ' s hall med cart was conducted on 9/5/19 at 8:58 AM. During the observation, it was noted 30 tablets of 50 mg sertraline had been dispensed for Resident #24 on 9/4/19 and was stored on the medication cart.

An interview was conducted on 9/5/19 at 3:35 PM with Nurse #10 to discuss the facility ' s procedures to acquire or refill medications needed for a resident. Nurse #10 was working as a hall nurse assigned to a med cart. During the interview, the nurse reported she usually re-ordered a medication when there were 7 to 8

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

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F 755	Continued From page 45	F 755		

doses left in the resident ' s bubble pack card. She stated some medications could be re-ordered electronically but if they were, the medications may not get sent out from the pharmacy that night. To improve the chances of getting a medication that night, Nurse #10 reported she tended to write out the refill request and fax it to the pharmacy before 5:00 PM. Upon inquiry as to what she would do if a resident was completely out of a medication when it was scheduled for administration, the nurse reported she would first check the facility ' s e-kit. If the medication was not there, she would call the pharmacy and see if it could be sent out STAT (which took approximately 2 hours to receive). If the medication could not be received by the facility in a timely manner, the pharmacy would contact a local retail pharmacy as their back-up pharmacy.

An interview was conducted on 9/5/19 at 4:16 PM with Nurse #9 to discuss the facility ' s procedures to acquire or refill medications needed for a resident. Nurse #9 was working as a hall nurse assigned to a med cart. Upon inquiry, the nurse stated, "We are having issues with this." Nurse #9 reported she would try to re-order a medication when there were 8 doses or so left in the resident ' s bubble pack card. If a resident was out of a medication that was scheduled for administration, the nurse stated she could check a "back up box" (referring to the e-kit) that carried quite a bit of basic medications. If the medication wasn ' t available in-house, Nurse #9 reported she could call their contracted pharmacy and tell them she needed the medication. She reported how soon the facility would receive the medication varied a lot. If the med was ordered from the pharmacy on a STAT basis, she

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 09/10/2019

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 755	Continued From page 46	F 755		

understood it was supposed to arrive in 4 hours but noted that was not always the case. When asked if there was another alternative to acquire the medication if it was needed sooner than 4 hours, Nurse #9 reported the pharmacy did have a local retail pharmacy they could use as a back-up pharmacy.

An interview was conducted on 9/6/19 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the facility ' s procedures for acquiring a medication needed for a resident were discussed. The DON reported if a resident was out of an over-the-counter medication, a member of the staff would go and pick it up at a retail store. If the medication was a prescription medication, she would expect the nursing staff to check the e-kits to see if that particular medication was available in-house. If not, nursing staff would be expected to notify the resident ' s physician to either put the medication order on hold or obtain an order for an appropriate alternative available in-house until the prescribed medication could be obtained. If no appropriate alternative was available, staff needed to call the pharmacy and ask for the medication to be sent out to the facility "STAT" (at once).

2-a) Resident #282 was admitted to the facility on 8/16/19. Her cumulative diagnoses included hypertension (high blood pressure).

A medication pass observation was conducted on 9/4/19 at 11:20 AM with Nurse #8 as she prepared medications for administration to Resident #282. The medications scheduled for administration to Resident #282 included 5 milligrams (mg) amlodipine (an antihypertensive

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 09/10/2019

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 755	Continued From page 47	F 755		

medication) to be given as 1 and ½ tablets (total dose of 7.5 mg). The nurse reported there wasn ' t enough amlodipine left on the cart with the ½ tablets that remained in the resident ' s bubble pack card. Nurse #8 stated she would need to call the pharmacy to have the medication sent out. Upon further inquiry, the nurse stated the medication would come from the pharmacy sometime today. However, she was not sure if the medication would come in to the facility that afternoon or evening.

A review of Resident #282 ' s physician ' s orders included a current medication order for 5 mg amlodipine to be given as one and one-half tablets (total dose of 7.5 mg) by mouth one time a day. The medication was scheduled to be administered at 9:00 AM each day.

A follow-up interview was conducted on 9/4/19 at 2:00 PM with Nurse #8. Upon inquiry, Nurse #8 stated the facility had some back up medications in an emergency (ER) medication kit (known as an e-kit) stored in the medication room. Nurse #8 was accompanied as she went to the med room. A review of the itemized list of medications stored in the e-kit revealed it included 4 - 2.5 mg tablets of amlodipine. When the nurse was shown the list included amlodipine, she was asked if this medication could have possibly been used for Resident #282 during the morning med pass. Nurse #8 reported she would double check the dosage and administer the medication since the amlodipine ordered for Resident #282 had not yet come in to the facility.

A telephone interview was conducted on 9/4/19 at 3:52 PM with a dispensing pharmacist who worked for the facility's contracted pharmacy.

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 09/10/2019

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 755	Continued From page 48	F 755		

During the interview, the pharmacist reported a 15-day supply of amlodipine was dispensed from the pharmacy for Resident #282 on 8/16/19. This supply included 1 bubble pack card containing 15 - 5 mg tablets of amlodipine and 1 bubble pack card containing 15 - ½ tablets of 5 mg amlodipine (to yield 2.5 mg). She noted only one withdrawal of 2 - 2.5 mg amlodipine tablets from the facility ' s e-kit was reported for this resident (on 9/4/19 at 2:50 PM) within the past month. The pharmacist also reported a request was received on 9/4/19 and was being processed for a refill of the resident ' s amlodipine. When asked, the pharmacist reported deliveries were made to the facility twice daily; one left the pharmacy around 12:00 PM and the second delivery shipment left at 9:00 PM. Upon inquiry, the pharmacist reported if a resident ran out of a medication that was needed before a scheduled delivery, the facility could contact the pharmacy and they would arrange to get the medication at a local retail pharmacy.

An observation of Resident #282 ' s hall med cart was conducted on 9/5/19 at 8:58 AM. The observation revealed only one card containing 15 - ½ tablets of 5 mg amlodipine (each ½ tablet contained 2.5 mg amlodipine) dispensed on 9/4/19 had come in from the pharmacy for Resident #282. Upon inquiry, Nurse #3 reviewed the med cart further and reported no whole tablets of 5 mg amlodipine were stored on the med cart for this resident.

A follow-up telephone interview was conducted on 9/5/19 at 2:42 PM with a pharmacy manager at the facility ' s contracted pharmacy. When asked, the pharmacy manager reported both of the medication cards for Resident #282 ' s

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 09/10/2019

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 755	Continued From page 49	F 755		

amlodipine (1 card containing whole 5 mg tablets and 1 card containing ½ tablets of 5 mg amlodipine) were sent out on 9/4/19 and would have been received by the facility the evening of 9/4/19.

An interview was conducted on 9/5/19 at 3:35 PM with Nurse #10 to discuss the facility ' s procedures to acquire or refill medications needed for a resident. Nurse #10 was working as a hall nurse assigned to a med cart. During the interview, the nurse reported she usually re-ordered a medication when there were 7 to 8 doses left in the resident ' s bubble pack card. She stated some medications could be re-ordered electronically but if they were, the medications may not get sent out from the pharmacy that night. To improve the chances of getting a medication that night, Nurse #10 reported she tended to write out the refill request and fax it to the pharmacy before 5:00 PM. Upon inquiry as to what she would do if a resident was completely out of a medication when it was scheduled for administration, the nurse reported she would first check the facility ' s e-kit. If the medication was not there, she would call the pharmacy and see if it could be sent out STAT (which took approximately 2 hours to receive). If the medication could not be received by the facility in a timely manner, the pharmacy would contact a local retail pharmacy as their back-up pharmacy.

