	-	ND HUMAN SERVICES				FOR	M APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> 0. 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		E SURVEY PLETED
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG _			
							С
		345258	B. WING			04	/07/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			810 CONCORD LAKE ROAD		
				K	CANNAPOLIS, NC 28083		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIZ TAG	Х	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
1/10		,			DEFICIENCY)		
F 000	INITIAL COMMENTS		F	000			
1 000							
		ered the facility on					
	The survey team ent	ct a revisit and complaint					
		04/04/2017. Additional					
	-	ined on 04/06/2017 and					
	04/07/2017. Therefo	re, the exit date was					
	changed to 04/07/20						
F 157	483.10(g)(14) NOTIF	Y OF CHANGES	F '	157			5/2/17
SS=G	(INJURY/DECLINE/F	ROOM, ETC)					
	(g)(14) Notification of	Changes.					
		rediately inform the resident;					
		ent's physician; and notify,					
		her authority, the resident					
	representative(s) whe	en mere is-					
	(A) An accident involv	ving the resident which					
		as the potential for requiring					
	physician intervention						
		ge in the resident's physical,					
	mental, or psychosoc	•					
		n, mental, or psychosocial					
	clinical complications	reatening conditions or					
),					
	(C) A need to alter tre	eatment significantly (that is,					
	a need to discontinue						
		erse consequences, or to					
	commence a new for	m of treatment); or					
	(D) A decision to tran						
	resident from the faci	lity as specified in					
	§483.15(c)(1)(ii).						
	(ii) When making noti	ification under paragraph (g)					
		the facility must ensure that					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
Electroni	cally Signed						04/27/2017

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/23/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		LETED
		345258	B. WING				C 07/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		18	10 CONCORD LAKE ROAD		
				K	ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	 is available and proving hysician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483. (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must a update the address (inghone number of the This REQUIREMENT by: Based on record rev physician interviews, physician of the reside when a resident experies a constraint of the transition of the reside infection, acute on chaspitalization for 1 of Findings included: Resident #1 was admire habilitation after a final section. 	on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident representative(s). is not met as evidenced iew, staff interviews and the facility failed to notify the ent 's change in condition erienced daily diarrhea, f treatment of a bacterial ironic renal failure and a of 3 residents (Resident #1.)	F 1	157	F 157 SS=G Notify of Changes 1. Resident #1 was transferred to the hospital and discharged from the facilit on 3/10/17. 2. On 4/28/17, the Director of Clinica Services (DCS) and or registered nurs designee completed a quality improvement monitoring of 93 current residents to identify residents with a change in condition including any episodes of diarrhea/loose stools, vomiting, decreased urinary output or decreased fluid intake to validate that the residents' physician and/or nurse	ty Il e	
					 practitioner (NP) and responsible party (RP) were notified of these changes. T physician and/or NP and RP received notification of any residents identified. By 5/2/17, the DCS and/or register 	ĥe	

