STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 and complaint investigation survey were conducted from 3/14/22 through 3/17/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # U83Q11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 3/14/22 through 3/17/22. Event ID# U83Q11. The following intakes were investigated NC00176407 and NC00186226. 1 of the 4 complaint allegations was substantiated resulting in deficiencies, F677.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to determine whether the self-administration of medication was clinically appropriate for 1 of 1 sample residents (Resident # 15) who was observed to have medications at bedside. The findings included: Resident #15 was admitted to the facility on 11/17/2014 with re-entry from a hospital on 1/5/2022. His cumulative diagnosis included encephalopathy, anxiety, and sclerosis.	F 554	1. Director of Nursing educated responsible nurse regarding medication administration on 3-16-22. Resident #15 was made aware that medications cannot be left at bedside on 4-7-22. Resident□s niece called on 4-7-22 and also informed medications cannot be left at bedside. 2. A quality review was completed by the Assistant Director of Nursing and the Unit Manager of all resident rooms on 3-18-22 and no further issues related to medications at the bedside were	4/12/22

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

Electronically Signed | 04/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 554	Continued From page 1 Resident #15's most recent Minimum Data Set (MDS) was a quarterly assessment dated 1/9/2022. The MDS revealed Resident #15 had intact cognitive skills for daily decision making. A review of Resident #15's most recent care plan dated 2/21/2022 included an area of focus which indicated the resident had potential for impaired or inappropriate behaviors. The resident was not care planned for the self-administration of his medications. The resident's current physician orders included the following medications: - A combination cream made up of nystatin power, hydrocortisone powder, and zinc oxide apply to sacrum and buttocks topically two times a day for skin irritation, ordered on 1/6/2022. - Fluticasone Propionate Suspension (steroid nasal spray) 2 sprays in both nostrils one time a day for nasal congestion/dryness, ordered on 1/6/2022. - Oxymetazoline (nasal decongestant spray) 1 spray in each nostril every 12 hours as needed for nasal congestion, ordered on 2/3/2022. The physician orders did not include an order for the resident to self-administer any of his medications. A review of Resident #15's electronic medical record revealed no assessments were completed for the self-administration of his medication. An observation was conducted on 3/14/2022 at 11:54 A.M. revealed Resident #15 had medication to include a bottle of fluticasone propionate and a bottle of oxymetazoline at his bedside.	F 554	identified. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director educated the Department Managers on monitoring for medications at the bedside when completing mock survey environmental rounds on 4-7-22. The Director of Nursing and/or the Assistant Director of Nursing provided education to licensed nurses regarding medication administration including not leaving medications at bedside, completed by 4-11-22. Director of Nursing / Assistant Director of Nursing / Unit Manager will provide education for any new licensed nursing staff at the time of orientation and to any contracted licensed nursing staff prior to the start of their first shift. 4. The Director of Nursing/Assistant Director of Nursing or Unit Manager will conduct random Quality reviews of resident□s rooms to ensure medications were not left at bedside on 10 random residents 3 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 554	Continued From page 2	F 554		

An observation was conducted on 3/16/2022 at 2:20 P.M. revealed a bottle of fluticasone propionate and a bottle of oxymetazoline on Resident #15's over bed table. On a piece of furniture beside Resident #15's bed was a container of combination cream made up of nystatin power, hydrocortisone powder, and zinc oxide with a prescription label on the container that revealed Resident #15's name and administration instructions.

An interview was conducted on 3/16/2022 at 2:21 P.M. with Resident #15 revealed the bottle of Fluticasone Propionate Suspension nasal spray and a bottle of Oxymetazoline nasal spray at his bedside were brought to him, per his request, by his niece. During the interview Resident #15 stated the combination cream was left in his room for staff to apply to his buttocks when needed with incontinence care.

A follow up interview was conducted with Resident #15 on 3/16/2022 at 3:05 P.M. revealed he self-administered the nasal sprays when the lids were not tightly applied.

An interview was conducted on 3/16/2022 at 3:22 P.M. with Nurse #9 revealed during her morning medication administration pass, Resident #15 asked her to administer him the Fluticasone Propionate Suspension and Oxymetazoline located on his bedside table. Nurse #9 stated she declined to administer Resident #15 the medications. During the interview the Nurse further stated the medication was left at the bedside while she spoke to the Unit Manager and then the medication was removed from Resident #15's bedside. Nurse #9 stated medication could not be left at Resident #15's bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 554	Continued From page 3 An interview conducted on 3/16/2022 at 4:17 P.M. with the Unit Manager revealed Resident #15 was observed with medication at his bedside and he did not have an order to self-administer medication. During the interview the Unit Manager stated she called and spoke with Nurse Practitioner #1 who stated Resident #15 was not to have medications at the bedside because he was not self-administering. The Unit Manager stated she would not expect to find unattended medications at Resident #15's bedside. An interview conducted on 3/16/2022 at 4:35 P.M. with the Director of Nursing (DON) revealed she was unaware Resident #15 had medication in his room and she would not expect to find any medication in his room for self-administration. An interview conducted on 3/17/2022 at 12:45 P.M. with the Nurse Practitioner (NP) #1 revealed Resident #15 was not able to administer his own medication. The NP further stated she was advised by staff the medication had been removed from Resident #15's bedside.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 578	Continued From page 4 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately document advanced directives (code status) throughout the medical record for 1 of 3 hospice residents (Resident #52) reviewed for advanced directives. The findings included:	F 578	1. Resident #52 care plan was updated by Social Service Director to accurately reflect code status of Do Not Resuscitate on 3-16-22. 2. A quality review was conducted by Social Service Director/ Social Services Assistant of current residents to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 578	Continued From page 5 Resident #52 was admitted to the facility on 12/3/21 with diagnoses which included: osteoporosis with age related pathological fracture, moderate protein-calorie malnutrition, peripheral vascular disease, thyroid disorder, atrial fibrillation, heart disease, stroke, hemiplegia (weakness of one side of the body), depression, generalized weakness, arthritis, and asthma. A review of Resident #52's Electronic Medical Record (EMR) revealed a physician ' s order dated 1/25/22 for the resident ' s code status to be Do Not Resuscitate (DNR). Resident #52 ' s medical record (hard chart) at the nurses ' station had a Do Not Resuscitate sheet which had an effective date of 1/27/22. Further review of the record revealed a Medical Orders for Scope of Treatment (MOST) form which indicated the resident was a DNR and it was dated 1/27/22. Review of Resident #52 ' s Care Plan revealed a Focus area for the resident receiving Hospice care, with a revision date of 2/17/22. Further review revealed a focus area for the resident having advanced directives of full code, which had a revision date of 3/8/22 by Minimum Data Set (MDS) Nurse #2. During an interview conducted on 3/16/22 at 3:22 PM MDS Nurse #1 and MDS Nurse #2, MDS Nurse #1 stated she reviewed the EMR for Resident #52 and she saw where the resident was a DNR and when she reviewed the care plan, she saw where the resident ' s care plan addressing advanced directives, had the resident as a full code. She stated the resident ' s advanced directives in the care plan should	F 578	care plans accurately reflect physician□s order for code status on 3-25-22. Results of quality review reflected all care plans accurately reflected physicians orders. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director provided education to the Social Services Department and MDS Coordinator on 4-7-22 regarding ensuring the code status on care plan accurately reflects physician order. 4. The Social Services Director/Social Services Assistant will conduct random Quality reviews of 10 residents care plans to ensure the code status in care plan accurately reflects the physician order 3 times a week for 8 weeks then weekly for 4 weeks. The Social Services Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 578	Continued From page 6	F 578		

match what is in the medical record. She explained the full code status had been entered by Social Worker (SW) #3, who was no longer employed at the facility. She further stated when a resident ' s code status changes, it is the responsibility of the Social Worker to update the resident ' s care plan. She said Social Worker #1 should have updated Resident #52 ' s code status to DNR when the resident ' s code status changed. MDS Nurse #2 stated the care plan had been recently reviewed after a significant change MDS assessment and it would have been the Social Worker ' s responsibility as well to validate the resident ' s advanced directives were accurate in the care plan and to update them if they were not.

An interview was conducted on 3/16/22 at 3:50 PM with Social Worker (SW) #1 and she stated the code status for Resident #52 was listed as DNR in the resident ' s EMR, on the resident dashboard. She said when she reviewed the care plan, she saw where the resident was listed as a full code, and it was incorrect. The SW explained, the resident had recently gone onto hospice, and the resident ' s code status had changed. She further stated whoever had completed the care plan focus area was responsible for updating the care plan, and for advanced directives, that was social work. The SW stated she was updating the resident ' s focus area to DNR at the time of the interview.

The Director of Nursing (DON) stated during an interview, conducted on 3/17/22 at 3:12 PM, a resident ' s code status should be updated immediately when there is a change, and it should be consistent, and accurate throughout the medical record. She further stated, the code

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 578	Continued From page 7 status still should have been updated in the care plan when the determination was made for the resident to have been a DNR.	F 578		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 585		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 585	Continued From page 8	F 585		

grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 585	Continued From page 9 the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document if a grievance was resolved, if a complainant was satisfied, complainant remarks, if the investigation results and resolution steps were reported to the family, resident, or resident council, how the results were communicated (verbal, written, other), and failed to sign the grievance resolution section as completed. This failure was discovered during investigation of grievances filed for two of three residents (Resident #58 and Resident #59) who were reviewed for grievances. Findings include: A review was completed of the Clinical Guideline-Complaint/Grievance, with a revision date of 8/9/28. The review revealed the guideline	F 585	1. The Social Service Director/Executive Director interviewed Resident/Responsible Party #58 and #59 on 4-7-22 to ensure any concerns with missing items from meals and personal items are resolved and determine if any other grievances exist or require follow-up. Resident #58 and #59 expressed their grievances were resolved any additional grievances were noted on a grievance form. All grievances were documented with a written summary of resolution. 2. A quality review was completed on 4-8-22 by the Social Service Director and Assistant by interviews of residents with Brief Interview of Mental Status score of 8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 585	Continued From page 10 read in part the center (facility) actively seeks a resolution, and keeps the resident appropriately apprised of its progress toward resolution. The purpose was to support each resident ' s right to voice grievances; resulting in a follow-up and resolution while keeping the resident apprised of its progress toward resolution. As part of the process for the grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. Further review revealed once the follow-up is complete, the results should be forwarded to the Executive Director (Administrator) for review and filing. The Administrator will log complaints/grievances in the monthly grievance log or electronic equivalent. The individual voicing the grievance shall be receive follow up communication with resolution, a copy of the grievance resolution will be provided to the resident upon request. 1. Resident #58 was admitted to the facility on 6/30/20. a. Review of a grievance form completed by a family member of Resident #58, dated 1/13/22, revealed no documentation if the grievance was resolved, if the complainant was satisfied, complainant remarks, if the investigation results and resolution steps were reported to the family, resident, or resident council, how the results were communicated (verbal, written, other), and there was no signature indicating the grievance resolution section was completed. b. During an interview conducted on 3/14/22 with a family member of resident #58 she stated the resident ' s lower dentures went missing some time last year, and a month ago the resident ' s upper dentures went missing. She stated the	F 585	or greater and the responsible party of un-interviewable residents, to ensure any missing items from meals and personal items are resolved and follow up provided. All grievances received were documented with a written summary of resolution. Any future residents identified with grievances will follow re-established grievance process. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Regional Director of Nursing educated the Executive Director, Director of Nursing, Social Services Director and Social Services Assistant on the federal regulations and guidelines related to the resident□s right to ensure grievances are resolved, followed up and a written summary to include the grievance resolution section is complete on 4-7-22. 4. Executive Director will conduct random quality reviews of 5 resident grievances 3 times per week for 8 weeks, then weekly for 4 weeks to ensure resident□s grievances are resolved and followed up on the grievance resolution section with signature. The Executive Director will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 585	Continued From page 11	F 585		

resident was awaiting replacement dentures and did not know the status of her replacement dentures.

Review of a grievance form completed by a family member of Resident #58, dated 2/10/22, revealed the resident ' s family had filed a grievance regarding the resident ' s missing dentures. Further review of the grievance revealed no documentation if the grievance was resolved, if the complainant was satisfied, complainant remarks, if the investigation results and resolution steps were reported to the family, resident, or resident council, how the results were communicated (verbal, written, other), and there was no signature indicating the grievance resolution section was completed.