An interview was conducted on 9/5/19 at 4:16 PM with Nurse #9 to discuss the facility ' s procedures to acquire or refill medications needed for a resident. Nurse #9 was working as a hall nurse assigned to a med cart. Upon inquiry, the nurse stated, "We are having issues with this." Nurse

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 09/10/2019

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 755	Continued From page 50	F 755		

#9 reported she would try to re-order a medication when there were 8 doses or so left in the resident ' s bubble pack card. If a resident was out of a medication that was scheduled for administration, the nurse stated she could check a "back up box" (referring to the e-kit) that carried quite a bit of basic medications. If the medication wasn ' t available in-house, Nurse #9 reported she could call their contracted pharmacy and tell them she needed the medication. She reported how soon the facility would receive the medication varied a lot. If the med was ordered from the pharmacy on a STAT basis, she understood it was supposed to arrive in 4 hours but noted that was not always the case. When asked if there was another alternative to acquire the medication if it was needed sooner than 4 hours, Nurse #9 reported the pharmacy did have a local retail pharmacy they could use as a back-up pharmacy.

An interview was conducted on 9/6/19 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the facility ' s procedures for acquiring a medication needed for a resident were discussed. The DON reported if a resident was out of an over-the-counter medication, a member of the staff would go and pick it up at a retail store. If the medication was a prescription medication, she would expect the nursing staff to check the e-kits to see if that particular medication was available in-house. If not, nursing staff would be expected to notify the resident ' s physician to either put the medication order on hold or obtain an order for an appropriate alternative available in-house until the prescribed medication could be obtained. If no appropriate alternative was available, staff needed to call the pharmacy and ask for 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 09/10/2019

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 755	Continued From page 51	F 755		

medication to be sent out to the facility "STAT" (at once).

2-b) Resident #282 was admitted to the facility on 8/16/19. Her cumulative diagnoses included hypertension (high blood pressure).

A medication pass observation was conducted on 9/4/19 at 11:20 AM with Nurse #8 as she prepared medications for administration to Resident #282. The medications scheduled for administration to Resident #282 included 50 milligrams (mg) losartan (an antihypertensive medication) to be given as 100 mg (2 tablets) by mouth one time a day. The nurse reported the resident was out of this medication so it needed to be ordered from the pharmacy. Nurse #8 stated she would need to call the pharmacy to have the medication sent out. Upon further inquiry, the nurse stated the medication would come from the pharmacy sometime today. However, she was not sure if the medication would come in to the facility that afternoon or evening.

A review of Resident #282 ' s physician ' s orders included a current medication order for 50 mg losartan to be given as 100 mg (2 tablets) by mouth one time a day. The medication was scheduled to be administered at 9:00 AM each day.

A follow-up interview was conducted on 9/4/19 at 2:00 PM with Nurse #8. Upon inquiry, Nurse #8 stated the facility had some back up medications in an emergency (ER) medication kit (known as an e-kit) stored in the medication room. Nurse #8 was accompanied as she went to the med room. A review of the itemized list of medications stored

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 09/10/2019

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 755	Continued From page 52	F 755		

in the e-kit revealed it included4 - 25 mg tablets of losartan. . When the nurse was shown the list included losartan, she was asked if this medication could have possibly been used for Resident #282 during the morning med pass. Nurse #8 reported she would double check the dosage and administer the medication since the losartan ordered for Resident #282 had not yet come in to the facility.

A telephone interview was conducted on 9/4/19 at 3:52 PM with a dispensing pharmacist who worked for the facility's contracted pharmacy. During the interview, the pharmacist reported a 15-day supply of losartan was dispensed from the pharmacy for Resident #282 on 8/16/19. She noted only one withdrawal of losartan tablets from the facility ' s e-kit was reported for this resident (on 9/4/19 at 2:50 PM) within the past month. The pharmacist also reported a request was received on 9/4/19 and was being processed for a refill of the resident ' s losartan. When asked, the pharmacist reported deliveries were made to the facility twice daily; one left the pharmacy around 12:00 PM and the second delivery shipment left at 9:00 PM. Upon inquiry, the pharmacist reported if a resident ran out of a medication that was needed before a scheduled delivery, the facility could contact the pharmacy and they would arrange to get the medication at a local retail pharmacy.

An observation of Resident #282 ' s hall med cart was conducted on 9/5/19 at 8:58 AM. The observation revealed no losartan was stored on the medication cart for Resident #282. Upon inquiry, Nurse #3 reviewed the med cart further and confirmed no losartan was stored on the med cart for this resident.

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 09/10/2019

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 755	Continued From page 53	F 755		

A follow-up telephone interview was conducted on 9/5/19 at 2:42 PM with a pharmacy manager at the facility ' s contracted pharmacy. When asked, the pharmacy manager reported Resident #282 ' s losartan had not yet been sent out to the facility. Upon inquiry as to why it had not been dispensed and delivered to the facility, the pharmacy manager reported she was unsure, but thought the medication order may have been held up in adjudication (referring to the process of submitting a claim to insurance).

An interview was conducted on 9/5/19 at 3:35 PM with Nurse #10 to discuss the facility ' s procedures to acquire or refill medications needed for a resident. Nurse #10 was working as a hall nurse assigned to a med cart. During the interview, the nurse reported she usually re-ordered a medication when there were 7 to 8 doses left in the resident ' s bubble pack card. She stated some medications could be re-ordered electronically but if they were, the medications may not get sent out from the pharmacy that night. To improve the chances of getting a medication that night, Nurse #10 reported she tended to write out the refill request and fax it to the pharmacy before 5:00 PM. Upon inquiry as to what she would do if a resident was completely out of a medication when it was scheduled for administration, the nurse reported she would first check the facility ' s e-kit. If the medication was not there, she would call the pharmacy and see if it could be sent out STAT (which took approximately 2 hours to receive). If the medication could not be received by the facility in a timely manner, the pharmacy would contact a local retail pharmacy as their back-up pharmacy.

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 09/10/2019

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 755	Continued From page 54	F 755		

An interview was conducted on 9/5/19 at 4:16 PM with Nurse #9 to discuss the facility ' s procedures to acquire or refill medications needed for a resident. Nurse #9 was working as a hall nurse assigned to a med cart. Upon inquiry, the nurse stated, "We are having issues with this." Nurse #9 reported she would try to re-order a medication when there were 8 doses or so left in the resident ' s bubble pack card. If a resident was out of a medication that was scheduled for administration, the nurse stated she could check a "back up box" (referring to the e-kit) that carried quite a bit of basic medications. If the medication wasn ' t available in-house, Nurse #9 reported she could call their contracted pharmacy and tell them she needed the medication. She reported how soon the facility would receive the medication varied a lot. If the med was ordered from the pharmacy on a STAT basis, she understood it was supposed to arrive in 4 hours but noted that was not always the case. When asked if there was another alternative to acquire the medication if it was needed sooner than 4 hours, Nurse #9 reported the pharmacy did have a local retail pharmacy they could use as a back-up pharmacy.

An interview was conducted on 9/6/19 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the facility ' s procedures for acquiring a medication needed for a resident were discussed. The DON reported if a resident was out of an over-the-counter medication, a member of the staff would go and pick it up at a retail store. If the medication was a prescription medication, she would expect the nursing staff to check the e-kits to see if that particular medication was available in-house. If not,

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 09/10/2019

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 755	Continued From page 55	F 755		

nursing staff would be expected to notify the resident ' s physician to either put the medication order on hold or obtain an order for an appropriate alternative available in-house until the prescribed medication could be obtained. If no appropriate alternative was available, staff needed to call the pharmacy and ask for the medication to be sent out to the facility "STAT" (at once).

3) Resident #39 was admitted to the facility on 5/4/17 with a cumulative diagnoses which included dementia and Parkinson ' s disease.