Event ID: XH5C11

Facility ID: 923060

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			EDICAID SERV				CONSTRUCTION		NO. 0938-03 DATE SURVEY	
	CORRECTION	> (IDENTIFICATION		` '				OMPLETED	
			3452	258	B. WING			С		
	ROVIDER OR SUF		0-101			ет	REET ADDRESS, CITY, STATE, ZIP CODE		04/07/2017	
	CONDER OR SUP									
TRANSITI	ONAL HEALTH	I SERVICES	S OF KANNAPOLI	S			10 CONCORD LAKE ROAD ANNAPOLIS, NC 28083			
(X4) ID	SL	JMMARY STAT	EMENT OF DEFICIEN	ICIES	ID		PROVIDER'S PLAN OF CORRECTION	DN	(X5)	
PREFIX TAG	(EACH	DEFICIENCY	MUST BE PRECEDED	BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	COMPLETIO	
F 157	Continued F	rom page	2		F 15	57				
-			– novement log re	healed			nurse designee completed reeducati	on to		
			ving diarrhea on				licensed nurses and nursing assista			
			oose bowel move				regulation 483.10(g)(14) regarding ti			
			ne exception of 3				notification of changes in residents'			
			there was a form				condition to prevent a delay of a new	,		
			were loose and				diagnosis and treatment and Consul			
	description v	was provid	ed.				policy N-105 "Change in Resident			
	1						Condition". Education included the			
	02/24/2017	8:28 PM	BM large	Loose			expectation of the licensed nurse to	notify		
	02/25/2017	11:22 AM	-	Formed			the residents' physician and/or NP a	-		
	02/25/2017	9:24 PM	BM small	Loose			when a resident exhibits a change in	1		
	02/25/2017	11:37 PM	1 BM large	Loose			condition including any episodes of			
	02/26/2017	1:27 PM	BM extra la	rge Loose			diarrhea/loose stool, vomiting, decre	ased		
	02/27/2017	1:25 PM	BM large	Loose			urinary output or fluid intake and to			
	02/27/2017	6:32 PM	BM small	Loose			document this notification on an SBA			
	02/28/2017		BM large	Loose			(Situation Back ground Assessment	and		
	02/28/2017			-			Review and notification) tool in the			
	03/01/2017		•	Loose			residents' medical record. Newly hire			
	03/01/2017		BM small	Loose			licensed nurses and nursing assistar	nts to		
	03/02/2017			Loose			be educated upon hire.			
	03/02/2017			rge Loose			The licensed nurse to notify the			
	03/02/2017		BM small	Loose			residents' physician and/or NP and F			
	03/02/2017			Loose			when a resident exhibits a change in	l		
	03/03/2017		BM medium				condition including any episodes of	acad		
	03/03/2017 03/03/2017	9:36 PM 11:23 PM	BM small	Loose			diarrhea/loose stool, vomiting, decre	aseu		
	03/03/2017	-	1 BM large BM small	Loose Loose			urinary output or fluid intake and to document this notification on an SBA	N R		
	03/04/2017		BM large	Loose			(Situation Back ground Assessment			
	03/05/2017		-				Review and notification) tool in the	anu		
	03/06/2017		BM large	Loose			residents' medical record. The licens	ed		
	03/07/2017		-				nurse supervisor to review SBARs, S			
	03/07/2017		BM mealuri BM small	Loose			and Watch Tools, 24 hour reports, B	•		
	03/08/2017	1:46 PM	BM extra la				and Bladder Care Tracker reports ar			
	03/08/2017			Loose			nursing shift reports daily and the DC			
	03/08/2017			Loose			and IDT (Interdisciplinary Team) to			
	03/09/2017		-				monitor for compliance during the			
	20.00.2011		2 6/4/4 14				morning clinical meeting Mondays-F	ridavs		
	A	ata data d	0/07/47	1.0.		- 1				
	A prodress r	lote daten	2/27/17 revealed	d the			to ensure compliance with physician			

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PRINTED: 05/23/2017 FORM APPROVED

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/23/2017 MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345258	B. WING			04	C //07/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				18	810 CONCORD LAKE ROAD		
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		к	ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From page	a 3		157			
1 107				157	when exhibit changes in condition to		
	frequent. The note in	essively become more			who exhibit changes in condition to maintain hydration and health.		
		cile infection. The NP noted			4. The DCS/registered nurse desig	nee	
		Citrucel and Metamucil for			to conduct quality improvement		
		ered C-Difficile stool culture			monitoring of 5 residents' medical rec	ord	
		rams (mg) every 6 hours as			to ensure that the residents' physicial		
	needed for loose stor	ols.			and/or NP and RP was promptly notif	ied	
					of changes in condition including any		
		practitioner 's order dated			episodes of diarrhea/loose stool, vorr		
		ool culture for C-Difficile and			decreased urinary output or decrease		
		6 hours as needed for			fluid intake at a frequency of daily for		
	diarrhea.				weeks, then 3 times a week for 8 wee	eks,	
	A review of the nurse	s ' notes from 2/27/17 to			then 1 time a month . Frequency of monitoring to be modified based on		
		resident had no changes in			findings.		
		d, and there was no notation			interngo.		
		movements or diarrhea.			The results of quality improvement		
	Nurses ' notes indica	ated the blood pressure and			monitoring to be reported to the Qual	ity	
		d within normal limits.			Assurance Performance Improvemer		
					Committee monthly by the Administra	itor	
	A review of the medic	cation administration record			and/or DCS. The Quality Assurance		
		3/10/17 revealed the 2/27/17			Performance Improvement Committe	e will	
		tool sample was added to			evaluate the effectiveness of the		
	the MAR, but had no	initials for being completed.			monitoring/observation tools for maki	ng	
	A progress poto data	d 3/8/17 revealed the ND			changes to the corrective action if		
		d 3/8/17 revealed the NP diarrhea. The NP re-ordered			necessary to maintain substantial compliance and ensure timely physic	ian	
		e and the resident was			and/or NP notification of changes in		
		4 mg every 6 hours as			residents' condition to prevent a delay	v of a	
		ols. The resident had a			new diagnosis and treatment. The Qu		
	blood pressure of 122				Assurance Improvement Committee	-	
		and was in no distress. The			members consist of, but not limited to	, the	
		nd the creatinine was at			Administrator, Director of Clinical		
		nt complained of dizziness			Services, Medical Director (quarterly	at a	
	and the NP planned of	orthostatic blood pressures.			minimum) and at least three other		
					members to include but not limited to	one	
		practitioner 's order dated ol culture for C-Difficile, to			direct care giver.		
		of culture for C-Difficile, to bod pressure for three days,			AOC date: 5/2/17		
	assess uninusidiic Dic	bou pressure for timee days,					

