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

PRINTED: 07/24/2018 FORM APPROVED

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TO. IIIIDUGSS S,		medic ord	lered stop date for 1 of 5		(orders have expired	
ABORATORY C SIGNATURE	ABORATORY (#		

Any deficienc

which the Institution may be excused from correcting providing it is determined that

other safeguards provide suffici tents. (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 to provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 202011

Facility ID: 923060

If continuation sheet Page 1 of 9

PRINTED: 07/24/2018

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	CMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		345258	B. WING		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07/19/2018
TRANSIT!	TONAL HEALTH SERVICE	ES OF KANNAPOLIS		1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083	en de St
(X4) ID PREFIX TAG	(EACH DEFICIENC)	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	PE COURT
F 755	Continued From page	9 1	F 766	Resident #43 had no side	e.
	Resident #43.		1 100	effects from the	
	The findings included:	* *		administration of the	
	Resident #43 was adr 3/20/15 and readmitte diagnoses of amputati knee; end stage kidne treatments, diabetes, i heart disease, anxiety Review of Resident #4 comprehensive Minim revealed he was cogn extensive assistance v	mitted to the facility on ed on 4/27/18 with tion of right leg above the ey disease with dialysis hypertension, chronic pain, y and depression. 43's most recent num Data Set Assessment of the pain in the bed, en the bed, and using the ed himself with set up	; \$.	Robitussin on 7/18/18 aff 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	on :
	revealed an order-was Cough (Dextromethorp medicine 10 milligrams give 10 millilliters by me cough for 7 days. Review of Resident #4 Administration Record and Cough (Dextromet	s written for a Cold and phan and Guaifenesin) s-100 milligrams/5 milliliters, outh every 6 hours for 43's Medication I for 6/2018 revealed a Cold athorphan and Guaifenesin) on 6/21/18 and continued		required. Quality review of current resident's physician order for discontinued orders were completed by the Director of Nursing on 7/23/18. Follow up based on findings.	a.

2018.

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,

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVED
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		PLE CONSTRUCTION G	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER IONAL HEALTH SERVICI	es of Kannapolis		STREETADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083	07/19/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RF COMPLETION
F 755	A Physician's Progres reviewed Resident #/ revealed the Physicia pain medication. The did not address the re the Cough and Cold re	ss Note dated 7/6/18 13's laboratory results and in ordered a change in his Physician's Progress Note isident's continued use of	F 78	education on Preventing Medication errors by on 8/1/18 by Director of Nursing. Nurse #2 had competency based	
	An interview with Nurs	se #2 on 7/18/18 at 3:31 pm		medication Administration	1

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 Gualfenesin) 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