A review of Resident #39 ' s physician ' s order included a current medication order for 10 milligrams (mg) donepezil to be given as 1 tablet by mouth at bedtime (start date 9/25/17). Donepezil is a medication indicated for the treatment of mild to severe Alzheimer ' s disease. It is also used for dementia associated with Parkinson ' s disease.

A review of Resident #39 ' s Medication Administration Records (MARs) from 3/1/19 to present was conducted. Documentation on the MARs indicated the following:
--March 2019: 10 mg donepezil was documented as administered once daily from 3/1/19-3/31/19;
--April 2019: 10 mg donepezil was documented as administered once daily except on 4/22/19 and 4/23/19;
--May 2019: 10 mg donepezil was documented as administered once daily except on 5/1/19, 5/4/19, 5/10/19, and 5/17/19;
--June 2019: 10 mg donepezil was documented as administered once daily except on 6/18/19;
--July 2019: 10 mg donepezil was documented as administered once daily except on 7/1/19 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 09/10/2019

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 755	Continued From page 56	F 755		

7/2/19;
--August 2019: 10 mg donepezil was documented as administered once daily except on 8/30/19; and,
--September 2019: 10 mg donepezil was documented as administered once daily except on 9/2/19.

A telephone interview was conducted on 9/4/19 at 3:52 PM with a dispensing pharmacist who worked for the facility's contracted pharmacy. During the interview, the pharmacist reported a one month supply (30-count) of 10 mg donepezil was dispensed for Resident #39 on each of the following dates during the last 6 months: 2/21/19, 5/22/19, 7/2/19, and 8/4/19. When asked, the pharmacist reported deliveries were made to the facility twice daily; one left the pharmacy around 12:00 PM and the second delivery shipment left at 9:00 PM. Upon inquiry, the pharmacist reported if a resident ran out of a medication that was needed before a scheduled delivery, the facility could contact the pharmacy and they would arrange to get the medication at a local retail pharmacy.

A review of the facility ' s itemized list of medications stored in an emergency medication kit (known as an e-kit) was conducted. The list indicated the e-kit included 4 - 5 mg tablets of donepezil.

A follow-up telephone interview was conducted on 9/5/19 at 2:42 PM with a pharmacy manager for the facility ' s contracted pharmacy. Upon request, the pharmacy manager reviewed Resident #39's medication records and determined there were no submissions from the facility to indicate donepezil was withdrawn from

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 09/10/2019

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 755	Continued From page 57	F 755		

an e-kit for Resident #39 during the past 6 months. An interview was conducted on 9/6/19 at 1:10 PM with the facility ' s Director of Nursing (DON) in the presence of Corporate Consultant #1 and Corporate Consultant #2. The DON reported the facility did not have any additional records to indicate withdrawals of donepezil were made from an e-kit for Resident #39.

In the presence of Nurse #12, an observation of Resident #39 ' s hall med cart was conducted on 9/6/19 at 8:50 AM. The observation revealed there were 11 tablets of 10 mg donepezil remaining in the bubble pack card dispensed from the pharmacy for Resident #39 on 8/4/19. Nurse #12 confirmed the number of donepezil tablets remaining in the bubble pack card.

An interview was conducted on 9/6/19 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the facility ' s procedures for acquiring a medication needed for a resident were discussed. The DON reported if a resident was out of a prescription medication, she would expect the nursing staff to check the e-kits to see if that particular medication was available in-house. If not, nursing staff would be expected to notify the resident ' s physician to either put the medication order on hold or obtain an order for an appropriate alternative available in-house until the prescribed medication could be obtained. If no appropriate alternative was available, staff needed to call the pharmacy and ask for the medication to be sent out to the facility "STAT" (at once). During the interview, the DON also reported she would expect documentation on the MAR to be consistent with the dispensing records from the pharmacy.

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 09/10/2019

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 758	Continued From page 58	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		10/8/19

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 09/10/2019

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

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F 758	Continued From page 59 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff, and resident interviews, the facility failed to document monitoring for side effects of psychotropic medications for two of five residents reviewed for unnecessary medications (Resident #67 and Resident #36). The findings included: Resident #67 was admitted to the facility 1/31/19. The resident's cumulative diagnoses included: Chronic pain syndrome, contracture, dementia, heart failure, adjustment disorder, anxiety, depression, and psychosis. Resident #67 had a Nursing Progress Note dated 3/5/19 and timed 2:36 PM which documented the resident stated during the night she saw a man with a dog in the hallway close to her door. The resident's door was documented as having been closed. The nurse documented she was unable to corroborate the resident's story through interviews with other residents. Review of Resident #67's physician progress notes revealed delusions and hallucinations were	F 758	F758 1. Resident #67 and #36 both receive psychotropic medications. On 9/5/19 orders received for behavior monitoring for both residents. 2. Current residents who receive psychotropic medications have the potential to be affected. On 9/25/19 residents receiving psychotropic where reviewed to ensure behavior monitoring/side effects monitoring is in place. Issues identified were addressed. 3. The Assistant Director of Nursing and/or Nurse Management will educate licensed nurses on Behavior Monitoring/Side Effect Monitoring for residents who receive psychotropic medications by 10/8/19. The education will be included in Orientation for new hires. 4. Nurse Management/Administrative Nursing will audit behavior monitoring/side effect monitoring 3x week for 4 weeks,	

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 09/10/2019

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 758	Continued From page 60 documented on 3/8/19, 3/21/19, 3/26/19, 4/5/19, 4/9/19, and 4/15/19. Resident #67 had a Nursing Progress Note dated 3/25/19 and timed 5:06 AM which documented the resident thought there was someone playing instruments just to annoy her, and reorientation was ineffective. Review of the progress notes from 6/1/19 through 9/4/19 revealed no discovery of recorded monitoring of potential side effects from psychotropic medications. Review of the progress notes for Resident #67 revealed a Nursing Progress Note dated 6/30/19 and timed 6:41 AM which documented the resident rang multiple times through the night hallucinating with complaints of a dog barking and seeing a man. The resident was documented as having had a history of hallucinating. A review completed of the Minimum Data Set (MDS) assessments for Resident #67 revealed the most recent completed assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 8/10/19. Review of the assessment revealed the resident was coded as having had no cognitive loss. The resident was coded as not having hallucinations or delusions during the assessment period. The resident was coded for a diagnosis of dementia. Further review revealed the resident was documented as having had received antipsychotic medications, antianxiety medications, and antidepressant medications. Resident #67's Treatment Administration Record (TAR) and Medication Administration Record	F 758	then 1x weekly for 2 months and then 1x monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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 09/10/2019

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 758	Continued From page 61	F 758		

(MAR) from 8/1/19 through 9/4/19 provided no discovery of recorded monitoring or observations of hallucinations or potential side effects from psychotropic medications.

Review of Resident #67's Medication Administration Record from 9/1/19 through 9/4/19 revealed the resident was prescribed and received the following: Escitalopram Oxalate tablet (an antidepressant) 20 milligrams (mg) orally once daily, at 9:00 AM, for depression-order date of 2/1/19, Quetiapine Fumarate (an antipsychotic) tablet 50 mg one tablet orally at bedtime each night, at 9:00 PM, for psychosis-order date of 6/18/19, Bupropion Hydrochloride (HCl) (an antidepressant) Extended Release (ER) 100 mg one tablet orally two times a day, at 9:00 AM and 5:00 PM, for depression-order date of 1/31/19, and Alprazolam (an anti-anxiety medication) 1 mg one tablet orally three times a day, at 9:00 AM, 1:00 PM, and 8:00 PM, for anxiety-order date of 1/31/19.

