## Statement of Deficiencies and Plan of Correction

### Name of Provider or Supplier

**TRANSCITIONAL HEALTH SERVICES OF KANNAPOLIS**

**Address:** 1810 CONCORD LAKE ROAD

**City, State, Zip Code:** KANNAPOLIS, NC  28083

### Provider's Plan of Correction

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>F 000 INITIAL COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>No deficiency cited as a result of the CI on 3/20/17, Event ID# Q5TL11</td>
</tr>
</tbody>
</table>

### Provider/Supplier/CLIA Identification Number:

345258

### Multiple Construction Wing:

A. BUILDING _____________________________

B. WING _____________________________

### Date Survey Completed:

03/20/2016

### Laboratory Director’s or Provider/Supplier Representative's Signature

Electronically Signed

**Title:**

**Date:** 04/01/2016

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