An interview was conducted on 3/17/22 at 1:04 PM with Social Worker (SW) #1. She stated she and the Social Worker Assistant (SWA) shared completing the resolution of grievances as well as they also share the responsibility of being the grievance coordinator. Regarding grievance a, dated 1/13/22 from Resident #58, she stated she would have to review that grievance with the Administrator for resolution with the complainant. For the other grievance, b, dated 2/10/22, she stated she wasn ' t sure if the resolution portion of the grievance should have been completed, because it was regarding missing dentures. She said they were working with a dentist who came to the facility, and the dentist was in the process of determining if the resident was a candidate for denture replacements, and that process took time.

An interview was conducted with the Administrator on 3/17/22 at 1:08 PM. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 585	Continued From page 12	F 585		

Administrator stated while the family of Resident #58 was still in the facility, she had discussed with the nursing staff matters related to Grievance a, and she was awaiting the resident ' s receipt of the dentures to finalize grievance b.

During an interview conducted on 3/17/22 at 3:12 with the Director of Nursing (DON), she stated she made sure her grievances were completed in 3 days, she follows up with the resident ' s family on the day she works on the grievance, and she documents on the grievance form she had followed up with the resident ' s family. She further stated the grievance was completed by the Grievance Coordinator, who was the facility social worker.

The Regional Nurse Consultant stated in an interview, conducted on 3/17/22 at 3:26 PM, the grievance policy addressed grievance needed to be resolved within 14 days, and she stated she verified that information in the policy.

During an interview conducted on 3/17/22 at 5:58 PM with the Administrator she stated grievance forms needed to be completed, including the resolution portion of the grievance form to make sure the complainant is aware of the grievance being resolved.

2. Resident #59 was admitted to the facility on 10/1/21.

During an interview with Resident #59 on 3/14/22 at 4:22 PM the resident expressed concerns with receiving items for meals.

Review of a grievance form completed by Resident #59, dated 1/3/22, revealed the 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 03/17/2022

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 585	Continued From page 13	F 585		

had expressed concern regarding what she had received for breakfast. The description of the concern was the resident only had eggs on her breakfast tray, no cereal/toast/grits. It was documented the resident would like to receive grits with eggs for breakfast. Under the documentation of investigation, the grievance was forwarded to the Dietary Manager (DM), and he documented he updated her request on her meal ticket. The DM signed the documentation section as completed and dated it 1/5/22. Further review revealed no documentation if the grievance was resolved, if the complainant was satisfied, complainant remarks, if the investigation results and resolution steps were reported to the family, resident, or resident council, how the results were communicated (verbal, written, other), and there was no signature indicating the grievance resolution section was completed.

An interview was conducted on 3/17/22 at 1:04 PM with Social Worker (SW) #1. She stated she and the Social Worker Assistant (SWA) shared completing the resolution of grievances as well as they also share the responsibility of being the grievance coordinator.

During an interview conducted on 3/17/22 at 3:12 with the Director of Nursing (DON), she stated she made sure her grievances were completed in 3 days, she follows up with the resident ' s family on the day she works on the grievance, and she documents on the grievance form she had followed up with the resident ' s family. She further stated the grievance was completed by the Grievance Coordinator, who was the facility social worker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 585	Continued From page 14 The Regional Nurse Consultant stated in an interview, conducted on 3/17/22 at 3:26 PM, the grievance policy addressed grievance needed to be resolved within 14 days, and she stated she verified that information in the policy. During an interview conducted on 3/17/22 at 5:58 PM with the Administrator she stated grievance forms needed to be completed, including the resolution portion of the grievance form to make sure the complainant is aware of the grievance being resolved.	F 585		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including	F 622		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 622	Continued From page 15	F 622		

Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 622	Continued From page 16 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: The facility failed to document a resident ' s discharge in the medical record for one of one resident (Resident #76) reviewed for hospitalization. The findings included: Resident #76 was admitted to the facility on 1/8/22 and was discharged to a local hospital on 1/17/22. A review of Resident #76's Electronic Medical Record (EMR) conducted on 3/17/22 revealed no progress note documenting the resident ' s condition prior to discharge, reason for discharge, time of discharge, who the resident was	F 622	1. Resident #76 no longer resides at the facility. A note was entered into the electronic chart of resident #76 to reflect the reason for the discharge, resident's condition prior to discharge, and family was present. Nurse #9 was re-educated regarding discharge documentation requirements when sending resident to emergency room/hospital on 4-10-22 by Director of Nursing. 2. A quality review of resident discharges to emergency room/hospital in last 30 days was completed by the Director of Nursing/Assistant Director of Nursing to ensure a progress note was documented	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 622	Continued From page 17 discharged with, where the resident was discharged to, or who the nurse was who discharged the resident. Further review revealed no information regarding the resident ' s discharge such as a discharge assessment, or change in condition form, notification form. The review did reveal a physician ' s verbal order dated 1/17/22 for the resident to be sent to the Emergency Room for evaluation and treatment. The Director of Nursing (DON) provided a document, which was not in the resident ' s medical record. The document detailed written communication in between Nurse #1 and an on-call Nurse Practitioner (NP). The document was time stamped as thread started 1/17/22 at 5:48 PM. Nurse #1 communicated Resident #59 ' s medical history and updated information such as vital signs, oxygen saturation, resident ' s complaints that she can ' t breathe, and the NP ordered a stat (immediately) chest x-ray. Further review of the thread revealed the resident had been sent out to the Emergency Room per family request. During an interview with the Unit Manager for the 400/500/600 hall unit conducted on 3/17/22 at 4:00 PM she stated the nurse who discharged the resident should have completed a change in condition assessment for Resident #76, but she did not know who the nurse was or how come the nurse did not complete the assessment. She further stated because there was no documentation regarding when the resident went out, or information regarding the resident ' s decline in condition, she did not know who to discuss the resident ' s discharge with to obtain further information. She reviewed the resident ' s Medication Administration Record for 1/17/22 and	F 622	to reflect reason for discharge, resident□s condition prior to discharge, whom the resident was discharged with (Emergency Medical Services-EMS, family), physician order with Medical Doctor-MD or Nurse Practitioner-NP/responsible party notification of discharge on 4-8-22. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing provided re-education to licensed nurses on documentation of discharges to include: reason for discharge, resident□s condition prior to discharge, whom the resident was discharged with (EMS, family), physician order with MD/responsible party notification of discharge by 4-10-22. All newly hired licensed nurses will be educated on their orientation date regarding Transfer and discharge documentation by the Director of Nursing / Assistant Director of Nursing / Unit Manager. Director of Nursing / Assistant Director of Nursing / Unit Manager will provide education to any contracted nursing services working in the facility prior to the start of their first shift. All discharges / Transfers will be reviewed at clinical meeting to ensure documentation in place to reflect reason for discharge, residents condition prior to discharge, whom resident was discharged with, physician order with MD/Responsible party notification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 622	Continued From page 18 stated Nurse #1 had administered her medications from 7:00 AM to 7:00 PM and possibly she had sent the resident out to the Emergency Room. A phone interview was conducted on 3/17/22 at 4:20 PM and Nurse #1 stated she remembered administering medications to Resident #76 but did not send her out to the hospital. Attempts to contact the nurse #9 who worked after Nurse #1 on 3/17/22, who started at 7:00 PM, were unsuccessful. During an interview with the Director of Nursing conducted on 3/17/22 at 5:44 PM she stated when a resident was sent out to the hospital there needed to be information in the medical record regarding the reason the resident was discharged to the hospital. An interview was conducted with the Administrator on 3/17/22 at 5:58 PM and she stated when a resident was discharged to the hospital from the facility there needed to be documentation such as the reason how come the resident was discharged, the time the resident was sent out to the hospital or emergency room, if the physician was aware, if the resident ' s family was aware, and how the resident was being transported.	F 622	4. The Director of Nursing/Assistant Director of Nursing or Unit Manager will conduct random Quality reviews of resident□s discharges to emergency room/hospital to ensure documentation complete to include reason for discharge, resident□s condition prior to discharge, whom the resident discharged with (EMS, family), physician order with MD and responsible party notification on 5 random residents 3 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 655	Continued From page 19	F 655		

implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 655	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to develop a baseline care plan within 48 hours of the resident ' s admission for 4 of 9 newly admitted residents reviewed (Resident #35, Resident #29, Resident #76, and Resident #77). The findings included: 1) Resident #35 was admitted to the facility on 6/29/21. Her cumulative diagnoses included dementia, diabetes, and renal insufficiency. A review of the resident ' s paper and electronic medical record (EMR) was conducted. Neither the paper chart nor the EMR included a baseline care plan. An interview was conducted on 3/16/22 at 3:35 PM with the facility ' s Minimum Data Set (MDS) Nurse #1 and MDS Nurse #2. During the interview, MDS Nurse #1 reported she would typically initiate a comprehensive care plan for newly admitted residents. MDS Nurse #2 would also work with the comprehensive care plans and update them on an as needed basis. However, the MDS nurses reported they did not complete residents ' baseline care plans. The nurses suggested a baseline care plan for Resident #35 may be stored in Medical Records as part of her thinned paper chart. An interview was conducted with the Medical Records staff member. She reported Resident #35 did not have a thinned paper chart. An interview was conducted on 3/16/22 at 3:45	F 655	1. Resident□s #29 had their baseline care plan completed and reviewed with the resident/RP on 4-10-22. Resident□s #35, #76 and #77 no longer reside at the facility. 2. A quality review of residents admitted in the last 30 days was conducted by the Director of Nursing and the Assistant Director of Nursing on 4-8-22. This quality review was to determine if the baseline care plans for these admitted residents were developed and reviewed with the resident within 48 hours. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director educated the Director of Nursing, Assistant Director and Unit Manager on the expectations of nursing management ensuring that the policy & procedures were adhered to regarding the completion of the baseline care plans on 4-7-22. The Director of Nursing and/or the Assistant Director of Nursing provided education to the nursing staff regarding developing and reviewing baseline care plans with the resident and/or responsible party within 48 hours to include instructions necessary to properly care for a resident including, but not limited to-(A) Initial goals based on admission orders.(B) Physician orders.(C) Dietary orders.(D) Therapy services.(E)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 655	Continued From page 21 PM with two hall nurses, Nurse #2 and Nurse #3. During the interview, the hall nurses reported they themselves did not fill out a baseline care plan for residents. Nurse #3 reported she thought a resident ' s baseline care plan was already filled out upon admission to the facility. Nurse #2 suggested the MDS nurses may be responsible for completing the baseline care plans. Assisted by Nurse #2 and Nurse #3, Resident #35 ' s paper chart was again reviewed. The paper chart for Resident #35 did not include a baseline care plan. An interview was conducted on 3/16/22 at 3:53 PM with the facility ' s Director of Clinical Services (DCS). During the interview, the DCS was asked who was responsible to complete a newly admitted resident's baseline care plan. She stated, "The nurse who does the admission assessments." The DCS further explained that the Assistant Director of Nursing (ADON), Unit Manager, or she herself would frequently help with a new resident ' s admission paperwork while the hall nurse was supposed to complete the admission assessment and then fill out the baseline care plan with the information obtained. Upon inquiry, the DCS reported she would expect a resident ' s baseline care plan to be kept in his/her paper chart. 2) Resident #29 was admitted to the facility on 1/31/22. Her cumulative diagnoses included diabetes and chronic obstructive pulmonary disease (COPD). A review of the resident ' s paper and electronic medical record (EMR) was conducted. The paper chart for Resident #29 had a blank baseline care plan form placed in the chart.	F 655	Social services.(F) PASARR recommendation, if applicable. The facility must provide the resident and their representative with a summary of the baseline care plan that include but is not limited to:(i) The initial goals of the resident.(ii) A summary of the resident's medications and dietary instructions.(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.(iv) Any updated information based on the details of the comprehensive care plan, as necessary by 4-11-22. The Director of Nursing / Assistant Director of Nursing / Unit manager to educate any new licensed nursing staff on Baseline Care plans at the time of their orientation as well as any contracted licensed nursing staff to be educated by Director of Nursing / Assistant Director of Nursing / Unit Manager on Baseline care plans prior to the start of their first shift. Baseline care plans will be reviewed at all Clinical Meetings by Director of Nursing / Assistant Director of Nursing / Unit Manager for completion. Any Friday or Saturday admissions will be reviewed by Department Head Manager on Duty or designee for review of completion. 4. The Director of Nursing/Assistant Director of Nursing or Unit Manager will conduct Quality reviews of 5 random resident□s chart 3 times a week for 8 weeks then weekly for 4 weeks to ensure baseline care plan developed and implemented within 48 hours with summary of care plan to the resident and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 655	Continued From page 22 An interview was conducted on 3/16/22 at 3:35 PM with the facility ' s Minimum Data Set (MDS) Nurse #1 and MDS Nurse #2. During the interview, MDS Nurse #1 reported she would typically initiate a comprehensive care plan for newly admitted residents. MDS Nurse #2 would also work with the comprehensive care plans and update them on an as needed basis. However, the MDS nurses reported they did not complete residents ' baseline care plans. The nurses suggested a completed baseline care plan for Resident #29 may be stored in Medical Records as part of her thinned paper chart. An interview was conducted with the Medical Records staff member. She reported Resident #29 did not have a thinned paper chart. An interview was conducted on 3/16/22 at 3:45 PM with two hall nurses, Nurse #2 and Nurse #3. During the interview, the hall nurses reported they themselves did not fill out a baseline care plan for residents. Nurse #3 reported she thought a resident ' s baseline care plan was already filled out upon admission to the facility. Nurse #2 suggested the MDS nurses may be responsible for completing the baseline care plans. An interview was conducted on 3/16/22 at 3:53 PM with the facility ' s Director of Clinical Services (DCS). During the interview, the DCS was asked who was responsible to complete a newly admitted resident's baseline care plan. She stated, "The nurse who does the admission assessments." The DCS further explained that the Assistant Director of Nursing (ADON), Unit Manager, or she herself would frequently help with a new resident ' s admission paperwork while	F 655	their representative. The Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 655	Continued From page 23	F 655		

the hall nurse was supposed to complete the admission assessment and then fill out the baseline care plan with the information obtained. Upon inquiry, the DCS reported she would expect a resident ' s baseline care plan to be kept in his/her paper chart.