During an interview conducted with Resident #67 on 9/3/19 at 11:39 AM the resident stated there had been a resident, a man, at the facility who played a flute or a recorder at night. The resident further stated the resident had a dog with him while he was at the facility. The resident stated the man returned to the facility at night with his dog and played the flute or recorder at the back door of the facility.

An interview was conducted on 9/4/19 at 12:05 PM with Nursing Assistant (NA) #5. She stated Resident #67 did have hallucinations including there was a dog who slept under the facility in an area which had been cleared out.

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 09/10/2019

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 758	Continued From page 62	F 758		

An interview was conducted on 9/4/19 at 2:53 PM with Nurse #5. She stated Resident #67 did have hallucinations including there was a person at the facility whose name was Kevin, who plays the flute, and he had a dog.

During an interview conducted on 9/5/19 at 10:35 AM Nurse #13 she stated she was the nurse who was assigned to Resident #67 and worked first shift (7:00 AM to 3:00 PM). She stated she had not observed Resident #67 to have had any side effects from psychotropic medications. The nurse stated the resident did not receive any psychotropic medications during her shift, so she would not document psychotropic medication side effects. She further stated there was no area in the MAR or the TAR to document the hallucinations the resident had and she would just basically chart them in the nurses' notes.

An interview was conducted on 9/5/19 at 11:21 AM with Nurse #11. She stated she was the Unit Manager and she was aware of Resident #67's hallucinations. She stated psychiatric services was working with the resident. The nurse stated there should be an area in her TAR or MAR to document the resident's hallucinations behaviors and side effects of psychotropic medications. She further stated sometimes when the nurses were doing orders the monitoring for side effects of medications or behaviors will "fall off" the MAR. She said at one time she thought it was on the resident's MAR but it was not on the resident's current MAR. The nurse stated she would add the monitoring for psychotropic medication side effects on to the resident's MAR.

An interview was conducted on 9/5/19 at 4:41 PM with the Director of Nursing (DON). The DON

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 09/10/2019

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 758	Continued From page 63	F 758		

stated she was aware Resident #67 had hallucinations. She also stated usually a behavior such as hallucinations would be on the resident's MAR to be monitored. The DON stated when a resident was on psychotropic medications there should be monitoring recorded in the resident's MAR. The DON reviewed Resident #67's MAR and stated there was no monitoring on the resident's MAR for hallucinations or side effects of psychotropic medications and she was not sure why the monitoring was not on the resident's MAR. The DON stated sometimes when an item is entered into the MAR such as monitoring for side effects of psychotropic medications the monitoring may have an expiration date and the monitoring may have come off or the monitoring was not entered initially. The DON stated it was her expectation for behavior monitoring for hallucinations and monitoring of potential side effects of psychotropic medications to on the resident's active and current MAR.

An interview was conducted on 9/6/19 at 11:43 AM with the Administrator. She further stated it was her expectation for the clinical team to monitor for side effects of psychotropic medications.

2. Resident #36 was admitted to the facility on 4-2-19 with multiple diagnosis that included cellulitis of the left lower limb, atrial fibrillation, dementia, major depressive disorder psychotic disorder with delusions and anxiety disorder.

The quarterly Minimum Data Set (MDS) dated 7-10-19 revealed Resident #36 was severely cognitively impaired and received antipsychotic medication 7 out of 7 days, antianxiety medication 7 out of 7 days and antidepressant medication 7 out of 7 days.

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 09/10/2019

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 758	Continued From page 64	F 758		

A review of the progress notes dated 7-13-19 to 9-3-19 did not reveal any monitoring of behaviors or side effects from Resident #36's medication.

Resident #36's Medication Administration Record (MAR) was reviewed from 7-1-19 to 9-4-19 which revealed no monitoring of the resident's behaviors or side effects from her medication.

Resident #36's care plan dated 8-14-19 revealed a goal that the resident would be free of psychotropic drug related complications. The interventions for that goal included in part; monitor for side effects and medication effectiveness every shift and review/monitor behaviors/interventions attempted and their effectiveness.

A review of the physicians' orders dated 8-20-19 revealed an order for Seroquel (antipsychotic medication) 50mg (milligrams) in the morning and 100mg in the evening for anxiety.

During an interview with nurse #1 on 9-4-19 at 2:35pm, the nurse stated Resident #36 had been combative, confused and refusing medication at times. She also stated the monitoring of the resident's behavior and side effects to medication were on the medication administration record (MAR) and that a brief narrative should be in the medical records. Nurse #1 was unable to state the last time she documented behaviors or side effects on the MAR as well as in the medical record. When asked, the nurse stated she had not been monitoring Resident #36's behaviors or side effects from her medication.

Nurse #4 was interviewed on 9-4-19 at 4:20pm.

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 09/10/2019

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 758	Continued From page 65	F 758		

The nurse stated Resident #36's medication side effects and behaviors were documented on the MAR. She reviewed Resident #36's MAR and stated, "she doesn't have it on there to assess but she should." When asked, Nurse #4 stated she did not remember monitoring the residents side effects form her medication or her behaviors "the last few times I worked."

The Director of Nursing (DON) was interviewed on 9-4-19 at 4:30pm. The DON stated if a resident had behaviors or side effects from their medication, the nurses would leave a note in the physician's communication notebook, but the nurses should be monitoring every shift with the assessment tool that was on the MAR. She also stated she did not know why Resident #36 did not have the assessment on her MAR.

During an interview with the facility's Psychiatrist on 9-5-19 at 3:30pm, the Psychiatrist stated he saw the resident monthly and that he expected staff to be monitoring and assessing Resident #36's behaviors and side effects of her medication on the MAR. He also stated he did not review the monitoring tool but that his assistant reviewed the assessment on the MAR and would report any irregularities to him.

The Psychiatrist assistant was interviewed on 9-5-19 at 4:20pm. The assistant denied reviewing the MAR of the residents and denied knowing there was a monitoring tool on the MAR for resident side effects and behaviors. The assistant stated she reviewed the physician's orders but did not review any monitoring of side effects from medication or behaviors. She also stated she had not received any information from staff that Resident #36 had psychotic behaviors.

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 09/10/2019

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

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F 758	Continued From page 66 The facility's psychiatrist was interviewed on 9-10-19 at 3:40pm. The Psychiatrist stated he had diagnosed Resident #36 with psychotic disorder with delusions in July 2019 due to the resident seeing family members in the hall in the middle of the night and becoming agitated when trying to find objects that were not there. The Administrator was interviewed on 9-6-19 at 12:20pm. The Administrator stated she did not know why some residents had the monitoring tool for side effects from medication and behaviors and other residents did not but that she expected residents' behaviors and side effects from their medication to be monitored.	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 5 medication errors out of 26 medication opportunities, resulting in a medication error rate of 19.2% for 3 of 7 residents (Resident #24, Resident #282, and Resident #283) observed during medication pass. The findings included: 1) On 9/3/19 at 10:19 AM, Nurse #11 was	F 759	F759 1. Nurse #11 educated by Director of Nursing 9/3/19 on checking emergency kit for resident #24 medication that was not available and on the differences between Senna vs Senna S. Nurse #8 is no longer employed at facility. Nurse #2 educated by Director of Nursing regarding administration of medication within one hour of scheduled time. Medication Error Reports completed for each incident with notification to Physician.	10/8/19