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,

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

PRINTED: 07/24/2018 FORM APPROVED OMB NO. 0938-0304

I STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	D.C. 1.44 11 74		OMB NO. 0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY
ļ		• "	A. BUILDING	Photography and the state of th	COMPLETED
_	44	0.150.50			
William on a	201 15 70 70 000	. 345258	B. WING		07/19/2018
NAME OF F	PROVIDER OR SUPPLIER		. [STREET ADDRESS, CITY, STATE, ZIP CODE	1 0771072010
TRANSIT	IONAL HEALTH SERV	ICES OF KANNAPOLIS	. [1810 CONCORD LAKE ROAD	
				KANNAPOLIS, NC 28083	¥i. _e ,
(X4) 1D	SUMMARY	STATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTION	ou.
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D RE COURTERNA
170	THE OPEN TOTAL	or too including the information)	TAG	CROSS-REFERENCED TO THE APPROA	PRIATE DATE
				DEFICIENCY)	
F 755	Continued From pa	200 3		then weekly x 4 weeks	
1,00			F 75	then monthly x 3 month	·
		correctly Into the electronic			
	errors.	here were no medication		then quarterly. Finding	s to
E 007		hannani A attatet - a		he reviewed at the more	
SS≂D	QAPI/QAA Improve CFR(s): 483.75(g)(STIENT ACTIVITIES	F 86	7	itiliy
ಧಿನ≂ರ	Os 13(8). 400.70(g)(2)(11)		Quality Assurance	
•	\$483.75(a) Qualify	assessment and assurance.			
	3 1041. 4(9) 4:4411()	area description.		Performance Improven	nent [
	§483.75(g)(2) The	quality assessment and		committee meeting.	
	assurance committ			Quality monitoring	
	(ii) Develop and im	plement appropriate plans of		adanty mornioring	1
	action to correct ide	entified quality deficiencies;		schedule based on	
		NT is not met as evidenced		findings.	
	by:			manigo:	
	Based on record re	eview, observations, and		F867 QAPI/QAA	4
•	interviews, the facil	ity 's Quality Assessment and			
	Performance Impro	vement (QAPI) Committee		Improvement Activities	8/7/18
	raned to maintain in	nplemented procedures and		483.75 (g) (2) (ii)	Ì
	put into place follow	/entions that the committee		400.70 (g) (z) (ii)	
		y. This was for a re-cited		A	
	deficiency in infection	on control (F441). This		A root cause analysis wa	s :
	deficiency was cited	d again on the current		completed on Facility's	
	recertification surve	y of 7/19/2018 (F880). The		•	
		the facility during two federal		quality Assurance	
		howed a pattern of the facility '		Performance Improvement	nt
	s inability to sustain	an effective QAPI program.			
				processes.	
	The findings include	ed:		0 " 0	
	med 4 4			Quality Review has been	* ·
	This tag is cross ref	erenced to:		conducted using the last (3
	EDOO Infaattan O	and .			
	F880- Infection Con			months Quality Assurance	9
		on and staff interview the die solled linens appropriately		Performance Improvemen	nt I
		alls. Dirty linen was observed		minutes by Posional	"
		that were on the floor on the		minutes by Regional	1
	facility 's 400 and 6			Director of Clinical	}
				Services, and reviewed by	,
.,		· · · · · · · · · · · · · · · · · · ·		, and leviewed b	y

PRINTED: 07/24/2018

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				FORM APPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MUI	TIPLE CONSTRUCTION	•	OMB NO, 0938-0391
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		······	(X3) DATE SURVEY COMPLETED
	- Western	. 345258	8. WING			<u>07/19/20</u> 18
MAMEOFF	ROVIDER OR SUPPLIER			STREET ADDRESS, CI	TY. STATE, ZIP CODE	V/18/2018
TRANSIT	IONAL HEALTH SERVICE	S OF KANNAPOLIS	•	1810 CONCORD LAK	E ROAD	is its Sac
	(0)	o or ranning out		KANNAPOLIS, NC	28083	V.
(X4) 1D	SUMMARY STA	ATEMENT OF DEFICIENCIES	lD	PRÓVI	DER'S PLAN OF CORRECTION	0.00
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	X (EACH CO	ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION TE DATE
F 867	Continued From page	44	ε	the Interd	lisciplinary Team	
			r		ality Assurance	
	During the recertificati facility was cited for fa	ion survey of 6/15/2017 the illure to follow hand washing		Performa	nce Improvemen	t ļ
	protocols after providi	ng care to residents who		Meeting F	Process. A focus	
	were under special en	teric contact precautions.		of Quality	review on	
	An interview was cond			Facility P	rocedures related	l k
	Administrator on 7/19/	201 at 2:47 PM, He		to infectio	n control was	
	with him the Director	eting took place monthly of Nurses (DON), Assistant				
	Director of Nurses, the	e medical director, dietician			low up based on	
	and other department	heads, as well as a nursing		findings		
	assistant. The Adminis	strator reported the QAPI		Regional	Consultant	
	Performance Improve	ciency and developed a ment Plan (PIP) to correct			re-education for	
ı	the deficiency and revi	iew the issues that were			terdisciplinary	
	shared the DON had r	tings. The Administrator			ited to Quality	
	position and he was at	n interim Administrator, The			e Performance	
	Administrator conclude	ed that the management / each morning during the		_		
	week and identified iss	sues, and later in the day,			nent Committee	
	the management team	would review those issues			maintenance of	
	Identified and resolved work. The Administrate				es implemented	
	management team had	d not identified the staff 's		on 8/1/18		i
	Improper handling of s	oiled linen as an issue.				1
	Infection Prevention &	Control		Administr	ator/Director of	Į.
SS=D	CFR(s): 483.80(a)(1)(2	2)(4)(e)(f)			esignee to	a
	§483.80 Infection Cont	trol		conduct (
	The facility must estab	lish and maintain an			•	,
	infection prevention an	d control program			nent Monitoring o	
	designed to provide a	safe, sanitary and		implemer	ıtation/maintenar	ı İ
	comfortable environme	ent and to help prevent the			edures/systems	
	diseases and infections	mission of communicable				
	and an interpretation	√,		related (O	linen/infection	1