3. Resident #76 was admitted to the facility on 1/8/22 and was discharged to a local hospital on 1/17/22. The resident ' s diagnoses included age related osteoporosis with pathological fracture, chronic kidney disease, generalized weakness, fracture of the pubis, peripheral vascular disease, osteoarthritis, heart disease, difficulty swallowing, depression, and diabetes.

A review of Resident #76's Electronic Medical Record (EMR) conducted on 3/17/22 revealed no baseline care plan.

A review of Resident #76 ' s medical record, or hard chart conducted on 3/17/22 revealed no paper care plan or paper copy of a baseline care plan.

An interview was conducted with Minimum Data Set (MDS) Nurse #1 and MDS Nurse #2 on 3/17/22 at 5:31 PM. MDS Nurse #1 stated the baseline care plan was a paper care plan, located in the resident ' s actual medical record, or hard chart. MDS Nurse #1 then stated the floor nurses, the Director of Nursing (DON), unit managers, or the nurse who completes the admission of a resident would initiate the paper copy of the baseline care plan. She said initiating the paper copy of the baseline care plan is part of the admission process for a new resident.

During an interview conducted with the DON on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 655	Continued From page 24	F 655		

3/17/22 at 5:42 PM she stated when a new resident is admitted the admitting nurse was supposed to initiate the baseline care plan, which is a paper document. She explained the admitting nurse would have completed an assessment of the resident and would have the most knowledge of the resident and was the person who was most capable of completing an accurate baseline care plan. She further stated the baseline care plan for the new admit resident would then be reviewed the next clinical meeting day after the admission. She added the baseline care plan was also reviewed during their journey home meeting, which is a meeting involving the facility staff, the resident, and the resident ' s family. The DON said it is very important to complete the baseline care plan and it was her expectation for baseline care plans to be completed for all new admissions.

An interview was conducted on 3/17/22 at 5:58 PM with the Administrator. The Administrator said she expected for the baseline care plan needed to be completed for all new admissions.
4. Resident #77 was admitted to the facility on 12/17/2021. Her cumulative diagnosis included small bowel obstruction, diabetes, hernia, and chronic respiratory failure.

A review of Resident #77's electronic medical record revealed no baseline care plan.

An interview was conducted on 3/17/2022 at 3:50 P.M. with Medical Records Coordinator revealed Resident #77 did not have a paper medical chart and all of Resident #77's medical information was scanned into her electronic medical record.

An interview was conducted on 3/17/2022 at 4:13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 655	Continued From page 25 P.M. with Nurse #9, who admitted Resident #77, revealed the nursing supervisor was the person responsible for completing initial baseline care plans. During the interview Nurse #9 revealed she did not complete an initial baseline care plan for Resident #77. An interview was conducted on 3/17/2022 at 4:33 P.M. with the Unit Manager revealed the admitting nurse was not responsible to complete a resident's initial baseline care plan. The Unit Manager stated a nurse in a management position was responsible for completing newly admitted resident initial baseline care plans. The Unit Manager revealed every resident required an initial care plan be completed on admission and Resident #77 should have had an initial care plan completed. An interview conducted on 3/17/2022 at 4:57 P.M. with the Director of Nursing (DON) revealed either the admitting nurse, or the nurse on the shift after the admission, was responsible to complete the initial baseline care plan for newly admitted residents. The DON stated Resident #77 was admitted to the Covid-19 unit and the initial care plan paperwork may not have been available on the unit. During the interview the DON stated she expected each resident to have an initial care plan started in the first 48 hours following a resident's admission.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 26 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 section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 656	1. Resident #59 care plan was updated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 27 facility failed to implement a care plan addressing a resident ' s code status for one of three residents reviewed for advanced directives (Resident #59). The findings included: Resident #59 was admitted to the facility on 10/1/21. A review was completed Resident #59 ' s current physician ' s orders on 3/14/22. The review revealed the resident had physician ' s orders for the resident to be a full code. A review was completed of Resident #59 ' s care plan on 3/14/22 and the review did not reveal a focus area, goal, or intervention addressing the resident ' s advanced directives. An interview was conducted with the Minimum Data Set (MDS) Nurse #1 and MDS Nurse #2 on 3/16/22 at 3:22 PM. MDS Nurse #1 stated Resident #59 ' s code status was not in her care plan. MDS Nurse #2 stated the Social Worker was supposed to enter a resident ' s advanced directives into the care plan. She further stated Resident #59 had a quarterly assessment in January, and it should have been caught then, that the resident ' s advanced directives had not been entered into the resident ' s care plan. She then reviewed the resident ' s electronic medical record (EMR) and stated Resident #59 was a full code and that information needed to be in the resident ' s care plan. During an interview conducted with Social Worker #3 she stated she did not see Resident #59 ' s advanced directives in her care plan. She	F 656	by Social Service Director to accurately reflect code status of Full Code on 3-16-22. 2. A quality review was conducted by Social Service Director/Social Services Assistant and Minimum Data Set(MDS) Coordinator of current residents to ensure care plans accurately reflect physician□s order for code status on 3-25-22. An ADHOC Quality Assurance Performance Improvement (QAPI) Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3.The Regional MDS Coordinator provided re-education to the Minimum Data Set Coordinator and Interdisciplinary Team to include Social Services Director and Social Services Assistant on accuracy of care plans including code status accurately reflects the physician□s order on 4-8-22. 4. The MDS coordinator will conduct random Quality reviews of 10 residents care plans to ensure the code status in care plan accurately reflects the physician order 3 times a week for 8 weeks then weekly for 4 weeks. The MDS Coordinator will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 28 explained the social work department were typically responsible for entering a resident ' s advanced directives into their care plan. The social worker then stated she would update the resident ' s care plan and enter the resident ' s advanced directives of full code immediately. She said she was aware the resident was a full code through the resident ' s code status being listed on the resident dash board in the EMR but had forgotten to double check the care plan. The Director of Nursing (DON) stated during an interview conducted on 3/17/22 at 3:12 PM a resident ' s advanced directives information needed to be in the resident ' s care plan and did not know what happened with code status of Resident #59 not being in her care plan.	F 656		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.	F 660		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 660	Continued From page 29	F 660		

(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 660	Continued From page 30 the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interviews with the Nurse Practitioner, Director of Rehabilitation, Home Health Services, and staff, and review of records, the facility failed to confirm home health services were in place, per physician order and as indicated in the discharge plan, prior to discharging a resident home from the facility for 1 of 3 residents sampled for discharge planning (Resident #426). The findings included: Resident #426 was admitted to the facility from the hospital on 10/15/21 and discharged home on 11/3/21. Diagnoses included adult failure to thrive, malignant neoplasm of kidneys, malignant neoplasm of bone, malignant neoplasm of brain, generalized muscle weakness, and chronic pain, among others. The hospital discharge (DC) summary, dated	F 660	1. Resident #426 no longer resides at the facility. Home Health Services called and verified services provided on 3-16-22. 2. A quality review of last 30 days of planned discharges were reviewed by Social Services Director and Assistant Social Services to ensure verification of home health services noted with name of home health agency whom spoke with and acceptance of resident before discharging from facility on 4-8-22. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director provided re-education to Social Services Director and Assistant Social Services on verification of home health services with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 660	Continued From page 31 10/15/21, documented Resident #426 was admitted to the facility because no one was at home to provide care at the time. An admission Minimum Data Set, dated 10/22/21, assessed Resident #426 with intact cognition, required staff set up assistance for eating and personal hygiene, physical help from staff for bathing and documented that Resident #426 was a participant in the assessment. A social services (SS) progress note dated 10/26/21, recorded in part, by the Social Worker (SW) that a DC planning meeting was held, and that Resident #426 had plans to return home. The SW documented that home health (HHS) services would be provided once Resident #426 DC from the facility. A SS progress note dated 10/28/21, recorded in part, that the Social Services Director (SSD) called the family to inform of Resident #426's upcoming DC and that a second family member was contacted who agreed to arrange for transportation at DC. A care plan, revised 10/28/21, documented Resident #426 was at risk for further decline in self-care regarding diagnoses of generalized muscle weakness, cancer and chronic pain. Interventions included to make referrals as ordered. A physical therapy (PT) DC summary, recorded Resident #426 ended PT services on 11/2/21 with a recommendation for HHS upon DC. A Nurse Practitioner (NP) progress note dated 11/2/21 documented that per her clinical findings,	F 660	home health agency whom spoke with and acceptance of resident before discharging resident from facility on 4-7-22. All new Social Services hires will be educated on the Discharge Planning Process on their date or orientation. All planned discharges will be reviewed in morning clinical meeting for discharge note by social services director or social services assistant. 4. The Executive Director will conduct random Quality reviews of resident□s planned discharges with home health services to ensure documentation complete to name of home health company, whom spoke with and acceptance of resident before discharge on 5 random residents 3 times a week for 8 weeks then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 660	Continued From page 32	F 660		

Resident #426 was ready for DC home with family on 11/3/21 and would need HHS to include PT, occupational therapy (OT), nurse medical management and assistance with activities of daily living due to generalized weakness and decreased strength.

A physician order dated 11/3/21, recorded to DC Resident #426 home with HHS to follow.

A nurse progress note dated 11/3/21 at 11:48 AM written by Nurse #10 recorded Resident #426 DC home with family.

An electronic mail (email) communication dated 11/4/21 at 10:38 AM from the SW to a home health agency recorded that Resident #426 was DC home on 11/3/21 and that orders were attached to the email for a home health referral.

An interview occurred on 3/15/22 at 5:07 PM with the SW and revealed that when a resident was ready for DC, his department was responsible to set up HHS. The SW stated that if the resident's insurance did not accept the referral, continued efforts were required to find another HHS agency accepted by the insurance provider. The SW stated that in the case of Resident #426, a care plan meeting regarding DC plans occurred on 10/26/21 and a referral was made for HHS on 11/2/21, but the insurance provider did not accept the referral. The SW stated that once he became aware of this on 11/4/21, Resident #426 had already DC home, so a second referral was sent to another HHS provider on 11/4/21. The SW stated that it was expected that referral for services were made prior to a resident's DC. The SW stated he did not have documentation regarding the referral for HHS made on 11/2/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 660	Continued From page 33	F 660		

An interview occurred on 3/16/22 at 9:53 AM with the SSD and revealed that she spoke to two family members of Resident #426 on 10/28/21 regarding an upcoming planned DC home. The SSD stated the family agreed to arrange for transportation home for Resident #426 upon DC. The SSD stated that a second HHS referral was made on 11/4/21 after Resident #426 had already DC home and the facility became aware that the initial referral was not accepted by the insurance provider. The SSD stated that the facility should have confirmed HHS were in place for Resident #426 prior to DC home.