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 09/10/2019

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 759	Continued From page 67 observed as she prepared medications for administration to Resident #24. The medications scheduled for administration to Resident #24 included 50 milligrams (mg) sertraline (an antidepressant). The nurse reported this medication was not on the med cart and she would need to call the pharmacy to have the sertraline sent out. A review of Resident #24 ' s physician ' s orders included a current medication order for 50 mg sertraline to be given as one tablet by mouth one time a day. The medication was scheduled to be administered at 9:00 AM each day. Review of the resident ' s Medication Administration Record (MAR) conducted on 9/4/19 at 11:35 AM revealed Resident #24 did not receive a dose of sertraline at any time on 9/3/19. On 9/4/19 at 2:00 PM, a review of an itemized list of medications stored within the facility ' s emergency (ER) med kit (known as an e-kit) in the medication storage room was conducted. This list indicated the e-kit contained 4 - 50 mg sertraline tablets. The 50 mg sertraline tablets were also observed to be stored in the e-kit at that time. An interview was conducted on 9/4/19 at 4:25 PM with Nurse #11. During the interview, the med pass administration observed on 9/3/19 (which omitted Resident #24 ' s sertraline) was discussed further. Upon inquiry, Nurse #11 reported she did not think she had checked the facility ' s e-kit for the availability of sertraline on 9/3/19. Nurse #11 acknowledged she did not administer any sertraline doses to Resident #24 on 9/3/19. When asked what the facility ' s	F 759	2. Current residents have the potential to be affected. On 9/30/19 medication carts audited to current residents medication record to ensure medications available. Issues identified were addressed. Standardized Medication Pass times established based on location (room number) to ensure timely administration, residents medication times updated. 3. The Assistant Director of Nursing and/or Nurse Management will educate licensed nurses on Medication Administration, Medication Pass Times, and Medication Availability (Ordering/Reordering Process, Emergency Medication Kit, and Back-up Pharmacy) by 10/8/19. The education will be included in Orientation for new hires. 4. Nurse Management will observe 2 nurses pass medications for 5 residents during medication administration passes on random shifts to include all shifts and weekends 3x week for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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 09/10/2019

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 759	Continued From page 68	F 759		

procedure indicated she should do if a medication was not available on the med cart to be administered to a resident at the time it was scheduled, Nurse #11 reported she should first go to the e-kit to see if the med was available. If not, she would go to the other med room to check if the med was available in a second e-kit stored there. When asked if she had taken these steps, the nurse reported she did not. She confirmed Resident #24 did not receive the sertraline as ordered on 9/3/19.

An interview was conducted on 9/6/19 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, observations from the med administration pass were discussed. The DON reported if a prescription medication was not available from the med cart, she would expect the nursing staff to check the e-kits to see if that particular medication was available in-house. If not, nursing staff should notify the resident ' s physician to either put the medication order on hold or obtain an order for an appropriate alternative available in-house until the prescribed medication could be obtained. If no appropriate alternative was available, staff needed to call the pharmacy and ask for the medication to be sent out to the facility "STAT" (at once).

2) On 9/3/19 at 10:19 AM, Nurse #11 was observed as she prepared medications for administration to Resident #24. The medications included one tablet containing 8.6 milligrams (mg) sennosides (a bowel stimulant) taken from a stock medication bottle stored on the med cart.

A review of Resident #24 ' s physician ' s orders included a current medication order for one-50 mg / 8.6 mg Senna tablet to be given two times a

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 09/10/2019

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 759	Continued From page 69	F 759		

day for constipation (initiated on 5/29/19). The combination medication ordered for Resident #24 included two active ingredients, including 50 mg docusate (a stool softener) in addition to 8.6 mg of sennosides.

An interview was conducted on 9/3/19 at 11:48 AM with Nurse #11. Upon inquiry, the nurse reviewed the labeling on the stock bottle containing the medication given to the resident, as well as the order on Resident #24's Medication Administration Record (MAR). Upon review of the stock bottle, only 8.6 mg sennosides was identified as an active ingredient. Review of the labeling on another stock bottle located on the med cart revealed this was a combination medication which contained both 50 mg docusate and 8.6 mg of sennosides. The nurse acknowledged she did not give the resident the combination medication as ordered by the physician.

An interview was conducted on 9/6/19 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the medication administration observations were discussed. The DON reported she would expect nursing staff to ensure the correct medication, dose, patient and administration time were observed during med pass.

3) On 9/4/19 at 11:20 AM, Nurse #8 was observed as she prepared medications for administration to Resident #282. The medications scheduled for administration to Resident #282 included 5 milligrams (mg) amlodipine (an antihypertensive medication) to be given as 1 and ½ tablets (total dose of 7.5 mg). The nurse reported there wasn ' t a full dose of

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 09/10/2019

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 759	Continued From page 70	F 759		

amlodipine available on the med cart for the resident (only the ½ tablet was available). Nurse #8 stated she would need to call the pharmacy to have the medication sent out. Upon further inquiry, the nurse stated the medication would come from the pharmacy sometime today. However, she was not sure if the medication would come in to the facility that afternoon or evening. On 9/4/19 at 11:30 AM, Nurse #8 was observed as she administered the medications to Resident #282. Amlodipine was not administered to the resident at that time; documentation on the resident ' s September 2019 Medication Administration Record (MAR) indicated it was not administered.

A review of Resident #282 ' s physician ' s orders included a current medication order for 5 mg amlodipine to be given as one and one-half tablets (total dose of 7.5 mg) by mouth one time a day. The medication was scheduled to be administered at 9:00 AM each day.

A follow-up interview was conducted on 9/4/19 at 2:00 PM with Nurse #8. During the interview, Nurse #8 stated the facility had some back up medications in the emergency (ER) kit (known as an e-kit) stored in the medication room. Accompanied by Nurse #8, a review of the itemized list of medications stored in the e-kit was conducted; the list included 4 - 5 mg tablets of amlodipine. When the nurse was shown the list included amlodipine, she was asked if this medication could have possibly been used for Resident #282 during the med pass. Nurse #8 reported she would double check the amlodipine dose ordered for the resident and could use this medication since her amlodipine had not yet come in from the pharmacy.

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 09/10/2019

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

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F 759	Continued From page 71	F 759		

A review of Resident #282 ' s September 2019 MAR revealed a second entry was documented by Nurse #8 to indicate the amlodipine was administered on 9/4/19.

An interview was conducted on 9/6/19 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, observations from the med administration pass were discussed. The DON reported if a prescription medication was not available from the med cart, she would expect the nursing staff to check the e-kits to see if that particular medication was available in-house. If not, nursing staff should notify the resident ' s physician to either put the medication order on hold or obtain an order for an appropriate alternative available in-house until the prescribed medication could be obtained. If no appropriate alternative was available, staff needed to call the pharmacy and ask for the medication to be sent out to the facility "STAT" (at once).

4) On 9/4/19 at 11:20 AM, Nurse #8 was observed as she prepared medications for administration to Resident #282. The medications scheduled for administration to Resident #282 included 50 milligrams (mg) losartan (an antihypertensive medication) to be given as 100 mg (2 tablets) by mouth one time a day. The nurse reported the resident was out of this medication so it needed to be ordered from the pharmacy. Upon further inquiry, the nurse stated the medication would come from the pharmacy sometime today. However, she was not sure if the medication would come in to the facility that afternoon or evening. On 9/4/19 at 11:30 AM, Nurse #8 was observed as she administered the prepared medications to

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 09/10/2019

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 759	Continued From page 72	F 759		

Resident #282. Losartan was not administered to the resident at that time; documentation on the resident ' s Medication Administration Record (MAR) indicated it was not administered.

A review of Resident #282 ' s physician ' s orders included a current medication order for 50 milligrams (mg) losartan (an antihypertensive medication) to be given as 100 mg (2 tablets) by mouth one time a day. The medication was scheduled to be administered at 9:00 AM each day.