control weekly x 4 weeks

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

PRINTED: 07/24/2018 FORM APPROVED OMB NO. 0938-0304

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CONSTRUCTION		OMB NO. 0938-0391	
AND PLANTOF	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILD		(4)	3) DATE SURVEY COMPLETED	
		345258	B. WING	<u> </u>		07/19/2018	
NAME OF P	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE			
TRANSIT!	TONAL HEALTH SERVICE	ES OF KANNAPOLIS	•	1810 CONCORD LAKE ROAD		1	
	Dalle M. Jacoby O.			KANNAPOLIS, NC 28083			
(X4) ID PREFIX TAG	(EAGH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTION SHOU	UED RE	(X5) COMPLETION DATE	
F 880	Continued From page	ie 5		then monthly. Findings	to		
• • .				be reviewed at monthly			
	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention			Quality Assurance			
	The facility must esta and control program	ablish an infection prevention (IPCP) that must include, at		Performance Improvem	nent		
	a minimum, the follow			Committee Meeting	•		
		em for preventing, identifying, ng, and controlling infections		monthly and as needed	1 .		
	and communicable d	diseases for all residents,		Regional Corporate			
	staff, volunteers, visit providing services un	tors, and other individuals inder a contractual		Representative to atten	'n		
	arrangement based u	upon the facility assessment		Quality Assurance	·u		
	conducted according accepted national sta	g to §483,70(e) and following		Performance Improvem	4		
	·				leni		
		n standards, policies, and		Committee Meeting			
	procedures for the probut are not limited to:	rogram, which must include, :		monthly x 3 months the	n		
	(i) A system of survei	illance designed to identify		quarterly validating			
	possible communicat	ble diseases or		implementation/mainter	nan		
	Infections before they persons in the facility			ce systems/procedures			
	(ii) When and to who	m possible incidents of		relating to Infection		m imila m	
	communicable diseas reported:	se or infections should be		Control: i.e. linen		8/7/18	
	•	nsmission-based precautions		storage/disposal			
	to be followed to prev	vent spread of infections;		otorage/alsposal			
	 (iv)When and how iso resident; including bu 	olation should be used for a					
	(A) The type and dura					ធ	
	depending upon the in	infectious agent or organism		F880 483.80 (a) (1) (2) (4)		
	involved, and (B) A requirement that	at the isolation should be the		(e) (f) Infection Control	ĺ		
	least restrictive possi	ble for the resident under the		• • • • • • • • • • • • • • • • • • • •			
	circumstances.			•			
		es under which the facility rees with a communicable					
		kin lesions from direct					

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

PRINTED: 07/24/2018 FORMAPPROVED OMB NO. 0938-0391

, — · · ·	OF DEFICIENCIES			<u> </u>	OMB NO. 0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		, 345258	B. WING	3	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	07/19/2018
	ONAL HEALTH SERVICE		At the	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083	(a ²
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
F 880	Continued From page contact with residents	or their food, if direct	F	A root cause analysis was	as
	contact will transmit the (vi)The hand hygiene by staff involved in directions.	procedures to be followed		processes for disposal of Soiled Linen.	f
	§483.80(a)(4) A syste identified under the fa corrective actions take			Certified Nursing Assista #1 has been provided individual re-education	nt
	§483.80(e) Linens. Personnel must handl transport linens so as infection.	e, store, process, and to prevent the spread of		regarding storage/dispos of soiled linens per policy/regulation on	al
	IPCP and update their This REQUIREMENT by: Based on observation facility failed to handle on 2 of 3 resident halk in open trash bags that	ot an annual review of its r program, as necessary, is not met as evidenced and staff interview the esciled linens appropriately a. Dirty linen was observed at were on the floor on the		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	g
	facility's 400 and 500 l The findings Included:			7/30/18 by the Director of Nursing.	
	On 7/18/18 at 5:51 am 500-hall revealed then bags which contained the 500-hall hallway. On 7/18/18 at 6:05 am 400-hall revealed them	e were two large open trash solled linen on the floor of an observation of the		Quality Monitoring throug observation completed 7/30/18 by Director of Nursing regarding soiled linen storage/disposal.	h '
	open trash bag of solle 400-hallway.	ed linen on the floor of the		Follow up based on findings.	

am revealed she was assigned to the 500-hall.