An interview with the Director of Rehabilitation/OT occurred on 3/16/22 at 10:31 AM and revealed it was recommended by PT that Resident #426 have HHS upon DC home because the Resident required supervision with ADL.

A phone interview occurred on 03/16/22 at 3:22 PM with HHS provider who confirmed receipt of an HHS referral from the facility for Resident #426. The HHS provider stated that receipt of the referral was confirmed with the facility on 11/4/21, after Resident #426 DC home on 11/3/21. Resident #426 was assessed for HHS on 11/4/21, but he declined services.

The NP stated in a phone interview on 3/16/22 at 11:41 AM that she assessed Resident #426 on 11/2/21 for DC, wrote an order for Resident #426 to DC home on 11/3/21, and expected the SW to set up DC plans per her order. The NP stated that by the time Resident #426 got home, HHS should have been in place. The NP stated that the facility should have made sure HHS were in place for Resident #426 prior to DC home on 11/3/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 660	Continued From page 34 The Administrator stated on 3/17/22 at 9:31 AM that she was confident that the SSD ensured HHS were provided for residents at DC and that in the case of Resident #426, the SSD followed up on 11/4/21 to make sure HHS were provided.	F 660		
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced	F 661		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 661	Continued From page 35 by: Based on interviews with staff, and record review, the facility failed to complete a recapitulation of stay for 1 of 1 sampled resident reviewed with a planned discharge from the facility to the community (Resident #426). This deficient practice had the potential to affect other residents discharged from the facility to the community. The findings included: Resident #426 was admitted to the facility from the hospital on 10/15/21 for short term rehab (STR) services. An admission Minimum Data Set, dated 10/22/21, assessed Resident #426 with intact cognition, and documented that Resident #426 was a participant in the assessment. Social services progress notes dated 10/26/21 and 10/28/21 both recorded that Resident #426's plans for an anticipated discharge (DC) home were discussed during a care plan meeting (10/26/21) and during a phone conversation with the family (10/28/21). A Nurse Practitioner (NP) progress note dated 11/2/21 documented Resident #426 was assessed for DC home on 11/3/21. A physician order dated 11/3/21, recorded in part, that it was okay to DC Resident #426 home. A nurse progress note dated 11/3/21 at 11:48 AM written by Nurse #10 recorded that Resident #426 DC home with family.	F 661	1. Resident #426 no longer resides at the facility 2. A quality review of last 30 days of discharges were reviewed by Executive Director to ensure discharge plan and instructions complete to include recapitulation of stay from activities, social services, nursing, nutrition and therapy on 4-8-22. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director provided re-education to Activity Director, Social Services Director, Director of Nursing Assistant Director of Nursing, Unit Managers, Dietary Manager and Therapy Director on completion of discharge plan and instructions to include recapitulation of stay on 3-30-22. All new hires in the following departments: Activities, Social services, nursing administration will be educated on discharge summary at orientation by the Executive Director. Any new Certified Dietary Managers or Rehab Directors will be educated by Executive Director on first day of contracted employment to facility on Discharge Summary. Upcoming discharges will be reviewed at clinical meeting to ensure discharge summary has been opened. Social Services Director or Social Services Assistant will ensure all sections are filled out by the interdisciplinary team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 661	Continued From page 36 Review of the document titled, Discharge Summary, dated 11/3/21 for Resident #426, recorded a summary of activity and social services, but did not record a summary of nursing, nutrition, therapy, medication, treatment or equipment. The DC summary was incomplete. An interview with the Director of Nursing (DON) occurred on 3/17/22 at 2:21 PM and revealed that when a resident admitted to the facility for STR the recapitulation of stay (DC Summary) was started a few days before DC when the DC was anticipated. The DON further stated that in the case of Resident #426, the DC summary was incomplete because Resident #426 made staff aware the day before DC that he wanted to go home which left staff with little notice to complete the DC summary. The DON stated that she was responsible for completion of the nursing services summary at DC, and that the DC summary was addressed as a joint team effort during care plan meetings. The Administrator stated in an interview on 3/17/22 at 5:17 PM that the DC summary for Resident #426 should have been completed by all departments upon DC.	F 661	4. The Executive Director will conduct random Quality reviews of resident□s discharge plan and instructions to ensure complete with recapitulation of stay from activities, social services, nursing, nutrition and therapy on 5 random residents 3 times a week for 8 weeks then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, a resident interview, staff interviews, and record review, the facility failed to	F 677	1. Resident #38 was provided ADL care including shaving on 3-16-22 by Nekosha	4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 677	Continued From page 37 shave a resident dependent on staff for assistance with activities of daily living (ADL) for 1 of 3 residents sampled for ADL dependence (Resident #38). The findings included: Resident #38 was admitted to the facility on 2/4/22. Diagnoses included Parkinson's disease, altered mental status (AMS), generalized muscle weakness and pain in right hand, among others. An admission Minimum Data Set, dated 2/11/22, assessed Resident #38 with minimal difficulty hearing, adequate vision, usually understood by others, sometimes understands others, severely impaired cognition, no behaviors, range of motion intact to his upper extremities, and required total staff assistance with personal hygiene. A care plan, revised 2/23/22, documented that Resident #38 was able to engage in simple conversation and totally dependent on staff for his personal hygiene needs. Resident #38 required staff to anticipate and meet his needs due to his communication, cognition, and hearing deficits, AMS, and refusal of care at times. Care plan interventions also included that if Resident #38 refused or became aggressive during care, staff were to return later to deliver care, or a different staff member would assist. Review of bath/shower records provided by the facility for Resident #38 revealed he received showers twice per week on Sunday and Thursday and bed baths on Monday, Tuesday, Wednesday, Friday and Saturday. Bath/Shower records documented that Resident #38 received a bath/shower per this schedule on 3/13/22 -	F 677	Reid NAIT. Resident #38 no longer resides at the facility. 2. A quality review was completed by the Assistant Director of Nursing and the Unit Manager of all current residents on 3-18-22 of ADL care specific to shaving. No negative findings were identified. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing/Assistant Director of Nursing re-educated CNAs on all shifts, including part-time and prn on ADL care specific to shaving by 4-11-22. Staff will not be allowed to return to work until education is complete. Rounds will be completed by Interdisciplinary Team to focus on ADL care provided for dependent residents with a focus on shaving being provided. All findings will be reported in morning meetings. All new Certified Nursing Assistants and Nurse Aides in Training will be provided with ADL care education at the time of orientation by Director of Nursing / Assistant Director of Nursing / Unit Managers. 4. The Director of Nursing/Assistant Director of Nursing or Unit Manager will conduct random Quality Reviews of residents to ensure residents are shaved with ADL care on 5 random residents 3 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 677	Continued From page 38 3/16/22. Resident #38 was observed in his room, dressed and in his wheel chair on 3/14/22 at 11:13 AM with short facial hair above his lips and to both cheeks. When asked if he wanted to be shaved, Resident #38 responded "Yes." Resident #38 was observed in his room in bed on 3/15/22 at 10:00 AM with facial hair above his lips and to both cheeks. He had not been shaved. Resident #38 was observed on 3/16/22 at 12:13 PM and 12:59 PM in his room dressed and eating lunch, with facial hair above his lips, and both cheeks which was thicker and longer than on 3/14/22 and covered the lower part of his face. He had not been shaved. Nurse Aide (NA) #1 was interviewed on 3/16/22 at 2:28 PM and described Resident #38 as aggressive at times. NA #1 stated she provided Resident #38 with a bed bath that day (3/16/22) on the 7 A - 3 P shift and a shower on Sunday, 3/13/22, and that he cooperated with the care. NA #1 stated that she noticed that Resident #38 did need to be shaved now, but that she did not offer to shave him during his bed bath that day. She stated she ran out of time. NA #1 also stated that she gave him a shower on Sunday 3/13/22, he was cooperative with the care, but that she did not offer to shave him that day because she did not think he needed to be shaved. NA #1 also stated that she was trained to offer to shave residents during a shower, and bed baths. NA #2 was interviewed on 3/17/22 at 11:25 AM. During the interview, NA #2 stated that she worked with Resident #38 at least twice per week	F 677	(audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 677	Continued From page 39	F 677		

on the 7 A - 3 P shift. She described that Resident #38 made his needs, and preferences known, at times, and answered simple questions. NA #2 stated Resident #38 was cooperative most of the time with care, but at times he was more resistive to care, and it was during those times, staff should stop the care and come back later to offer again. NA #2 stated she was assigned to care for Resident #38 on Tuesday, 3/15/22 on the 7 A - 3 P shift, and gave him a bed bath that day and that he was cooperative with the care. NA #2 stated that she did not offer to shave him that day because she did not notice that he needed to be shaved. NA #2 stated that she was trained to offer to shave residents with baths/showers and when the resident asked to be shaved.

An interview with Nurse #9 occurred on 3/16/22 at 12:19 PM. Nurse #9 stated she was assigned to care for Resident #38 routinely on the 7 A - 3 P shift. Nurse #9 stated Resident #38 received showers twice per week on Sunday/Thursday, and as needed, and bed baths the remaining days of the week. Nurse #9 stated that residents were to be shaved during ADL care, and as needed. She stated that Resident #38 was usually cooperative with care, but at times staff returned later if he was not accepting of the ADL care when first offered. She stated she was not aware of Resident #38 refusing ADL care, to be shaved, or staff having any difficulty providing him ADL care that week.

During a follow up interview with Nurse #9 on 3/17/22 at 11:37 AM, she stated that Resident #38 was confused, and staff had to anticipate his needs. Nurse #9 stated that Resident #38 may decline care initially when offered, but it was because he was confused. Nurse #9 stated that if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 677	Continued From page 40 staff explained the care that was to be provided, Resident #38 would cooperate with the care. Nurse #9 also stated staff were expected to offer to shave residents when they received a shower, and as needed, if the NA had time. Nurse #9 stated that residents who were scheduled a shower were shaved first and then other residents who were not assigned a shower that day were shaved as needed and as the NAs had time. The Director of Nursing (DON) was interviewed on 3/17/22 at 12:11 PM. She stated that residents should be shaved per their preference. Staff were encouraged to offer to shave residents during showers, but that this care should be provided per the resident's preference and as needed. The DON further stated that Resident #38 had a history of accepting care in the beginning, and then during the care, he became aggressive, and verbally abusive. The DON further stated that department managers rounded to see if any of the male residents need to be shaved, and NAs were asked to provide the care as they had time. The DON also stated that if Resident #38 became aggressive or resistant to care, and staff could not give the care at that time, staff should come back later to offer the care.	F 677		
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	F 755		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 41 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 observations, staff interviews, and record reviews, the facility failed to: 1) Identify unused controlled substance medications for disposition (the process of returning and/or destroying unused medications) for 1 of 1 discharged resident (Resident #76) whose medications were observed to remain in 1 of 2 medication carts (400 Hall med cart); and 2) Implement facility ' s procedures to replace the emergency supply of narcotics available in the automated dispensing system with the controlled substances observed on 1 of 2 medication carts (400-500-600 Hall med cart) labeled for the	F 755	1. Resident #76 discharged resident□s controlled substance medications were returned to the pharmacy on 3-23-22. Emergency narcotic kit medications were place in Omincell (automated dispensing system) on 3-14-22. 2. A Quality Review of current medication carts has been completed on 4-4-22 by the Director of Nursing to ensure all discharged resident□s controlled substance medications have been returned to the pharmacy and all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 42 Emergency Narcotic Kit. The findings included: 1-a) Accompanied by Nurse #4, an observation was made of the 400 Hall medication cart (for Rooms 402-416) on 3/14/22 at 3:17 PM. The observation revealed a bubble pack card containing 15 tablets of 0.5 mg lorazepam (a controlled substance used to treat anxiety) was stored in the locked controlled substance drawer of the med cart. The medication was dispensed on 3/2/22 from the pharmacy for Resident #76. Nurse #4 reported the resident had expired and stated this medication should have been pulled from the med cart and sent back to the pharmacy. A review of the Resident #76 ' s electronic medical record (EMR) revealed the resident passed away on 3/6/22. An interview was conducted on 3/15/22 at 3:32 PM with the facility ' s Director of Clinical Services (DCS) in the presence of the Regional Nurse Consultant. Upon inquiry, the DCS reported her preference would be for controlled substance medications intended for a resident no longer residing at the facility to be pulled from the medication cart and sent back to the pharmacy as soon as possible. The DCS she typically sent controlled substances back to the pharmacy once a week on Friday. However, she missed sending the controlled substances back last week. 1-b) Accompanied by Nurse #4, an observation was made of the 400 Hall medication cart (for Rooms 402-416) on 3/14/22 at 3:17 PM. The observation revealed a plastic bag containing 18 -	F 755	emergency narcotic substance medications are uploaded into the Omnicell. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Regional Director of Nursing re-educated the Director of Nursing on ensuring discharged residents controlled medications returned to the pharmacy and all emergency narcotic substance medications are uploaded into the Omnicell on 4-7-22. The Director of Nursing/Assistant Director of Nursing educated nurses on notifying Director of Nursing when resident is discharged and controlled medications not sent with resident and to ensure emergency substance medications are uploaded in the Omnicell by 4/11/22. If unable to upload number provided to call for assistance with the Omnicell. The Director of Nursing/Assistant Director of Nursing will review medication carts two times weekly to check for discharged residents□ narcotic medications and ensure all emergency narcotic substance medications are uploaded into the Omnicell with no stop date to this process to ensure this does not recur. Director of Nursing / Assistant Director of Nursing / Unit Manager will educate all new licensed Nursing staff on day of orientation on notifying Director of Nursing when resident is discharged and controlled medications not sent with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 43 5 milligram (mg) / 0.25 milliliter (ml) oral solution of morphine sulfate (an opioid pain medication) dispensed as 0.25 ml in individual oral syringes were stored in the locked controlled substance drawer of the med cart. The medication was dispensed on 3/2/22 from the pharmacy for Resident #76. Nurse #4 reported the resident had expired and stated this medication should have been pulled from the med cart and sent back to the pharmacy. A review of the Resident #76 ' s electronic medical record (EMR) revealed the resident passed away on 3/6/22. An interview was conducted on 3/15/22 at 3:32 PM with the facility ' s Director of Clinical Services (DCS) in the presence of the Regional Nurse Consultant. Upon inquiry, the DCS reported her preference would be for controlled substance medications intended for a resident no longer residing at the facility to be pulled from the medication cart and sent back to the pharmacy as soon as possible. The DCS she typically sent controlled substances back to the pharmacy once a week on Friday. However, she missed sending the controlled substances back last week. 2-a) An observation was conducted on 3/14/22 at 3:40 PM of the 400-500-600 Hall medication cart in the presence of Nurse #5 and Nurse #6. The observation revealed a plastic bag containing 10 tablets of 5 milligrams (mg) oxycodone (an opioid pain medication) was stored in the locked controlled substance drawer of the med cart. The medication was dispensed from the pharmacy on 3/3/22 with a label which read, "Replace to Emergency Narcotic Kit." The medication was not labeled for an individual resident's use.	F 755	resident and to ensure emergency substance medications are uploaded in the Omnicell. Any contracted licensed nurses will be educated on notifying Director of Nursing when resident is discharged and controlled medications not sent with resident and to ensure emergency substance medications are uploaded in the Omnicell prior to working their first shift. 4. The Director of Nursing/Assistant Director of Nursing will conduct random Quality reviews of medication carts to ensure discharged resident□s narcotic medications removed from cart and sent back to pharmacy and any emergency narcotic substance medications are uploaded into the Omnicell on 3 random medication carts 3 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 44	F 755		