A follow-up interview was conducted on 9/4/19 at 2:00 PM with Nurse #8. During the interview, Nurse #8 stated the facility had some back up medications in the emergency (ER) kit (known as an e-kit) stored in the medication room. Accompanied by Nurse #8, a review of the itemized list of medications stored in the e-kit was conducted; the list included 4 - 25 mg tablets of losartan. When the nurse was shown the list included losartan, she was asked if this medication could have possibly been used for Resident #282 during the med pass. Nurse #8 reported she would check the losartan dose ordered for the resident and could use this medication since her losartan had not yet come in from the pharmacy.

A review of Resident #282 ' s September 2019 MAR revealed a second entry was documented by Nurse #8 to indicate the losartan was administered on 9/4/19.

An interview was conducted on 9/6/19 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, observations from the med administration pass were discussed. The DON

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 09/10/2019

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

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F 759	Continued From page 73	F 759		

reported if a prescription medication was not available from the med cart, she would expect the nursing staff to check the e-kits to see if that particular medication was available in-house. If not, nursing staff should notify the resident ' s physician to either put the medication order on hold or obtain an order for an appropriate alternative available in-house until the prescribed medication could be obtained. If no appropriate alternative was available, staff needed to call the pharmacy and ask for the medication to be sent out to the facility "STAT" (at once).

5) On 9/4/19 at 11:40 AM, Nurse #2 was observed as she prepared medications for administration to Resident #283. The medications scheduled for administration to Resident #283 included one tablet of 200 milligrams (mg) cefpodoxime (an antibiotic). The medication was administered to the resident on 9/4/19 at 11:41 AM.

A review of Resident #283 ' s physician ' s orders included a current medication order for 200 mg cefpodoxime to be given as one tablet by mouth every 12 hours. The medication was scheduled to be administered at 9:00 AM and 9:00 PM each day.

According to Lexi-Comp, a comprehensive electronic medication database used by medical professionals, cefpodoxime's half-life elimination is approximately 2-3 hours (a relatively short half-life). A drug ' s half-life is the time required for the concentration of a medication in the body to decrease by half.

An interview was conducted on 9/4/19 at 1:55 PM with Nurse #2. When asked about the scheduled

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 09/10/2019

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

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F 759	Continued From page 74 time versus the actual administration time observed for the resident's medications (particularly the cefpodoxime), the nurse responded by saying, "They were behind this morning." An interview was conducted on 9/6/19 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the observations made during the medication administration pass were discussed. The DON reported she would expect an antibiotic such as cefpodoxime to be given within one hour of the scheduled administration time.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		10/8/19

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 09/10/2019

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

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F 761	Continued From page 75 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired medications on 2 of 3 medication carts observed (300 Hall Med Cart and 600 Hall Med Cart); and failed to label medications with a shortened expiration date (300 Hall Med Cart). The findings included: 1) In the presence of Nurse #8, an observation was conducted of the 300 Hall Med Cart on 9/4/19 at 2:25 PM. The observation revealed an opened Lantus Solostar (insulin) pen dispensed by the pharmacy on 5/9/19 and labeled for use by Resident #22 was stored on the medication cart. The insulin pen was dated as having been opened on 6/30/19 and was dated also with an expiration date of 7/27/19. The pharmacy auxiliary sticker placed on the insulin pen read, "Refrigerate until opened. Discard unused medication aft (after) 28 days." At the time of the observation, Nurse #8 reported the opened insulin pen was expired and needed to be discarded. A review of the manufacturer ' s storage instructions indicated that Lantus prefilled pens that have been punctured (in use) should be used within 28 days. A review of the resident's physician orders revealed Resident #22 had a current order for the Lantus insulin.	F 761	F761 1. Expired medications (insulin) for resident #22, resident #42, and #44 were discarded and reordered from pharmacy. 2. Current residents who receive insulin have the potential to be affected. Audit completed on 9/25/19 of residents with insulin orders to ensure insulin on cart not expired and labeled correctly. Medication carts checked on 9/25/19 for expired medications. Issues identified were addressed. 3. The Assistant Director of Nursing/Nurse Management will reeducate licensed nurses by 10/8/19 on Medication Storage and Expiration Dating of Medications. The education will be included in Orientation for new hires. 4. Nurse Management/Administrative Nursing will audit 2 medication carts 3x week for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The	

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	345258	A. BUILDING _____ B. WING _____	C 09/10/2019

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

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F 761	Continued From page 76 An interview was conducted on 9/6/19 at 11:00 AM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported nursing staff was expected to mark insulin pens and vials when they were opened to indicate either the date the insulin was opened or the insulin ' s shortened expiration date; and, expired insulin should be discarded. 2) In the presence of Nurse #9, an observation was conducted of the 600 Hall Med Cart on 9/3/19 at 3:50 PM. The observation revealed an opened Basaglar (insulin) pen dispensed by the pharmacy on 6/24/19 and labeled for use by Resident #42 was stored on the medication cart. The insulin pen was dated as having been opened on 7/1/19. The pharmacy auxiliary sticker placed on a plastic bag containing the insulin pen read, "Refrigerate until opened. Discard unused medication aft (after) 28 days." The shortened expiration date was calculated to be 7/29/19. At the time of the observation, Nurse #9 reported the opened insulin pen was expired and needed to be discarded. A review of Resident #42's MD orders revealed the resident had a current order for Basaglar. A review of the manufacturer ' s storage instructions indicated that Basaglar prefilled pens that have been punctured (in use) should be used within 28 days. A review of the resident's physician orders revealed Resident #42 had a current order for the Basaglar insulin.	F 761	Quality Assurance Improvement Committee meets monthly and as needed.	

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 09/10/2019

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

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F 761	Continued From page 77	F 761		

An interview was conducted on 9/6/19 at 11:00 AM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported nursing staff was expected to mark insulin pens and vials when they were opened to indicate either the date the insulin was opened or the insulin ' s shortened expiration date; and, expired insulin should be discarded.

3) In the presence of Nurse #8, an observation was conducted of the 300 Hall Med Cart on 9/4/19 at 2:25 PM.
The observation revealed an opened vial of Humalog insulin dispensed by the pharmacy on 7/9/19 and labeled for use by Resident #44 was stored on the medication cart. The opened vial of Humalog insulin was not dated as to when it had been opened. At the time of the observation, Nurse #8 reported she did not know when the vial of insulin had been opened.

A review of the manufacturer ' s storage instructions indicated that once punctured (in use), vials should be used within 28 days.

A review of Resident #44's physician orders revealed the resident had a current medication order for Humalog insulin.

An interview was conducted on 9/6/19 at 11:00 AM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported nursing staff were expected to mark insulin pens and vials when they were opened to indicate either the date the insulin was opened or the insulin ' s shortened expiration date.