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _			
		345258	B. WING				C 07/2017
NAME OF P	ROVIDER OR SUPPLIER	1		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			1810 CONCORD LAKE ROAD		
				-	KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 167							
F 157	10	e Citrucel 500 milligrams	F 1	157			
		tamucil 6 grams each day.					
		cian 's order dated 3/8/17					
	revealed normal salin (cubic centimeters) po	e intravenous fluid at 125 cc					
		d 3/9/17 indicated the NP					
		an abnormal lab result of al range 0.6 - 1.3). The					
		ssure was 140/70 and pulse					
	80. The same progre	ess note further revealed the					
		te kidney injury on chronic					
		•					
		metabolic panel (BMP)					
		cian 's order dated 3/9/17					
		•					
	and to repeat the BM	P lab.					
	A review of Resident	#1 's laboratory results for a					
		-					
		s positive for C-difficile on					
	3/13/17.						
	A review of the physic	cian 's order dated 3/10/17					
		U					
	room for an evaluatio	n of the dehydration.					
	The NP indicated in a	a progress note dated					
	3/10/17 she saw the i	resident for elevated white					
		,					
	kidney disease from dehydration. The resident was started on intravenous fluids at 125 cubic centimeters (cc) per hour. The nephrologist ordered a stat (urgent) renal ultrasound for today and repeat the basic metabolic panel (BMP) tomorrow. A review of the physician 's order dated 3/9/17 revealed an additional order for normal saline intravenous fluid at 125 cc per hour for one liter and to repeat the BMP lab. A review of Resident #1 's laboratory results for a stool culture of C-difficile collected on 3/9/17 revealed the stool was positive for C-difficile on 3/13/17. A review of the physician 's order dated 3/10/17 stated to send Resident #1 to the emergency room for an evaluation of the dehydration. The NP indicated in a progress note dated 3/10/17 she saw the resident for elevated white blood cell count (WBC). The resident 's blood pressure was 106/60 and pulse 62. The assessment was worsening kidney function and						
		resident had acute kidney					

Facility ID: 923060

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/23/2017 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345258	B. WING				C 07/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE. ZIP CODE	• • •	
			1	810 CONCORD LAKE ROA	D		
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS		ANNAPOLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 157	to the emergency roo Resident #1 was adm 3/10/17 and the hospit Resident #1 had C-Di failure in the setting o state and moderate m was seen by her nepf with Flagyl (antibiotic) had a two-week histor weakness. The disch diagnoses were nono stop urinating when d injury on chronic kidn leukocytosis (elevated hypocalcemia (low ca acidosis (body was to treated or can be fata aggressive IV fluid resident dehydration. At the ti on 3/22/17, the resident baseline. On 4/3/17 at 4:50 pm with the NP. The NP was informed by staff loose stools, but not et that she asked the resi and was informed the C 2/27/17 for the reside NP asked the staff for test on 3/6/17, the NF were pending. The N	The NP sent the resident m for evaluation. itted to the hospital on tal history and physical was al course documented fficile colitis and acute renal f a generalized debilitated halnutrition. The resident prologist and was treated and IV fluids. The resident of diarrhea with arge summary revealed liguric (body was unable to ehydrated), acute kidney ey disease, C-Difficile colitis, d white blood cells), anemia, lcium), and metabolic o acidic to function, must be l). The resident received suscitation for acute me of the hospital discharge ent's creatinine returned to an interview was conducted stated that on 2/27/17 she Resident #1 was having every day. The NP stated sident about her diarrhea diarrhea was every day. c-Difficile stool culture on nt's diarrhea. When the the results of the C-difficile was informed the results P stated she did not write	F 157		EFICIENCY)		
	but was waiting for the	nplete a stool for C-Difficile, e C-Difficile results from ed she was not aware until					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/23/2017 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345258	B. WING		_		C 07/2017
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS		1810 CONCORD LAKE ROA KANNAPOLIS, NC 2808			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	3/8/17 that the stool of The NP stated that he to follow orders as wr changes. The resider emergency room on 3 her nephrologist while On 4/4/17 at 8:40 am with the Director of Nr stated that she expect s orders. The DON a staff was educated re to contact the physicia a change in condition On 4/4/17 at 9:00 am with Nursing Assistan the resident had 4 to on day shift for over a hospitalization. NA # nurse that Resident # movements. An additional interview at 2:02 pm via telepho stated that the diarrhe day and frequency wa she did not have time resident care. NA #1 liquid with mucous an informed the nurse or over 10 days the resident that everything she ea The resident also had #1 stated that she dis diarrhea with the NP of	culture had not been done. er expectation was for staff itten and to notify her of any itten and to notify her of any an interview was conducted t (NA) #1. NA #1 stated that 6 loose bowel movements a week leading up to the 1 stated she reported to the 1 had multiple bowel w was conducted on 4/6/17 one with NA #1. NA #1 ea was more than once a as not documented because to document and provide stated that the diarrhea was id foul smelling. She n duty at least once a shift dent had diarrhea. NA #1 nt was tired and commented ats goes right through her. a decrease in appetite. NA cussed the resident ' s	F 157				

TEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		345258	B. WING		0	C 4/07/2017
ME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				1810 CONCORD LAKE ROAD		
RANSIII	ONAL HEALTH SERVICI	S OF KANNAPOLIS		KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 157	physician stated he r	e resident ' s physician. The emembered Resident #1 and	F 15	7		
	physician stated he remembered Resident #1 and had reviewed the records when the stool culture was missed as part of quality review. The physician explained he was informed by the facility that the order for C-Difficile stool sample on 2/27/27 was missed. The physician stated he was informed by his NP that the resident had one loose stool a day. The resident did not present with a C-Difficile infection because the facility staff informed the NP that Resident #1 had one bowel movement a day.					
F 281 SS=G	#4 stated that she ren was on duty 3/3/17 fo two loose stools on d administered Imodium resident 's request. have a concern for de resident was drinking further diarrhea after Imodium. Nurse #4 s physician if a residen as needed medicatio diarrhea.	one with Nurse #4. Nurse membered Resident #1 and or day shift. Resident #1 had ay shift and that she n once at 10:00 AM per the Nurse #4 stated she did not ehydration because the fluids and there was no the resident received the stated she would inform the t had repeated need for an n or concerns regarding	F 28	1		4/27/17
	(b)(3) Comprehensive					
	(i) Meet professional This REQUIREMEN					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/23/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345258	B. WING				C 1 07/2017
	ROVIDER OR SUPPLIER ONAL HEALTH SERVICE	ES OF KANNAPOLIS		18	TREET ADDRESS, CITY, STATE, ZIP CODE 810 CONCORD LAKE ROAD ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 281	physician interviews, a lab order for a stool infection (Clostridium of diagnosis and trea resident to become d acute renal failure for #1.) Findings included: Resident #1 was adm rehabilitation after a h resident had the diag chronic kidney diseas The admission minim dated 1/30/17 reveale cognitively intact and assistance of one sta daily living. The resid and occasionally inco A review of the bowel Resident #1 started h and had one or more day until 3/9/17, with when she received Im formed stool. The bo and no other descript A progress note dater. Nurse Practitioner (N stools that had progres frequent. The note in concerned for C-Diffie Resident #1 was on C	iew, staff interviews and the facility failed to complete I culture for a bacterial difficile) resulting in a delay tment which caused the ehydrated and to develop of 1 of 3 residents (Resident hitted on 1/25/17 for hip fracture surgery. The noses of femur fracture and se stage III. hum data set for Resident #1 ed the resident was required extensive ff member with activities of dent was continent of bowel ontinent of urine. I movement log revealed having diarrhea on 2/24/17 loose bowel movements per the exception of 3/3/17 nodium and there was a wel movements were loose ion was provided. d 2/27/17 revealed the P) saw the resident for loose essively become more	F	281	Past noncompliance: no plan of correction required.		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED C
		345258	B. WING				07/2017
NAME OF PI	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	 2/27/17 revealed a str Imodium 4 mg every f diarrhea. A review of the medic (MAR) for 2/27/17 to order for C-Difficile str the MAR, but had no A review of Resident 2/27/17 through 3/8/1 laboratory result press C-Difficile, which was A review of the laboration s creatinine dated 3/7 (kidney function) result 0.6 - 1.3) and the bloct [shows hydration] rest 3-25). The resident ' 1.6. A progress note dated saw the resident for do C-Difficile stool culture treated with Imodium needed for loose stoot blood pressure of 122 temperature of 98 F at labs were reviewed at 	 practitioner 's order dated ool culture for C-Difficile and 6 hours as needed for ation administration record 3/10/17 revealed the 2/27/17 ool sample was added to initials for being completed. #1 's laboratory results from 7 revealed there was no ent for a stool culture for ordered on 2/27/17. atory results of the resident ' 7/17 revealed the creatinine for urea nitrogen (BUN) ult was 33 (normal range s baseline creatinine was 4 mg every 6 hours as obs. The resident had a 	F	281			
	A review of the nurse 3/8/17 revealed a sto	orthostatic blood pressures. practitioner ' s order dated ol culture for C-Difficile, to bod pressure for three days,					