An interview was conducted on 3/14/22 at 3:50 PM with Nurse #6. During the interview, the nurse was shown the controlled substance medication along with the pharmacy labeling . The nurse reported the oxycodone should have been put into the Emergency Narcotic Kit. However, she thought it may have been pulled and placed on the cart for a resident until his/her medication arrived from the pharmacy.

An interview was conducted on 3/15/22 at 3:49 PM with the facility ' s Director of Clinical Services (DCS). During the interview, the DCS reported she had experienced a problem getting the bar code for the oxycodone to scan into the facility ' s automated dispensing system. The problem was fixed last evening (3/14/22) and the oxycodone tablets have since been put into the automated dispensing system in accordance with the facility ' s usual procedures.

2-b) An observation was conducted on 3/14/22 at 3:40 PM of the 400-500-600 Hall medication cart in the presence of Nurse #5 and Nurse #6. The observation revealed a plastic bag containing 1 tablet of 5 milligrams (mg) oxycodone (an opioid pain medication) was stored in the locked controlled substance drawer of the med cart. The medication was dispensed from the pharmacy on 1/5/22 with a label which read, "Replace to Emergency Narcotic Kit." The medication was not labeled for an individual resident's use.

An interview was conducted on 3/14/22 at 3:50 PM with Nurse #6. During the interview, the nurse was shown the controlled substance medication along with the pharmacy labeling . The nurse reported the oxycodone should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 45 been put into the Emergency Narcotic Kit. However, she thought it may have been pulled and placed on the cart for a resident until his/her medication arrived from the pharmacy. An interview was conducted on 3/15/22 at 3:49 PM with the facility ' s Director of Clinical Services (DCS). During the interview, the DCS reported she had experienced a problem getting the bar code for the oxycodone to scan into the facility ' s automated dispensing system. The problem was fixed last evening (3/14/22) and the oxycodone tablets have since been put into the automated dispensing system in accordance with the facility ' s usual procedures.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 46 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to act on recommendations made by the consultant pharmacist and retain documentation of the provider ' s review and response to the pharmacist ' s findings / recommendations in the resident ' s medical record for 4 of 5 residents reviewed for unnecessary medications (Resident #35, Resident #29, Resident #40 and Resident #10). The findings included: 1) Resident #35 was admitted to the facility on 6/29/21. Her cumulative diagnoses included major depressive disorder. Resident #35 ' s 6/29/21 admission orders included the following, in part: 50 milligram (mg) quetiapine (an antipsychotic medication) to be given as two tablets by mouth at bedtime; and 60	F 756	1. The pharmacy consultant recommendations for Residents□ #29, #40 and #10 were reviewed and addressed by the physician on 4/11/22. Resident #35 no longer resides at the facility. 2. A quality review was completed by the Director of Nursing on the last 30 days of pharmacy consultant recommendations to ensure reviewed and addressed by the physician on 4-6-22. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director educated the Director of Nursing and Assistant Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 47 mg duloxetine (an antidepressant) Delayed Release (DR) to be given as one capsule by mouth two times a day for depression. The resident ' s electronic medical record (EMR) revealed a consultant pharmacist conducted monthly Medication Regimen Reviews (MRRs). The pharmacist ' s notes dated 9/22/21, 11/15/21, and 1/13/22 read: "This resident's medical record including electronic documentation was reviewed on this date." A box was checked in each MRR note to indicate, "See report for any noted irregularities and/or recommendations." A review of Resident #35 ' s paper chart and EMR revealed there were no pharmacist ' s Consultation Reports from 9/22/21, 11/15/21, or 1/13/22 included in the resident ' s medical record. Additionally, there was no documentation in Resident #35 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider with regards to these pharmacist ' s Consultation Reports. Resident #35 ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 2/2/22. The MDS assessment revealed the resident had severely impaired cognitive skills for daily decision making. The medication section of her MDS indicated Resident #35 received an antipsychotic, antidepressant, anticoagulant and antibiotic during the 7-day look back period. Resident #35 ' s EMR included the consultant pharmacist ' s monthly MRR dated 2/10/22. The pharmacist ' s note read: "This resident's medical record including electronic documentation was reviewed on this date." A box was checked in the	F 756	of Nursing on the facility policy and procedure for Monthly Drug Regimen Review regarding pharmacist irregularities addressed to the physician must be acted upon on 4-7-22. Pharmacist will send recommendations to Director of Nursing via email, Pharmacy Consultant documents in resident chart any recommendations. Director of Nursing provides Medical Doctor / Nurse Practitioner pharmacy recommendations to review / address. Medical Doctor / Nurse practitioner review at scheduled visit to facility and provide completed pharmacy recommendations form to Director of Nursing. Director of Nursing ensure recommendations have been completed in resident's electronic chart. Director Nursing will review all pharmacy recommendations at weekly standard of care meeting. 4. The Executive Director will conduct random quality monitoring of 10 pharmacy consults to ensure pharmacy consults completed and follow-up completed monthly for 3 months. The Executive Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 48	F 756		

note to indicate, "See report for any noted irregularities and/or recommendations."

Further review of Resident #35 ' s paper chart and EMR revealed the pharmacist ' s 2/10/22 Consultation Report was not included in the resident ' s medical record. Additionally, there was no documentation in Resident #35 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider related to the 2/10/22 Consultation Report.

Resident #35 ' s EMR included the consultant pharmacist ' s monthly MRR dated 3/10/22. The pharmacist ' s note read: "This resident's medical record including electronic documentation was reviewed on this date." A box was checked in the note to indicate, "See report for any noted irregularities and/or recommendations."

Further review of Resident #35 ' s paper chart and EMR revealed the pharmacist ' s 3/10/22 Consultation Report was not included in the resident ' s medical record. Additionally, there was no documentation in Resident #35 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider with regards to the 3/10/22 pharmacist ' s Consultation Report.

A copy of the pharmacist's Consultation Reports dated 2/10/22 and 3/10/22 was provided by the facility for review on 3/16/22 and included the following information:
--The pharmacist ' s 2/10/22 Consultation Report noted Resident #35 recently experienced a fall on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 49	F 756		

1/15/22. The pharmacist indicated a comprehensive review of the medical record was conducted and identified the following medications which may contribute to falls: 50 mg quetiapine given as two capsules (total dose of 100 mg) every night at bedtime for behavioral and psychological symptoms of dementia (BPSD); and 125 mg Depakote (a mood stabilizer) administered twice daily for mood (added 2/8/22). The pharmacist recommendation read, "Please evaluate these medications as possibly causing or contributing to this fall and consider decreasing quetiapine to 50 mg qhs (every night at bedtime)." The Medical Doctor ' s (MD ' s) response written on the Consultation Report indicated he re-evaluated this therapy and wished to decrease the quetiapine to 50 mg at bedtime. He requested the mental health Nurse Practitioner (NP) be notified if the resident exhibited behaviors. This 2/10/22 Consultation Report was signed and dated by the MD on 3/14/22.
--The pharmacist ' s 3/10/22 Consultation Report noted Resident #35 recently experienced a fall on 2/19/22. A comprehensive review of the medical record was conducted by the pharmacist and identified the following medications which may contribute to falls: 50 mg quetiapine given as two capsules (total dose of 100 mg) every night at bedtime for BPSD with no gradual dose reductions (GDRs) since 6/29/21; 60 mg duloxetine administered twice daily; and 125 mg Depakote (a mood stabilizer) administered twice daily for mood. The pharmacist recommendation read, "Please evaluate these medications as possibly causing or contributing to this fall and decrease quetiapine to 50 mg qhs." The MD ' s response indicated he re-evaluated this therapy and wished to decrease the quetiapine to 50 mg at bedtime. The pharmacist ' s 3/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 50	F 756		

Consultation Report was signed and dated by the MD on 3/14/22. A hand-written notation signed by the Director of Clinical Services (DCS) on the Consultation Report read, "updated order 3/16/22."

An interview was conducted on 3/16/22 at 12:52 PM with the facility ' s DCS. During the interview, the DCS provided copies of the pharmacy Consultation Reports not available in Resident #35 medical record. Consultation Reports for 9/22/21, 11/15/21, and 1/13/22 were not available for review. The DCS reported she could not speak to the process for handling the pharmacist ' s monthly MRRs and Consultation Reports prior to her starting at the facility in September of 2021. Since September, she reported the pharmacist emailed the consults to the DCS and she would print them out. Consultation Reports intended for the MD ' s review and response would be put in his box located in the conference room. Once he responded to the Consultation Reports, the MD would leave them on the table in the conference room. The DCS reported she discovered "some of them went missing" in January of 2022. Since that time, the MD has been handing the Consultation Reports to the DCS and she has been storing them in a binder. Additional Consultation Reports were found in a book used by the previous DCS and she reported a couple of reports needed to be retrieved and printed this morning from the pharmacy ' s electronic system.

A follow-up interview was conducted on 3/16/22 at 4:00 PM with the facility's DCS in the presence of the Regional Nurse Consultant. When asked, the Regional Nurse Consultant and DON agreed if the facility did not receive a response from the provider within 21 days of the pharmacist ' 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 03/17/2022

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 756	Continued From page 51	F 756		

Consultation Report, follow-up needed to be done. The DCS and Regional Nurse Consultant reported if the MD's signed responses to the pharmacist's Consultation Reports were not in the resident's EMR, they were not in the medical record.

2) Resident #29 was admitted to the facility on 1/31/22. Her cumulative diagnoses included diabetes, depression, and post-traumatic stress disorder.