4) In the presence of Nurse #8, an observation was conducted of the 300 Hall Med Cart 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 09/10/2019

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

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F 761	Continued From page 78 9/4/19 at 2:25 PM. The observation revealed an opened vial of Humalog insulin dispensed for Resident #44 on 7/31/19 was stored on the medication cart. The opened vial of Humalog insulin was not dated as to when it had been opened. At the time of the observation, Nurse #8 reported she did not know when the vial of insulin had been opened. A review of the manufacturer ' s storage instructions indicated that once punctured (in use), vials should be used within 28 days. A review of Resident #44's physician orders revealed the resident had a current medication order for Humalog insulin. An interview was conducted on 9/6/19 at 11:00 AM with the facility ' s Director of Nursing (DON). Upon inquiry, the DON reported nursing staff were expected to mark insulin pens and vials when they were opened to indicate either the date the insulin was opened or the insulin ' s shortened expiration date.	F 761		
F 806 SS=B	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		10/8/19

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 09/10/2019

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 806	Continued From page 79 by: Based on observation and staff interviews the facility failed to honor food preferences on trays from 2 of 5 tray carts reviewed for food preferences resulting in three residents receiving tuna fish sandwiches despite having fish listed as a dislike on their tray cards (Residents #13, #27 and #63). Findings included: 1. Resident #13 was admitted to the facility on 6/6/17. Review of the resident's most recent Minimum Data Set (MDS), which was a quarterly with an Assessment Reference Date (ARD) of 7/4/19, revealed the resident was coded as having had intact cognition. During an interview conducted in conjunction with an observation of the tray line on 9/4/19, which started at 4:49 PM, Dietary Aide #1 stated the dining room tray cart was ready to leave the kitchen and be delivered to the residents. Resident #13's tray was observed to have a tuna fish sandwich on the plate. A review of Resident #13's tray card, which was on the resident's tray, revealed a preference of no fish. During the observation on 9/4/19, which started at 4:49 PM, an interview was conducted with the Dietary Manager (DM). The DM stated the tray card did identify the resident did not want fish and a tuna fish sandwich had been plated for the resident. The DM stated the resident should not have received tuna fish due to the tray card information regarding the resident's request for no fish. The DM stated it was her expectation for the dietary staff to follow the information on the tray cards when plating food for the residents.	F 806	F 806 1. Residents who had received tuna fish were immediately interviewed to clarify their preferences of fish/tuna fish. Immediate changes were made to the tray cards. 2. Residents who receive food trays from the kitchen have potential to be affected. A 100% audit of all residents was done on 10-2/10-4 2019 by the Certified Dietary Manager to review all residents preference food likes/dislikes it was completed for current residents and updates were made as needed. All new residents will have preferences procured within 24 hours of admit. 3. Executive Director/designee educated Healthcare Services Certified Dietary Manager and Assistant Certified Dietary Manager on the importance of F 806 Resident Allergies, Preferences, and Substitutes. In-servicing was done with Healthcare Services kitchen staff by Certified Dietary Manager to ensure that preferences are completed within 24 hours of admission for new residents. Also Healthcare Services staff was in-serviced that if a meal tray does not reflect the tray card then it is changed/substituted. 4. Certified Dietary Manager will bring copies of preference sheets on all new admits to Executive Director/Designee who will monitored 3 x weeks for 4 weeks, then 1x week for 2 months and then 1x monthly for 3 months. The findings will be reviewed monthly by the 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 09/10/2019

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 806	Continued From page 80 The DM further stated sometimes a resident may want tuna fish but does not want other fish. She stated she would prepare an alternate plate for the resident and then follow up with Resident #13 to verify her preference. During an interview conducted on 9/6/19 at 11:43 AM the Administrator stated it was her expectation for dietary staff and nursing staff to read the tray cards and follow the resident's identified food preferences. The Administrator further stated she expected for clarification of likes and dislikes on resident tray cards in the event a resident does not want fish but would like to have tuna fish. 2. Resident #27 was admitted to the facility on 10/2/18. Review of the resident's most recent MDS, which was a quarterly with an ARD of 7/12/19, revealed the resident was coded as having had intact cognition. During an interview conducted in conjunction with an observation of the tray line on 9/4/19, which started at 4:49 PM, Dietary Aide #1 stated the 300 Hall tray cart was ready to leave the kitchen and be delivered to the residents. Resident #27's tray was observed to have a tuna fish sandwich on plate. A review of Resident #27's tray card, which was on the resident's tray, revealed a fish was listed as a dislike. During the observation on 9/4/19, which started at 4:49 PM, an interview was conducted with the Dietary Manager (DM). The DM stated the tray card did identify the resident did not want fish and a tuna fish sandwich had been plated for the resident. The DM stated the resident should not have received tuna fish due to the tray card	F 806	Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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 09/10/2019

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 806	Continued From page 81	F 806		

information regarding the resident's identified dislike of fish. The DM stated it was her expectation for the dietary staff to follow the information on the tray cards when plating food for the residents. The DM further stated sometimes a resident may want tuna fish but does not want other fish. She stated she would prepare an alternate plate for the resident and then follow up with Resident #27 to verify her preference.

During an interview conducted on 9/6/19 at 11:43 AM the Administrator stated it was her expectation for dietary staff and nursing staff to read the tray cards and follow the resident's identified food preferences. The Administrator further stated she expected for clarification of likes and dislikes on resident tray cards in the event a resident does not want fish but would like to have tuna fish.

3. Resident #63 was originally admitted to the facility on 3/11/19 and was most recently readmitted on 8/22/19. Review of the resident's most recent MDS, which was a quarterly with an ARD of 8/6/19, revealed the resident was coded as having had intact cognition.

During an interview conducted in conjunction with an observation of the tray line on 9/4/19, which started at 4:49 PM, Dietary Aide #1 stated the 300 Hall tray cart was ready to leave the kitchen and be delivered to the residents. Resident #63's tray was observed to have a tuna fish sandwich on plate. A review of Resident #63's tray card, which was on the resident's tray, revealed a preference of no fish.

During the observation on 9/4/19, which started 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 09/10/2019

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

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F 806	Continued From page 82 4:49 PM, an interview was conducted with the Dietary Manager (DM). The DM stated the tray card did identify the resident did not want fish and a tuna fish sandwich had been plated for the resident. The DM stated the resident should not have received tuna fish due to the tray card information regarding the resident's identified dislike of fish. The DM stated it was her expectation for the dietary staff to follow the information on the tray cards when plating food for the residents. The DM further stated sometimes a resident may want tuna fish but does not want other fish. She stated she would prepare an alternate plate for the resident and then follow up with Resident #63 to verify her preference. Further observation revealed a tray card for another resident which identified a preference of no fish but tuna OK. The DM stated when she identified the resident's preference and if tuna fish was OK, she would put the information on the tray card in a similar manner. During an interview conducted on 9/6/19 at 11:43 AM the Administrator stated it was her expectation for dietary staff and nursing staff to read the tray cards and follow the resident's identified food preferences. The Administrator further stated she expected for clarification of likes and dislikes on resident tray cards in the event a resident does not want fish but would like to have tuna fish.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		10/8/19

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F 812	Continued From page 83 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to remove a build-up of dried debris from food service equipment. The facility failed to maintain clean handles, knobs, or top surface on four of five pieces of kitchen equipment observed for cleanliness. Findings Included: Observations of the kitchen conducted on 9/3/19 at 9:40 AM, 9/4/19 at 4:49 PM, and 9/5/19 at 3:47 PM revealed the following: a. Two of two handles on the reach in cooler were observed to have a buildup of dried debris on the interior aspect of each handle. b. Two of two handles on the convection oven were observed to have a buildup of dried debris on the interior aspect of each handle. c. One of two knobs on the convection oven were observed to have a buildup of dried debris. d. Eleven of eleven knobs on the stove/oven/flat	F 812	F 812 1. The kitchen was immediately scrubbed and had dried debris cleaned off of handles, knobs, and top surfaces of kitchen equipment. 2. Residents who receive their nutrition from the kitchen have potential to be affected. 3. Executive Director/designee educated HSG Dietary CDM on the importance of F 812 Food Procurement, Store/Prepare/Service-Sanitary. A weekly cleaning audit tool was created to ensure that the Kitchen knobs, surfaces and handles remain clean and free from debris. 4. The Dietary manager will utilize the Weekly Kitchen Audit tool to monitor each item (Handles, Knobs, and Surfaces) for cleanliness 3 x weeks for 4 weeks, then	