Facility ID: 923060

If continuation sheet Page 10 of 34

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345258	B. WING				C /07/2017
NAME OF P	ROVIDER OR SUPPLIER	L	I		STREET ADDRESS, CITY, STATE, ZIP CODE	• -	
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 281	each day and the Mer A progress note dated saw the resident for a creatinine 5.85 (norm resident 's blood pres 80. The same progres assessment showed a chronic kidney diseas resident was started of cubic centimeters (cc ordered a stat (urgent and repeat the basic tomorrow. A review of the physic revealed an additional intravenous fluid at 12 and to repeat the BMI A review of Resident stool culture of C-diffi revealed the stool wa 3/13/17. Laboratory r creatinine (kidney fun 9.61 (normal range 0). nitrogen (BUN) [show on 3/10/17 (normal ra baseline creatinine was A review of the physic stated to send Resider room for an evaluatio and BUN. The NP indicated in a 3/10/17 she saw the r	e Citrucel 500 milligrams tamucil 6 grams each day. d 3/9/17 indicated the NP in abnormal lab result of al range 0.6 - 1.3). The ssure was 140/70 and pulse ess note further revealed the an acute kidney injury on be from dehydration. The on intravenous fluids at 125) per hour. The nephrologist t) renal ultrasound for today metabolic panel (BMP) cian 's order dated 3/9/17 il order for normal saline 25 cc per hour for one liter P lab. #1 's laboratory results for a cile collected on 3/9/17 s positive for C-difficile on results of the resident 's inction) dated 3/10/17 was .6 - 1.3). The blood urea vs hydration] result was 55 inge 3-25). The resident 's as 1.6. cian 's order dated 3/10/17 ent #1 to the emergency n of the elevated creatinine	F	28			

If continuation sheet Page 11 of 34

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/23/2017 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION			SURVEY PLETED
		345258	B. WING					07/2017
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CO	DE	•	
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS			1810 CONCORD LAKE ROAD			
	·····				KANNAPOLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI		(X5) COMPLETION DATE
F 281	elevated WBC. The I creatinine of 9.61 and had acute kidney inju became injured due to NP sent the resident f evaluation. Resident #1 was adm 3/10/17 and the hosp reviewed. The hospit Resident #1 had C-D failure in the setting o state and moderate m was seen by her nepl with Flagyl (antibiotics resident had a two-we weakness. The resid to 9.7. The discharged diagnoses were nono stop urinating when d injury on chronic kidn leukocytosis (elevated hypocalcemia (low ca acidosis (body was to treated or can be fata aggressive IV fluid residenydration and sodii At the time of the hos the resident ' s creatin 1.6. Resident #1 was not i had been discharged On 4/3/17 at 4:50 pm with the NP. The NP	and pulse 62. The sening kidney function and ab result showed a d a BUN 55. The resident ry due to diarrhea (kidney o a lack of blood flow). The to the emergency room for hitted to the hospital on ital history and physical was cal course documented ifficile colitis and acute renal of a generalized debilitated halnutrition. The resident horologist and was treated s) and IV fluids. The eek history of diarrhea with ent ' s creatinine increased e summary revealed liguric (body was unable to lehydrated), acute kidney ey disease, C-Difficile colitis, d white blood cells), anemia, licium), and metabolic to acidic to function, must be l). The resident received	F	28				