Resident #29 ' s admission orders dated 1/31/22 included the following, in part: 0.5 milligrams (mg) alprazolam (an antianxiety medication) to be given as one tablet by mouth every 12 hours as needed for anxiety (with no stop date).

Resident #29 ' s electronic medical record (EMR) included a consultant pharmacist ' s monthly Medication Regimen Review (MRR) dated 2/3/22. The pharmacist ' s note read: "This resident's medical record including electronic documentation was reviewed on this date." A box was checked in the note to indicate, "See report for any noted irregularities and/or recommendations."

Further review of Resident #29 ' s paper chart and EMR revealed the pharmacist ' s 2/3/22 Consultation Report was not included in the resident ' s medical record. Additionally, there was no documentation in Resident #29 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider with regards to the pharmacist ' s 2/3/22 Consultation Report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 52	F 756		

On 2/3/22, a new order was received for Resident #29 for 0.5 mg alprazolam to be given as one tablet by mouth every 12 hours as needed for anxiety for 14 days.

Resident #29 ' s admission Minimum Data Set (MDS) was dated 2/7/22. The MDS assessment revealed Resident #29 had intact cognitive skills for daily decision making. The medication section of her MDS indicated the resident received the following types of medication (in part) during the 7-day look back period: insulin, antidepressant, antianxiety, anticoagulant, antibiotic, diuretic, and an opioid.

On 2/15/22, an order was received to discontinue the alprazolam order written on 2/3/22. The resident ' s EMR included a new order for 0.5 mg alprazolam to be given as one tablet by mouth every 8 hours as needed for anxiety (with no stop date).

Resident #29 ' s EMR included a consultant pharmacist ' s monthly MRR dated 3/10/22. The pharmacist ' s note read: "This resident's medical record including electronic documentation was reviewed on this date." A box was checked in the note to indicate, "See report for any noted irregularities and/or recommendations."

Further review of Resident #29 ' s paper chart and EMR revealed the pharmacist ' s 3/10/22 Consultation Report was not included in the resident ' s medical record. Additionally, there was no documentation in Resident #29 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 53	F 756		

A copy of the pharmacist's Consultation Reports dated 2/3/22 and 3/10/22 was provided by the facility for review on 3/16/22 and included the following information:
--The 2/3/22 Consultation Report noted Resident #29 had an anxiolytic (alprazolam) ordered for administration on an as needed (PRN) basis without a stop date. The pharmacist recommendation read, "Please discontinue PRN alprazolam tapering as necessary." The pharmacist ' s 2/3/22 Consultation Report was signed and dated on 3/14/22 by the Medical Doctor (MD). A hand-written notation on the report read, "14 d (day) stop date please notify Mental Health NP (Nurse Practitioner) to evaluate next visit."
--The pharmacist ' s 3/10/22 Consultation Report noted Resident #29 had another PRN order for an anxiolytic, which had been in place for greater than 14 days without a stop date. The pharmacist ' s recommendation read, "Please discontinue PRN alprazolam, tapering as necessary." The pharmacist ' s 3/10/22 Consultation Report was also signed and dated on 3/14/22 by the Medical Doctor (MD). A hand-written notation on the report read, "14 d stop date."

On 3/11/22, an order was received to discontinue the alprazolam order written on 2/15/22. A new order was written on 3/11/22 for 0.5 mg alprazolam to be administered to Resident #29 as one tablet by mouth given every 8 hours as needed for anxiety for 14 days.

An interview was conducted on 3/16/22 at 12:52 PM with the facility ' s Director of Clinical Services (DCS). During the interview, the DCS provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 54	F 756		

copies of the pharmacy Consultation Reports requested for Resident #29. The DCS reported she could not speak to the process for handling the pharmacist ' s MRRs and Consultation Reports prior to her starting at the facility in September of 2021. Since September, she reported the pharmacist emailed the consults to the DCS and she would print them out. Consultation Reports intended for the MD ' s review and response would be put in his box located in the conference room. Once he responded to the Consultation Reports, the MD would leave them on the table in the conference room. The DCS reported she discovered "some of them went missing" in January of 2022. Since that time, the MD has been handing the Consultation Reports to the DCS and she has been storing them in a binder. Additional Consultation Reports were found in a book used by the previous DCS and she reported a couple of reports needed to be retrieved and printed this morning from the pharmacy ' s electronic system. Upon inquiry, the DCS reported she identified the order for Resident #29 ' s PRN alprazolam on 3/11/22 and noted it did not have a stop date. A new order was then written for the PRN alprazolam to include a stop date.

A follow-up interview was conducted on 3/16/22 at 4:00 PM with the facility's DCS in the presence of the Regional Nurse Consultant. When asked, the Regional Nurse Consultant and DON agreed if the facility did not receive a response from the provider within 21 days of the pharmacist ' s Consultation Report, follow-up needed to be done. The DCS and Regional Nurse Consultant reported if the MD's signed responses to the pharmacist's Consultation Reports were not in the resident's EMR, they were not in the medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 55	F 756		

record.

3) Resident #40 was admitted to the facility on 7/19/17. Her cumulative diagnoses included diabetes, chronic obstructive pulmonary disease, and gastro-esophageal reflux disease (GERD).

A review of Resident #40 ' s medical record included an order dated 10/13/21 for 40 milligrams (mg) pantoprazole Delayed Release (a medication used to treat GERD) to be given as one tablet by mouth in the evening. Her medication orders also included an order dated 12/23/21 for 40 mg famotidine (a medication also used to treat GERD) to be given as one tablet by mouth in the morning. The order for famotidine included instructions to continue the administration of pantoprazole at night.

Resident #40 ' s electronic medical record (EMR) included the consultant pharmacist ' s monthly Medication Regimen Review (MRR) dated 1/12/22. The pharmacist ' s note read: "This resident's medical record including electronic documentation was reviewed on this date." A box was checked in the note to indicate, "See report for any noted irregularities and/or recommendations."

Further review of Resident #40 ' s paper chart and EMR revealed the pharmacist ' s 1/12/22 Consultation Report was not included in the resident ' s medical record. Additionally, there was no documentation in Resident #40 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider with regards to the pharmacist ' s 1/12/22 Consultation Report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 56	F 756		

A copy of the pharmacist's Consultation Report dated 1/12/22 was provided by the facility for review on 3/16/22. The Consultation Report noted Resident #40 was receiving both pantoprazole and famotidine. The pharmacist ' s recommendation read, "Please discontinue famotidine." The rationale for the recommendation was "Combination gastroprotective therapy is not recommended for most individuals with GERD, dyspepsia (persistent or recurrent pain in the upper abdomen), or NSAID (non-steroidal anti-inflammatory drug) - induced ulcer prevention." The Consultation Report was not signed or dated by the provider.

Resident #40 was admitted to the hospital on 1/29/22. The orders for both famotidine and pantoprazole were discontinued on 2/2/22. The resident was discharged from the hospital and returned to the facility on 2/7/22.

Resident #40 ' s most recent completed Minimum Data Set (MDS) was an annual assessment dated 2/8/22. The MDS assessment revealed Resident #40 had intact cognitive skills for daily decision making. The medication section of her MDS indicated the resident received the following types of medications (in part) during the 7-day look back period: insulin, antidepressant, antianxiety, hypnotic, anticoagulant, antibiotic, diuretic, and opioid.

A review of Resident #40 ' s EMR included an order dated 2/8/22 for 40 mg pantoprazole Delayed Release (DR) to be given as one tablet by mouth in the morning. Her medication orders also included an order dated 2/8/22 for 40 mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 57	F 756		

famotidine to be given as one tablet by mouth one time a day.

Resident #40 ' s EMR included the consultant pharmacist ' s monthly MRR dated 2/9/22. The pharmacist ' s note read: "This resident's medical record including electronic documentation was reviewed on this date." A box was checked in the note to indicate, "See report for any noted irregularities and/or recommendations."

Further review of Resident #40 ' s paper chart and EMR revealed the pharmacist ' s 2/9/22 Consultation Report was not included in the resident ' s medical record. Additionally, there was no documentation in Resident #40 ' s medical record to indicate the consultant pharmacist ' s findings / recommendations were reviewed or a response was received from the provider.

A copy of the pharmacist's Consultation Report dated 2/9/22 was provided by the facility for review on 3/16/22. The Consultation Report indicated this was a repeated recommendation from 1/12/22 and noted Resident #40 was receiving both pantoprazole and famotidine. The pharmacist recommendation read, "Please discontinue famotidine." The rationale for the recommendation was "Combination gastroprotective therapy is not recommended for most individuals with GERD." The Consultation Report included a hand-written notation next to the recommendation, "OK." The report was signed (not dated) by the provider.

Resident #40 ' s EMR indicated an order was received to discontinue the famotidine on 2/9/22. The resident continued to receive pantoprazole

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 58	F 756		

until she was discharged to a hospital on 2/23/22; she returned to the facility on 2/25/22.

The resident ' s EMR included a medication order dated 2/25/22 for 40 mg pantoprazole DR to be given as one tablet by mouth in the evening. On 2/26/22, an order was received for 40 mg famotidine to be given as one tablet by mouth in the morning. The 2/26/22 order for famotidine was discontinued on 3/1/22.

An interview was conducted on 3/16/22 at 12:52 PM with the facility ' s Director of Clinical Services (DCS). During the interview, the DCS provided copies of the pharmacy Consultation Reports requested for Resident #40. The DCS reported she could not speak to the process for handling the pharmacist ' s MRRs and Consultation Reports prior to her starting at the facility in September of 2021. Since September, she reported the pharmacist emailed the consults to the DCS and she would print them out. Consultation Reports intended for the Medical Doctor ' s (MD ' s) review and response would be put in his box located in the conference room. Once he responded to the Consultation Reports, the MD would leave them on the table in the conference room. The DCS reported she discovered "some of them went missing" in January of 2022. Since that time, the MD has been handing the Consultation Reports to the DCS and she has been storing them in a binder. Additional Consultation Reports were found in a book used by the previous DCS and she reported a couple of reports needed to be retrieved and printed this morning from the pharmacy ' s electronic system.

A follow-up interview was conducted on 3/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 59	F 756		

at 4:00 PM with the facility's DCS in the presence of the Regional Nurse Consultant. When asked, the Regional Nurse Consultant and DON agreed if the facility did not receive a response from the provider within 21 days of the pharmacist ' s Consultation Report, follow-up needed to be done. The DCS and Regional Nurse Consultant reported if the MD's signed responses to the pharmacist's Consultation Reports were not in the resident's EMR, they were not in the medical record.

3) Resident #10 was admitted to the facility on 1/21/15. His cumulative diagnoses included depression, Chronic Obstructive Pulmonary Disease (COPD), insomnia, and anxiety.

Resident #10 had a physician ' s order dated 2/16/22 for 200 milligram (mg) trazodone (an antidepressant which is also used for insomnia) to be given orally each night at bedtime. Further review revealed a physician ' s order dated 4/6/21 10 mg loratadine (an antihistamine) to be given orally daily.

The resident ' s electronic medical record (EMR) revealed a consultant pharmacist conducted monthly Medication Regimen Reviews (MRRs). The pharmacist ' s notes from the December 2021 review which took place on 12/13/21 and 12/14/21 read: "This resident's medical record including electronic documentation was reviewed on this date." A box was checked in each MRR note to indicate, "See report for any noted irregularities and/or recommendations."

A review of Resident #10 ' s paper chart and EMR revealed there were no pharmacist ' 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 03/17/2022

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 756	Continued From page 60	F 756		

Consultation Reports (recommendations) from the December 2021 review included in the resident ' s medical record. Further review revealed, there was no documentation in Resident #10 ' s medical record to indicate the consultant pharmacist ' s findings/recommendations were reviewed by the resident ' s physician/physician extender nor was there a response received from the provider with regards to these pharmacist ' s consultation Reports.

Resident #10 ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 12/31/21. The MDS assessment revealed the resident had mildly impaired cognitive skills for daily decision making. The medication section of his MDS indicated Resident #10 received an antidepressant, an anxiolytic, anticoagulant each day of the 7-day look back period, and an opioid for 3 days of the 7-day look back period.

Resident #10 ' s EMR included the consultant pharmacist ' s monthly MRR for the months of January 2021 and February 2021. The pharmacist ' s documented the resident's medical record including electronic documentation was reviewed.

