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 _____	07/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755	**Preparation and/or execution of this plan does not constitute agreement or admission by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.**	

§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 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 record review, observation, and staff interview the facility failed to discontinue a medic ordered stop date for 1 of 5 res[illegible] unnecess s,

F755 D 483.459(a) (b) (1)-(3) Pharmacy Services/Procedures/Pharmacy Records 8/7/18

A root cause analysis was completed regarding administration of medication when physician orders have expired.

LABORATORY [illegible] SIGNATURE Executive Director TITLE (X6) DATE 8-28-18

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

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 _____	07/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 1 Resident #43. The findings included: Resident #43 was admitted to the facility on 3/20/15 and readmitted on 4/27/18 with diagnoses of amputation of right leg above the knee; end stage kidney disease with dialysis treatments, diabetes, hypertension, chronic pain, heart disease, anxiety and depression. Review of Resident #43's most recent comprehensive Minimum Data Set Assessment revealed he was cognitively intact and required extensive assistance with turning in the bed, transferring to and from the bed, and using the toilet; and he could feed himself with set up assistance by staff. Review of Resident #43's medication orders revealed an order was written for a Cold and Cough (Dextromethorphan and Guaifenesin) medicine 10 milligrams-100 milligrams/5 milliliters, give 10 milliliters by mouth every 6 hours for cough for 7 days. Review of Resident #43's Medication Administration Record for 6/2018 revealed a Cold and Cough (Dextromethorphan and Guaifenesin) was first administered on 6/21/18 and continued through 6/30/18. Review of Resident #43's Medication Administration Record for 7/2018 revealed the Cold and Cough (Dextromethorphan and Guaifenesin) continued to administer every six hours every day from July 1, 2018 to July 18, 2018.	F 755	Resident #43 had no side effects from the administration of the Robitussin on 7/18/18 after medication discontinuation order/date. A respiratory assessment was completed no negative outcomes were noted. Physician notified and orders received, initiated. No further follow up was required. Quality review of current resident's physician orders for discontinued orders were completed by the Director of Nursing on 7/23/18. Follow up based on findings.	

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 _____	07/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 2 A Physician's Progress Note dated 7/6/18 reviewed Resident #43's laboratory results and revealed the Physician ordered a change in his pain medication. The Physician's Progress Note did not address the resident's continued use of the Cough and Cold medicine (Dextromethorphan and Guaifenesin) as ordered. An interview with Nurse #2 on 7/18/18 at 3:31 pm revealed he wasn't aware the Cough and Cold (Dextromethorphan and Guaifenesin) was ordered with a stop date. He stated when the order is put into the computer the nurse entering it should put the stop date into a specific box. He stated if the stop date is not put into the box it will continue as an indefinite order. Nurse #2 stated he would correct the order in the electronic system, complete a med error report, and let Resident #43's Responsible Party and Physician know about the error. An interview with the Director of Nursing on 7/19/18 at 10:37 am revealed Nurse #2 had completed a Medication Error Report and reported the medication error of the failure to stop the Cough and Cold medicine (Dextromethorphan and Guaifenesin) to the Director of Nursing. Nurse #2 had also notified the Responsible Party and the Physician regarding the medication error. She stated the facility had educated Nurse #2 and the nurse that entered the order without the stop date on how to appropriately enter physician's orders in the electronic system. She stated the nurse that entered the error did not know she should complete the box giving the stop date in the electronic system which caused the medication error. The Director of Nursing stated her expectation was that all nursing staff would enter	F 755	Nurse #2 received re-education on Preventing Medication errors by on 8/1/18 by Director of Nursing. Nurse #2 had competency based medication Administration Observations completed times three by Unit manager/designee 8/1/18 who provided re-education to licensed nurses on 8/1/18; regarding Preventing Medication Errors. New employees to be provided education during orientation. Director of Nursing/Designee to complete Quality Improvement Monitoring of Medication orders and Medication Administration records (MAR) for physician ordered stop dates daily x 2 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 _____	07/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 3 physician's orders correctly into the electronic system to ensure there were no medication errors.	F 755		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews, the facility ' s Quality Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 6/15/2017 recertification survey. This was for a re-cited deficiency in infection control (F441). This deficiency was cited again on the current recertification survey of 7/19/2018 (F880). The continued failure of the facility during two federal surveys of record showed a pattern of the facility ' s inability to sustain an effective QAPI program. The findings included: This tag is cross referenced to: F880- Infection Control Based on observation and staff interview the facility failed to handle soiled linens appropriately on 2 of 3 resident halls. Dirty linen was observed in open trash bags that were on the floor on the facility ' s 400 and 500 halls.	F 867	then weekly x 4 weeks, then monthly x 3 months then quarterly. Findings to be reviewed at the monthly Quality Assurance Performance Improvement committee meeting. Quality monitoring schedule based on findings. **F867 QAPI/QAA Improvement Activities 483.75 (g) (2) (ii)** A root cause analysis was completed on Facility's quality Assurance Performance Improvement processes. Quality Review has been conducted using the last 6 months Quality Assurance Performance Improvement minutes by Regional Director of Clinical Services, and reviewed by	8/7/18