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F 812	Continued From page 84 top grill were observed to have a buildup of dried debris. e. The dish machine was observed to have had food debris residue on the top of the machine from the ware washing cycles. An interview and observation were conducted with the Dietary Manager (DM) on 9/5/19 at 3:47 PM. The observation revealed the following: two of two handles on the reach in cooler were observed to have a buildup of dried debris on the interior aspect of each handle, two of two handles on the convection oven were observed to have a buildup of dried debris on the interior aspect of each handle, and one of two knobs on the convection oven were observed to have a buildup of dried debris. The DM stated it was her expectation for the knobs, handles, and other hand contact surfaces to be maintained clean. The dish machine was observed to have had food debris residue on the top of the machine from the ware washing cycles. The DM stated it was her expectation for the dish machine to be wiped down daily or when it had become dirty. During an interview conducted on 9/6/19 at 11:43 AM the Administrator stated it was her expectation for handles, hand contact surfaces such as knobs, and food service equipment to be kept clean. In addition, the Administrator stated it was her expectation for the kitchen equipment to be cleaned routinely and kept clean as part of the cleaning schedule.	F 812	1x week for 2 months and then 1x monthly for 3 months. The findings will be brought to the Quality Assurance Improvement Committee and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	
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	F 842		10/8/19

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F 842	Continued From page 85	F 842		

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;
(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

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F 842	Continued From page 86 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 observations, staff interviews and record reviews, the facility failed to maintain accurate medical records in the area of diabetic testing (Resident #14) and medication administration (Resident #24). This was for 2 of 33 residents reviewed for accurate medical records. The findings included: 1) Resident #14 was admitted to the facility on 3/28/19 with diagnoses that included diabetes, history of cerebrovascular accident (CVA- a stroke) and hypertension.	F 842	F842 Resident Records 1) Resident #14 admitted to facility on 3/28/19 no accucheck documentation noted for 6 days (4/4/19 thru 4/9/19) accucheck order received on 4/10/19. On 9/4/19 Nurse #8 documented inaccurately on Medication Administration Record that resident #24 receive her Sertraline. Once nurse was made aware of the inaccurate documentation, nurse retrieved the medication from emergency medication kit and administered medication to resident #24. Nurse #8 no longer employed at facility.	

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F 842	Continued From page 87 Review of the medical record revealed Resident #14 had been seen in the Emergency Room on 4/2/19 for a hypoglycemic (low blood sugar) episode. A review of the April 2019 physician orders indicated orders dated 4/3/19 for accuchecks before meals and at bedtime with no coverage. Review of the April 2019 Medication Administration Record (MAR) revealed accuchecks were not documented as obtained by the nurse or refused by the resident for 6 out of 30 days (4/4/19, 4/5/19, 4/6/19, 4/7/19, 4/8/19 and 4/9/19). A review of the quarterly Minimum Data Set (MDS) dated 7/5/19 revealed Resident #14 to be cognitively intact and received extensive to total assistance from staff for all Activities of Daily Living (ADLs). The active care plan revealed a care plan for diabetes with interventions that included blood sugar checks as ordered. A phone call was placed to Nurse #5, who was scheduled to work 3rd shift on 4/6/19, on 9/6/19 at 8:34am. A message was left for a return call which was not received during the survey. A phone call was placed to Nurse #6, who was scheduled to work 3rd shift on 4/7/19, on 9/6/19 at 8:35am. A message was left for a return call that was not received during the survey. On 9/6/19 at 8:39am a telephone interview occurred with Nurse #7, who worked 3rd shift on 4/8/19 and 4/9/19. She indicated she was no	F 842	2) Current residents who require diabetic testing and residents who have ordered medications have the potential to be affected. On admission nurse will initiate accuchecks for diabetic residents and record results on the medication administration record. Medications carts audited to ensure medications are available for residents on 9/27/19. On 9/26/19 diabetic residents were audited to ensure accucheck orders in place and are being recorded accurately in medication administration record. Issues identified were addressed. 3) The Assistant Director of Nursing/Nurse Management will reeducate licensed nurses on Accurate Documentation, Recording Accuchecks in Point Click Care, and emergency medications availability by 10/8/19. The education will be included in Orientation for new hires. 4) Nurse Management/Administrative Nursing will audit 3 diabetic residents requiring diabetic testing to ensure accuchecks are being recorded, and 2 carts will be audited for med availability 3x week for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months. Nurse Management/Administrative Nursing will observe 3 random nurses on random shifts during medication administration pass to ensure accurate documentation 3x week for 4 weeks, then 1x weekly for 2 months and then 1x monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement	

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F 842	Continued From page 88 longer employed at the facility and couldn't recall why the accuchecks were not documented on the MAR or vital sign record. A telephone interview was conducted with the facility's former Nurse Practitioner (NP) on 9/6/19 at 9:28am. She indicated it would be her expectation for accuchecks to be obtained as ordered and documented on the MAR. An interview occurred with Nurse #2 on 9/6/19 at 10:23am, who worked 1st shift on 4/5/19, 4/6/19 and 4/7/19. She stated she had obtained the accuchecks as ordered but could not recall why they were not documented on the MAR or vital sign record. On 9/6/19 at 10:41am an interview was held with Nurse #1, who worked 1st shift on 4/4/19, 4/8/19 and 4/9/19. She stated she obtained the accuchecks as ordered but failed to document them on the MAR or vital sign record. An interview was completed with the Director of Nursing on 9/6/19 at 11:45am and stated it was her expectation for accuchecks to be obtained as ordered by the physician and documented on the MAR. 2) Resident #24 was admitted to the facility on 7/5/16 with re-entry from a hospital on 9/8/16. Her cumulative diagnoses included depression. A review of Resident #24 ' s physician ' s orders included a current medication order for 50 milligrams (mg) sertraline to be given as one tablet by mouth one time a day. The medication was initiated on 10/24/17 and scheduled to be administered at 9:00 AM each day.	F 842	committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	

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F 842	Continued From page 89	F 842		

A medication pass observation was conducted on 9/3/19 at 10:19 AM with Nurse #11 as she prepared medications for administration to Resident #24. The medications scheduled for administration to Resident #24 included 50 milligrams (mg) sertraline (an antidepressant). The nurse reported this medication was not on the med cart and she would need to call the pharmacy to have it sent out. Nurse #11 correctly documented on the resident ' s Medication Administration Record (MAR) the sertraline was not administered at that time.

An observation was conducted on 9/4/19 at 11:35 AM of the med cart used for Resident #24. The observation revealed there was no sertraline available on the med cart for administration to the resident. However, a review of Resident #24 ' s September 2019 MAR revealed sertraline was documented as having been administered to the resident the morning of 9/4/19.

An interview was conducted on 9/4/19 at 2:00 PM with Nurse #8. Nurse #8 was the 1st shift nurse assigned to Resident #24 ' s med cart. Upon request, the nurse reviewed both the medications stored on the cart for Resident #24 and the resident ' s MAR. Nurse #8 confirmed no sertraline was stored on the med cart for this resident. However, she also confirmed she had documented on the MAR that sertraline was administered to the resident the morning of 9/4/19. She stated, "It was missed." Upon further inquiry, Nurse #8 reported the facility had some back up medications in an emergency (ER) medication kit (known as an e-kit) stored in the medication room. The nurse stated she did not check the e-kit earlier that day when Resident #24 ' s sertraline was scheduled for

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F 842	Continued From page 90 administration at 9:00 AM. Nurse #8 was observed as she went to the med room. A review of the itemized list of medications stored in the e-kit revealed it contained both 25 mg and 50 mg tablets of sertraline. The nurse was then observed to obtain a 50 mg tablet of sertraline from the e-kit and administer it to Resident #24. An interview was conducted on 9/6/19 at 11:00 AM with the facility's Director of Nursing (DON). During the interview, the DON reported she would expect documentation on a resident ' s MAR to be accurate.	F 842		