Further review of Resident #10 ' s paper chart and EMR revealed the pharmacist ' s December 2021 visit Consultation Report was not included in the resident ' s medical record. Additionally, there was no documentation in Resident #10 ' s medical record to indicate the consultant pharmacist ' s findings/recommendations were reviewed or a response was received from the provider with regards to the December pharmacist ' s Consultation Report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 61	F 756		

A copy of the pharmacist's Consultation Reports dated 12/13/21 was provided by the facility for review on 3/16/22 and included the following information:
-The pharmacist ' s 12/13/21 Consultation Report noted Resident #10 was receiving Trazodone 200 mg every evening since 4/5/21. There was a recommendation to please attempt a gradual does reduction (GDR) to Trazodone 150 mg every evening, with the end goal of discontinuation, while concurrently monitoring a re-emergence of insomnia and withdrawal symptoms. There was a Facility note: A new prescription is required for controlled substances. The documented rationale for the recommendation was a GDR should be attempted in 2 separate quarters, with at least 1 month between attempts, within the first year in which an individual is admitted on a psychotropic medication or after the facility has initiated such medication, and then annually unless clinically contraindicated. References were provided to federal regulations for Long Term Care Facilities. The areas for the physician to accept the recommendations, accept the recommendations with modifications, or decline the recommendations were not marked, nor was the recommendation signed off as reviewed by the resident ' s physician.
-The pharmacist ' s 12/13/21 Consultation Report noted Resident #10 was receiving a long-acting antihistamine, Loratadine 10 mg each day since 4/6/21 for seasonal allergies. There was a recommendation to please assess continued use and consider changing to Loratadine 10 mg each day as needed for allergies. The rationale for the recommendation was listed as administration of the medication should be limited to the allergy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 62	F 756		

season in order to avoid adverse events attributed to daily long-term use. The areas for the physician to accept the recommendations, accept the recommendations with modifications, or decline the recommendations were not marked, nor was the recommendation signed off as reviewed by the resident ' s physician.

An interview was conducted on 3/16/22 at 12:52 PM with the facility ' s Director of Clinical Services (DCS). During the interview, the DCS provided copies of the pharmacy Consultation Reports not available in Resident #10 ' s medical record. The DCS reported she could not speak to the process for handling the pharmacist ' s monthly MRRs and Consultation Reports prior to her starting at the facility in September of 2021. Since September, she reported the pharmacist emailed the consults to the DCS and she would print them out. Consultation Reports intended for the physician ' s review and response would be put in his box located in the conference room. Once he responded to the Consultation Reports, the physician would leave them on the table in the conference room. The DCS reported she discovered "some of them went missing" in January of 2022. Since that time, the physician has been handing the Consultation Reports to the DCS and she has been storing them in a binder. Additional Consultation Reports were found in a book used by the previous DCS and she reported a couple of reports needed to be retrieved and printed this morning from the pharmacy ' s electronic system.

A follow-up interview was conducted on 3/16/22 at 4:00 PM with the facility's DCS in the presence of the Regional Nurse Consultant. When asked, the Regional Nurse Consultant and DON agreed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 756	Continued From page 63 if the facility did not receive a response from the provider within 21 days of the pharmacist ' s Consultation Report, follow-up needed to be done. The DCS and Regional Nurse Consultant reported if the physician's signed responses to the pharmacist's Consultation Reports were not in the resident's EMR, they were not in the medical record.	F 756		
F 761 SS=E	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 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:	F 761		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 761	Continued From page 64 Based on observations and staff interviews, the facility failed to: 1) Label medications with the minimum information required, including the name of the resident, on 1 of 2 medication carts observed (400-500-600 Hall Med Cart); 2) Discard expired medications on 2 of 2 medication carts observed (400 Hall Med Cart and the 400-500-600 Hall Med Cart); and 3) Accurately label a medication stored on 1 of 2 medication carts observed (400-500-600 Hall Med Cart) to allow its shortened expiration date to be determined. The findings included: 1) An observation was conducted on 3/14/22 at 3:40 PM of the 400-500-600 Hall medication cart in the presence of Nurse #5 and Nurse #6. The observation revealed an opened Lantus Solostar insulin pen was stored on the med cart. There was no label on the insulin pen to indicate the resident's name, dispensed date, or date opened. When asked about this pen, Nurse #5 stated, "I don't know who had it." The nurse was observed as she pulled the insulin pen from the medication cart. An interview was conducted on 3/15/22 at 3:52 PM with the facility ' s Director of Clinical Services (DCS) in the presence of the Regional Nurse Consultant. During the interview, the DCS reported she would expect insulin pens and vials to be stored in the med room refrigerator until needed. Once the insulin pen or vial was punctured (put into use), the insulin should be dated with the date opened and discarded based on the shortened expiration date indicated by the manufacturer. She confirmed the unlabeled insulin pen needed to be discarded.	F 761	1. Expired tramadol and insulin lispro and lantus were removed from the medication cart and discarded on 3-14-22 by Director of Nursing. Nurse #5 and Nurse #6 no longer works at the facility. Nurse #4 was re-educated on expired medications to include insulin expiration and shelf life by the Director of Nursing on 4-7-22. 2. A quality review was completed by the Director of Nursing and the Assistant Director of Nursing of all medication carts and medication rooms to ensure all mediations are in date on 4-7-22. Any issues identified were addressed. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing/Assisted Director of Nursing re-educated licensed nursing staff to include medication aides on expired medication including insulin expiration and shelf life by 4-11-22. Medication cart audits will continue to be audited weekly by Unit Managers to ensure there are no expired medications and insulin is dated. Director of Nursing / Assistant Director of Nursing / Unit Manager will educate all new licensed nursing staff at the time of their orientation on Labeling of drugs and biologicals. Any contracted licensed nursing staff will be educated by Director of Nursing / Assistant Director of Nursing / Unit Manager prior to their first shift at 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 03/17/2022

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 761	Continued From page 65 2-a) Accompanied by Nurse #4, an observation was made of the 400 Hall medication cart (for Rooms 402-416) on 3/14/22 at 3:17 PM. The observation revealed a bubble pack card containing 11 tablets of 50 milligrams (mg) tramadol (an opioid pain medication) was stored in the locked controlled substance drawer of the medication cart. The pharmacy labeling indicated this medication was dispensed on 2/3/21 for Resident #58 with an expiration date of 11/30/21. Nurse #4 confirmed the medication was expired. She stated the medication should have been pulled and sent back to the pharmacy. A review of the resident's physician orders revealed Resident #58 had a current order for 50 mg tramadol to be given as one tablet by mouth every 12 hours as needed for chronic pain. A review of Resident #58's Medication Administration Records (MARs) and/or controlled substance declining inventory log indicated 6 doses of tramadol were withdrawn from the med cart after its expiration date. One dose was removed from cart on each of the following dates: 12/8/21, 12/11/21, 12/19/21, 1/11/22, 2/18/22, and 2/22/22. An interview was conducted on 3/15/22 at 3:52 PM with the facility ' s Director of Clinical Services (DCS) in the presence of the Regional Nurse Consultant. Upon inquiry, the DCS reported she would expect expired controlled substance medications to have been pulled from the medication cart and sent back to the pharmacy. 2-b) Accompanied by Nurse #4, an observation was made of the 400 Hall medication cart (for	F 761	4. The Director of Nursing/Assistant Director of Nursing or Unit Manager will conduct random Quality reviews of medication carts to ensure medication carts are free from expired medications to include insulin not dated on 3 random medication carts 3 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 761	Continued From page 66	F 761		

Rooms 402-416) on 3/14/22 at 3:17 PM. The observation revealed a bubble pack card containing 30 tablets of 50 milligrams (mg) tramadol (an opioid pain medication) was stored in the locked controlled substance drawer of the medication cart. The pharmacy labeling indicated this medication was dispensed on 2/3/21 for Resident #58 with an expiration date of 11/30/21. Nurse #4 confirmed the medication was expired. She stated the medication should have been pulled and sent back to the pharmacy.

A review of the resident's physician orders revealed Resident #58 had a current order for 50 mg tramadol to be given as one tablet by mouth every 12 hours as needed for chronic pain.

An interview was conducted on 3/15/22 at 3:52 PM with the facility ' s Director of Clinical Services (DCS) in the presence of the Regional Nurse Consultant. Upon inquiry, the DCS reported she would expect expired controlled substance medications to have been pulled from the medication cart and sent back to the pharmacy.

2-c) An observation was conducted on 3/14/22 at 3:40 PM of the 400-500-600 Hall medication cart in the presence of Nurse #5. The observation revealed a vial of insulin lispro dispensed by the pharmacy on 1/29/22 was stored on the medication cart for Resident #67. The vial was dated as having been opened on 1/30/22. When Nurse #5 was shown the vial of insulin, she confirmed it was expired and needed to be discarded.

A review of the manufacturer ' s storage instructions for insulin lispro indicated that once punctured (in use), the insulin vial should be used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 761	Continued From page 67	F 761		

within 28 days.

A review of Resident #67's medical record revealed she had a current order for insulin lispro to be injected subcutaneously before meals and at bedtime using a sliding scale regimen (where the dose is based upon the blood glucose or sugar level).

An interview was conducted on 3/15/22 at 3:52 PM with the facility ' s Director of Clinical Services (DCS) in the presence of the Regional Nurse Consultant. Upon inquiry, the DON reported she would expect insulin pens and vials to be stored in the refrigerator until needed. Once the insulin pen or vial was punctured (put into use), the insulin should be dated with the date opened and discarded based on the shortened expiration date indicated by the manufacturer.

3) An observation was conducted on 3/14/22 at 3:40 PM of the 400-500-600 Hall medication cart in the presence of Nurse #5. The observation revealed an insulin lispro prefilled pen dispensed by the pharmacy on 1/29/22 was stored on the medication cart for Resident #5. The insulin pen was dated as having been opened on "12/15/22." When Nurse #5 was shown the insulin pen, she acknowledged the opened date written on the pen was inaccurate and she could not determine the actual date it was opened or put into use.

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

A review of Resident #5's medical record revealed she had a current order for insulin lispro