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 _____	07/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 4 During the recertification survey of 6/15/2017 the facility was cited for failure to follow hand washing protocols after providing care to residents who were under special enteric contact precautions. An interview was conducted with the Administrator on 7/19/201 at 2:47 PM. He reported the QAPI meeting took place monthly with him, the Director of Nurses (DON), Assistant Director of Nurses, the medical director, dietician and other department heads, as well as a nursing assistant. The Administrator reported the QAPI team outlined the deficiency and developed a Performance Improvement Plan (PIP) to correct the deficiency and review the issues that were identified in QAPI meetings. The Administrator shared the DON had recently started in her position and he was an interim Administrator. The Administrator concluded that the management team toured the facility each morning during the week and identified issues, and later in the day, the management team would review those issues identified and resolved, or required additional work. The Administrator reported the management team had not identified the staff ' s improper handling of soiled linen as an issue.	F 867	the Interdisciplinary Team of the Quality Assurance Performance Improvement Meeting Process. A focus of Quality review on Facility Procedures related to infection control was done. Follow up based on findings Regional Consultant provided re-education for facility Interdisciplinary team related to Quality Assurance Performance Improvement Committee Process/maintenance of procedures implemented on 8/1/18. Administrator/Director of Nursing/Designee to conduct Quality Improvement Monitoring of implementation/maintenance of procedures/systems related to linen/infection control weekly x 4 weeks	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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 _____	07/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct		then monthly. Findings to be reviewed at monthly Quality Assurance Performance Improvement Committee Meeting monthly and as needed. Regional Corporate Representative to attend Quality Assurance Performance Improvement Committee Meeting monthly x 3 months then quarterly validating implementation/maintenance systems/procedures relating to Infection Control: i.e. linen storage/disposal **F880 483.80 (a) (1) (2) (4) (e) (f) Infection Control**	8/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING _____ B. WING _____	07/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to handle soiled linens appropriately on 2 of 3 resident halls. Dirty linen was observed in open trash bags that were on the floor on the facility's 400 and 500 halls. The findings included: On 7/18/18 at 5:51 am an observation of the 500-hall revealed there were two large open trash bags which contained soiled linen on the floor of the 500-hall hallway. On 7/18/18 at 6:05 am an observation of the 400-hall revealed there was one large, black, open trash bag of soiled linen on the floor of the 400-hallway. An interview with Nurse Aide #1 at 7/18/18 at 6:45 am revealed she was assigned to the 500-hall.	F 880	A root cause analysis was completed on the processes for disposal of Soiled Linen. Certified Nursing Assistant #1 has been provided individual re-education regarding storage/disposal of soiled linens per policy/regulation on 7/30/18 by the Director of Nursing. Certified Nursing Assistant #2 has been provided re-education on storage and disposal of linens per policy/regulation 7/30/18 by the Director of Nursing. Quality Monitoring through observation completed 7/30/18 by Director of Nursing regarding soiled linen storage/disposal. Follow up based on findings.	

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 _____	07/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 She stated the dirty linen and trash should be gathered up after each room in small trash bags and taken to the dirty utility room. She stated after they put the linen and trash in the bins in the dirty utility room they should wash their hands and then go to the next room during their rounds. NA #1 stated she was in a hurry and placed the linen on the floor of the 500-hallway instead of taking it to the dirty utility after each room. On 7/18/18 at 6:51 am Nurse #1 was interviewed and stated she was assigned the 400, 500, and 600 halls. She stated the staff had an Infection Control In-service one month ago. She stated she was aware Nurse Aide #1 and Nurse Aide #2 had placed the soiled linen on the floor in open bags this morning. She stated they should take the soiled linen to the dirty utility room after each room instead of leaving the soiled linen in the hall. An interview on 7/18/18 at 7:08 am with Nurse Aide #2 revealed she was assigned to the 400-hall and had an Infection Control In-service last year. She stated they were taught to take the linen to the dirty utility room after they changed each resident. Nurse Aide #2 stated she had placed the open bag of dirty linen on the 400-hallway floor and should have taken it to the dirty utility room after each room. On 7/19/18 at 10:30 am an interview with the Director of Nursing revealed her expectation was that staff would bag soiled linen from each room and take it to the soiled utility room to place in the linen bins. She stated they should complete hand hygiene and then return to their hall. She stated the facility had implemented taking the soiled linen in small garbage bags to the dirty utility room to prevent odors on the halls.	F 880	Current Certified Nursing Assistants and licensed nurses re-educated by the Director of Nursing/Designee regarding ensuring infection control is maintained per professional standards related to proper storage/disposal of soiled linen on 8/1/18. New employees provided education during orientation. Director of Nursing/Designee to complete Quality Improvement monitoring of proper disposal/ soiled linen daily x 2 weeks, then weekly x 4 weeks, then monthly x 3 months then quarterly. Findings to be reviewed at the monthly Quality Assurance	

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 _____	07/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Performance Improvement committee meeting. Quality monitoring schedule based on findings.	8/7/18