		AND HOMAN SERVICES		•	FORM APROAVED
1 .		MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,		. 345258	B. WING		Sertialoga Ser
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07/19/2018
TRANSIT	TONAL HEALTH SERVICE	FS OF KANNAPOLIS	. 1	1810 CONCORD LAKE ROAD	* 3
				KANNAPOLIS, NC 28083	٧.
(X4) ID PREFIX TAG	(EACH DEFICIENC	MATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DE (X5) DE COMPLETION ATE DATE
F880	a a minimum a r roim parga		F 88	Current Certified Nursing	
l	She stated the dirty li	linen and trash should be		Assistants and licensed	
l	gatnered up alter eac and taken to the dirty	ch room in small trash bags y utility room. She stated		nurses re-educated by the	.
l	 after they put the liner 	en and trash in the bins in the		Director of	;
	 then go to the next ro- 	should wash their hands and com during their rounds. NA		Nursing/Designee	
i	#1 stated she was in a	a hurry and placed the linen			
i	on the floor of the 500	00-hallway instead of taking it		regarding ensuring	
i	to the dirty utility after	/ each room.		infection control is	
į	On 7/18/18 at 6:51 ar	m Nurse #1 was interviewed		maintained per	
-	and stated she was a	assigned the 400, 500, and		professional standards	
	Control in-service on	d the staff had an Infection se month ago. She stated		related to proper	
	she was aware Nurse	e Aide #1 and Nurse Aide #2		storage/disposal of soiled	
i	had placed the soiled	linen on the floor in open			
i	bags this morning. or the soiled linen to the	She stated they should take e dirty utility room after each		linen on 8/1/18. New	
i	room instead of leavir	ing the soiled linen in the hall.		employees provided	;
i				education during	
i	An interview on 7/18/1 Aide #2 revealed she	/18 at 7:08 am with Nurse		orientation.	
	400-hall and had an Ir	Infection Control In-service			
ı	last year. She stated	they were taught to take the		Director of	
	linen to the dirty utility	y room after they changed Alde #2 stated she had		Nursing/Designee to	
	placed the open bag o	Alde #2 stated she had of didy linen on the		complete Quality	
,	400-hallway floor and	I should have taken it to the			_
	dirty utility room after o	each room.		Improvement monitoring of	F Q
	On 7/19/18 at 10:30 ε	am an interview with the		proper disposal/ soiled	•
	Director of Nursing rev	vealed her expectation was		linen daily x 2 weeks, then	
	that staff would bag so	coiled linen from each room		weekly x 4 weeks, then	
	and take it to the solle	ed 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.

monthly x 3 months then

quarterly. Findings to be

reviewed at the monthly

Quality Assurance

CENTERS FOR MEDICARE & MEDICAID SERVICES JATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: 345258 B. WING TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS. CITY, STATE, ZIP CO 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083 (X4) ID PREFIX GEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TO THE CONSTRUCTION A. BUILDING STREET ADDRESS. CITY, STATE, ZIP CO 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083 CROSS-REFERENCED TO THE CONCORD LAKE ROAD TAG CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING B. WING TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING B. WING TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING B. WING TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING B. WING TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING B. WING TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING B. WING TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS CROSS-REFERENCED TO THE CONSTRUCTION A. BUILDING CROSS-REFERENCED TO THE CON	. OM (X3)	FORM APPROVED B NO. 0938-0391 DATE SURVEY COMPLETED 07/19/2018
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 345258 B. WING MAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIVE TAG CROSS-REFERENCED TO THE	(X3)	DATE SURVEY COMPLETED 07/19/2018
MAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTUAL PROFIX (EACH CORRECTIVE ACTUAL PR		.15
MAME OF PROVIDER OR SUPPLIER TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CO KANNAPOLIS, NC 28083 (X4) ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIVE TAG CROSS-REFERENCED TO THE DEFICIENCY		.15
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (CROSS-REFERENCED TO THE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH CORRECTIVE ACTIVE ACTI		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIV TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY	CODECTION	7
, D	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
Performance Important committee meeti Quality monitorin schedule based of findings.	orovement ng.	8/7/18