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 761	Continued From page 68 to be injected subcutaneously before meals and at bedtime using a sliding scale regimen (where the dose is based upon the blood glucose or sugar level). An interview was conducted on 3/15/22 at 3:52 PM with the facility ' s Director of Clinical Services (DCS) in the presence of the Regional Nurse Consultant. Upon inquiry, the DON reported she would expect insulin pens and vials to be stored in the refrigerator until needed. Once the insulin pen or vial was punctured (put into use), the insulin should be dated with the date opened and discarded based on the shortened expiration date indicated by the manufacturer.	F 761		
F 880 SS=E	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. §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	F 880		4/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 69	F 880		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 70 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 observations, staff interviews and record reviews, the facility failed to: 1) Post the appropriate signage to implement transmission based precautions (TBP) as recommended by the Center for Disease Control and Prevention (CDC) and as directed by the facility's policy for 1 of 2 newly admitted residents who was unvaccinated against COVID-19 (Resident #526); 2) Follow the CDC guidelines for personal protective equipment (PPE) when a nurse was observed entering a quarantined resident's room without wearing gloves and a gown as instructed by the TBP signage for 1 of 2 newly admitted residents (Resident #526); and, 3) Implement measures specified by the CDC when dietary staff member(s) were observed on multiple occasions as they failed to wear a facemask while they worked in the facility. These failures occurred during a COVID-19 pandemic. The findings included: 1) Review of CDC guidance titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" (updated 2/2/22) with a Summary of Recent Changes for managing new admissions and readmissions read in part: "In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have	F 880	1. No residents were affected related to this citation. The Assistant Director of Nursing and Unit Manager were re-educated on precautionary signage that includes enhanced droplet precautions by the Executive Director for new admit and readmit residents who are unvaccinated or not up to date on COVID-19 Vaccinations on 4-7-22. Nurse #1 was re-educated by the Director of Nursing on 4-8-22 on wearing of PPE including gown and gloves as well as facemask and eye protection while entering a room on transmission based precautions in accordance to CDC guidance. The Dietary staff were educated by the Dietary Manager on 3-17-22 on wearing of facemask per CDC guidelines while in the facility at all times while working. 2. A quality review by Observation of the quarantine unit was conducted by the Director of Nursing and Enhanced Droplet Precaution signage and proper PPE Donning and Doffing was posted on the doors of residents that were identified as being a new admission or readmission unvaccinated or not up to date on COVID 19 vaccinations was completed on 3-18-22. A quality review by observation of nursing staff entering quarantine room with PPE on to include facemask, eye	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 71 a negative test upon admission..." Review of a facility policy titled, "COVID-19 - Pandemic Plan" (Dated 3/2/20; Revised 2/28/22) addressed "Emergency Procedures - Pandemic COVID-19." This policy read in part: "13. New admissions/readmissions: --Residents not up to date with all recommended COVID-19 vaccines (even those with a negative test upon admission) will be quarantined for 10 days (if they do not develop symptoms). Quarantine may be shortened to 7 days if the resident does not develop symptoms and a viral test for COVID-19 is negative. The specimen will be collected and tested within 48 hours before planned discontinuation of TBP. --Initiate transmission based precautions based on CDC guidance, including PPE - N95 or higher respirator, eye protection, gown and gloves..." Resident #526 was admitted to the facility's 200 Hall on 3/11/22. Resident #526's admission orders (dated 3/11/22) indicated she was to be placed on quarantine / isolation. Further review of the resident's medical record included a Nursing Note dated 3/12/22 at 12:09 AM and authored by the facility's Assistant Director of Nursing (ADON) read, in part: " ...Resident is on isolation non vaccinated quarantine ..." An observation conducted on 3/14/22 at 10:40 AM of the 200 Hall revealed only one resident's room (not Resident #526's) had signage to indicate a resident was on TBP. There was no signage placed on or near Resident #526's doorway to indicate this resident was on isolation precautions. Additional observations made on	F 880	protection, gown and gloves was completed on 3-18-22. A quality review by observation of dietary department was conducted by Executive Director and dietary staff were wearing facemask according to CDC guidelines on 3-18-22. An ADHOC Quality Assurance Performance Improvement Committee was held on 4-7-22 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director re-educated the Director of Nursing, Assistant Director of Nursing, Unit Managers and Admission Coordinator on Placing signage on the doors and isolation carts for residents placed on the COVID-19 quarantine unit for new admissions and readmissions to identify residents/ rooms that require Healthcare Personnel to wear PPE prior to entering room per CDC guidance that are unvaccinated or not up to date on COVID vaccinations on 4-7-22. The Executive Director and Director of Nursing re-educated current staff to including: licensed nurses, certified nursing assistants, temporary nursing staff, housekeeping, dietary and therapy as well as Department managers on wearing of personal protective equipment to include facemask, eye protection, gown and gloves when entering a room as identified as quarantine with posting of transmission based precautions according to CDC guidance by 4-11-22. The Executive Director re-educated current dietary staff on wearing of facemask per CDC guidelines while in the facility at all times	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 72 3/14/22 at 11:20 AM and 11:45 AM also revealed no TBP signage was placed on or near Resident #526's door to indicate she was quarantined. On 3/14/22 at 12:58 PM, a TBP sign was observed to be posted on the wall to right of Resident #526's door. An interview was conducted on 3/17/22 at 8:58 AM with the facility's Assistant Director of Nursing (ADON), who also assumed responsibilities as the Infection Control Nurse. During the interview, the missing TBP signage at Resident #526's doorway upon entrance to the facility on 3/14/22 was discussed. The ADON reported all newly admitted residents who were not fully vaccinated were put on TBP for a period of 10 days. When asked who was responsible to post the TBP signage for new admissions, the ADON stated she herself had put up the sign outside of Resident #526's doorway on 3/11/22. She reported if the sign was taken down or fell down at some point in time over the weekend, the hall nurse would be responsible to put the TBP sign back up. The ADON reported extra signs were available at the nurse ' s station. Upon further inquiry, the ADON stated not having the TBP signage posted for Resident #526 "would be a concern." An interview was conducted on 3/17/22 at 10:50 AM with the facility's Director of Clinical Services (DCS). During the interview, the infection control concerns related to Resident #526 were discussed. The DCS confirmed the resident was placed on TBP upon admission. She was informed the ADON recalled posting a TBP sign at the entrance for Resident #526's room on 3/11/22. However, no signage was posted on or	F 880	while working on 4-7-22. All new staff will be provided with education for Infection Control and Infection prevention and control programs at the time of orientation by Director of Nursing / Assistant Director of Nursing / Unit Manager. Director of Nursing / Assistant Director of Nursing / Unit Manager will provide education to any contracted services prior to the start of their first shift to facility. 4. The Director of Nursing/Assistant Director of Nursing or designee will conduct random Quality reviews of resident□s quarantine rooms to ensure proper signage placed on the doors with isolation carts on 3 random residents rooms daily for 3 weeks, then 5 times per week for 3 weeks, then 3 times a week for 3 weeks, then weekly for 3 weeks. The Director of Nursing/Assistant Director of Nursing or Designee will conduct random quality reviews by observation of 3 staff members, one on each shift, upon entering quarantine room to ensure proper PPE is donned to include facemask, eye protection, gloves and gown daily for 3 weeks, then 5 times per week for 3 weeks, then 3 times a week for 3 weeks, then weekly for 3 weeks. The Executive Director or designee will conduct random Quality reviews by observation of 5 dietary staff to ensure facemask are being worn in accordance to CDC guidance daily for 3 weeks, then 5 times per week for 3 weeks, then 3 times a week for 3 weeks, then weekly for 3 weeks. The Executive Director and Director of Nursing will report the results	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 73 near Resident #526's doorway to indicate she was on TBP the morning of 3/14/22. The DCS stated she would have expected the hall nurse or unit manager to replace the signage and kept it in place until the TBP were discontinued. 2) Review of CDC guidance titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" (updated 2/2/22) with a Summary of Recent Changes for managing new admissions and readmissions read in part: "In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission..." Review of a facility policy titled, "COVID-19 - Pandemic Plan" (Dated 3/2/20; Revised 2/28/22) addressed "Emergency Procedures - Pandemic COVID-19." This policy read in part: "13. New admissions/readmissions: --Residents not up to date with all recommended COVID-19 vaccines (even those with a negative test upon admission) will be quarantined for 10 days (if they do not develop symptoms). Quarantine may be shortened to 7 days if the resident does not develop symptoms and a viral test for COVID-19 is negative. The specimen will be collected and tested within 48 hours before planned discontinuation of TBP. --Initiate transmission based precautions based on CDC guidance, including PPE- N95 or higher respirator, eye protection, gown and gloves..." On 3/14/22 at 12:58 PM, a TBP sign was observed to be posted on the wall to the right of Resident #526's door. The signage indicated the	F 880	of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 74	F 880		

required PPE to be worn prior to entering the resident's room included an N95 or higher level respirator, protective eyewear or face shield, a gown, and gloves. PPE equipment was observed to be placed on Resident #526 ' s door.

At the time of the observation made on 3/14/22 at 12:58 PM, Nurse #1 was observed as she entered Resident #526's room. The nurse was wearing a face shield and an N95 mask. She did not don a gown or gloves prior to entering the room. Nurse #1 was observed from the hallway as she talked with Resident #526 and raised her head of the bed using the resident's bed controls prior to exiting the room.

An interview was conducted on 3/14/22 at 1:03 PM with Nurse #1. During the interview, the nurse was asked about the TBP signage on Resident #526's room. Nurse #1 stated the resident was admitted on Friday (3/11/22) and was not vaccinated so she automatically went into quarantine. Upon further inquiry as to what PPE staff was required to wear when entering the resident's room, the nurse stated if she was going to work with the resident she would need to gown up and to don gloves. When asked about her visit to the resident's room, the nurse stated she just went in to check on the resident's meal. The nurse was then asked if she should have donned the required PPE (including gloves) since she adjusted the resident's bed while in the room, the nurse stated, "probably."

An interview was conducted on 3/17/22 at 8:58 AM with the facility's Assistant Director of Nursing (ADON), who also assumed responsibilities as the Infection Control Nurse. During the interview, the observation made of Nurse #1 entering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 75	F 880		

Resident #526's room without donning a gown and gloves was discussed. The ADON reported staff entering a resident's room needed to observe and implement the instructions on the TBP signage. She stated the TBP signage indicated staff needed to wear the following PPE when going into Resident #526's room: a mask, goggles, gown, and gloves. When asked if Nurse #1's observed failure to don a gown and gloves when entering the room would be a concern, the ADON stated, "Yes it is."

An interview was conducted on 3/17/22 at 10:50 AM with the facility's Director of Clinical Services (DCS). During the interview, the DCS reported the incident observed of Nurse #1 entering Resident #526's room without donning the appropriate PPE was discussed. The DCS stated the hall nurse was re-educated on the importance of observing the PPE requirements prior to entering a room for a resident on TBP. The DCS reported she was aware the hall nurse had adjusted the resident's bed while in the room.

3) A review of the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker on 3/14/22 indicated the county where the facility was located had a "substantial" level of community transmission for COVID-19.

Review of CDC guidance titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" (updated 2/2/22) included information on the implementation of source control measures which read in part: "Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose 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 03/17/2022

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 76	F 880		

prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing ...Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission ..." The CDC guidance defined health care personnel (HCP) as "all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include but are not limited to ...persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel)."

Review of a facility policy titled, "COVID-19 - Pandemic Plan" (Dated 3/2/20; Revised 2/28/22) addressed "Emergency Procedures - Pandemic COVID-19." This policy read in part, "#42 (of #48) ...Implement Universal Source control for all staff per CDC guidance."

An observation was conducted on 3/15/22 at 2:00 PM in the Dietary Department. Upon entry to the kitchen, Cook #1 was observed working on food preparation tasks at the cook's table without wearing a face mask. An interview was conducted on 3/15/22 at 2:03 PM with Cook #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 77	F 880		

When asked why he was not wearing a face mask, the cook stated he had gotten hot so he took it off. After questioning, Cook #1 was observed to get a face mask out of his pocket and put it on to cover his nose and mouth.

An observation was conducted on 3/15/22 at 2:05 PM as two Dietary staff members were observed working in the dish machine area of the kitchen. Dietary Aide #1 did not have a mask on and no mask was visible around her neck or face. Dietary Aide #2 was observed to have her face mask pulled down below her chin. Her face mask was not covering either her nose or her mouth.

When joined by the facility ' s consultant Registered Dietitian (RD) on 3/15/22 at 2:10 PM, additional observations were conducted as the two dietary aides continued to work without wearing face masks. An interview was conducted at that time with the RD. When asked what her thoughts were, the RD reported she would expect the dietary aides to be wearing face masks. The RD was observed as she went over to talk with Dietary Aide #1. Dietary Aide #1 was observed as she left the area while Dietary Aide #2 was observed to place her face mask over her nose and mouth.

An interview was conducted with the Dietary Manager on 3/15/22 at 2:30 PM. During the interview, the Dietary Manager reported both Dietary Aide #1 and Dietary Aide #2 had medical conditions which made it difficult to wear a face mask. However, he stated both of the dietary aides wore face masks when they worked on the tray line.

An observation was conducted on 3/16/22 at 6:53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 78	F 880		

AM. Upon entering the kitchen, Dietary Aide #2 was observed as she prepared for the breakfast meal. She did not have a mask on. The dietary aide was then observed as she donned a face mask.

An interview was conducted on 3/17/22 at 8:58 AM with the facility ' s Assistant Director of Nursing (ADON), who also assumed responsibilities as the Infection Control Nurse. During the interview, the ADON was asked what PPE staff members were required to wear while in the facility. She reported staff were required to wear an N95 face mask and either goggles or face shields. When asked if the requirement included all staff members, the ADON stated, "That includes all staff members in the facility and in every department." When the observed failure of Dietary staff members to wear a face mask was discussed, the ADON reported the Dietary staff had given feedback on the use of masks saying, "it's hot in there." The ADON added, "But it doesn't matter. The rules are the rules...there is no medical clearance for not wearing a mask."

An observation was conducted on 3/17/22 at 9:19 AM of Cook #1 as he was talking to the Dietary District Manager across the cook's preparation table. Cook #1 was observed to have his mask under his chin as he talked. Neither his mouth nor his nose were covered.

An interview was conducted on 3/17/22 at 9:20 AM with the facility's Dietary Manager and Dietary District Manager. During the interview, concerns identified from the observations made of Dietary staff failing to wear face masks on 3/15/22, 3/16/22, and 3/17/22 were expressed. The Dietary Manager stated both Dietary Aide #1 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 03/17/2022

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 79 #2 had medical conditions which made it difficult for them to wear an N95 mask. The Dietary District Manager reported at the time the observation of Cook #1 was made that morning, he had just taken his mask down to talk with her. When asked what the expectation was for Dietary Department staff, the Dietary District Manager stated, "To follow the facility policy on PPE."	F 880		