Facility ID: 923060

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CENTERS FOR MEDICARE & MEDICAID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) N	IULTIPLE CONSTRUCTION LDING	(X3) DATE SURVEY COMPLETED
345258 B. WI	١G	C 04/07/2017
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	• • • •
	1810 CONCORD LAKE ROAD	
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	KANNAPOLIS, NC 28083	
	ID PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD AG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
 F 281 Continued From page 12 loose stools, but not every day. The NP stated that she asked the resident about her diarrhea and was informed the diarrhea was every day. The NP ordered the C-Difficile stool culture on 2/27/17 for the resident 's diarrhea. When the NP asked the staff for the results of the ordered C-difficile test on 3/6/17, the NP was informed the results were pending. The NP stated she did not write any new orders to complete a stool for C-Difficile, but was waiting for the C-Difficile results from 2/27/17. The NP stated she was not aware until 3/8/17 that the stool culture had not been done. The NP stated that she contacted the resident 's elevated creatinine, and the nephrologist or 3/9/17 regarding the resident 's elevated creatinine, and the nephrologist ordered a stat (immediate) ultra sound of the kidneys. The NP stated that the physician ordered on 3/8/17 for the resident was to go for an evaluation of the elevated creatinine of 5.85, but instead the resident was to the ER to have an IV placed. The NP stated that her expectation was for staff to follow orders as written. The NP stated that the physicians and NPs now have direct access to the lab results on-line to improve follow up. The NP further stated the increased creatinine lab result was related to acute injury to the kidney from dehydration secondary to diarrhea. The NP stated that another creatinine lab level was completed on 3/10/17 and it had increased to 9.6, and it had not improve difter Resident #1 received intravenous fluids. The resident was sent to the emergency room on 3/10/17 and was referred to her nephrologist while she was hospitalized. 	F 281	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345258	B. WING				07/2017
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 281	stated that she expects s orders. On 4/4/17 at 10:30 ar was conducted with t root cause analysis w C-difficile lab order da stated that the error w was provided for all s lab process, a quality assurance summary a QAPI (quality assur improvement) meetin medical director, and orders and the process four-point plan of corri audit revealed no oth the incident and no or incident to date. The four-point plan of and all components w An additional interviet at 2:02 pm via telephi stated that she discuss with the NP and a cul #1 collected that spect An interview was convia telephone with the physician stated he h when the stool culture quality review. The p informed by the faciliti C-Difficile stool samp	ursing (DON). The DON ted staff to follow physician ' n an additional interview he DON. The DON stated a vas conducted for the missed ated 2/27/17. The DON vas investigated, education taff that was responsible for improvement/quality was documented, there was rance performance g, which included the a prospective review of lab as was performed. The rection was completed. An er missed labs at the time of ther missed labs since the f correction was reviewed vere present on 3/31/17. w was conducted on 4/6/17 one with NA #1. NA #1 ased the resident ' s diarrhea ture was ordered, and NA cimen. ducted on 4/6/17 at 3:40 pm e resident ' s physician. The ad reviewed the records e was missed as part of hysician explained he was	F	281			

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			LETED
		345258	B. WING				C 07/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	01/2011
TRANSITI					1810 CONCORD LAKE ROAD		
IRANSIII	ONAL HEALTH SERVICE	S OF KANNAPULIS			KANNAPOLIS, NC 28083		
(X4) ID PREFIX	(EACH DEFICIENC			PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
TAG	REGULATORT OR I	SC IDENTIFYING INFORMATION)	TAG	1	DEFICIENCY)		DATE
E 004			ĺ _				
F 281	Continued From page		F	281	1		
		of the plan of action dated t revealed Resident #1 had					
		rder for C-Difficile laboratory					
	dated 2/27/17. On 3/	8/17 the management team					
	created an error repo						
		ory process audit going back med. On 3/10/17 a Quality					
	-	nce Improvement committee					
		d a root cause analysis was					
		was determined that the					
		e was not placed into the					
	-	electronic system. On ent team put in place an					
		orders and the process for					
	-	r 30 days and each week					
		ultant Nurse reviewed the					
	laboratory error repor	-					
		ation in-service attendance ve/ongoing audits. No other					
	laboratory errors were						
		plan of action showed					
	-	sing staff of the laboratory					
	The documentation s	was completed on 3/9/17.					
		3/10/17, 3/13/17, 3/15/17,					
		2/17, 3/24/17, 3/27/17,					
		and there were no further					
		errors. Sign-in sheets for					
		ewed and interviews with the ere aware of the process for					
	timely completion of la	-					
	An interview was con	ducted on 4/6/17 at 2:10 pm					
	via telephone with Nu	Irse #2. Nurse #2 stated the					
	expected laboratory p						
	laboratory vendor wo	uld draw or retrieve a er it was ordered and placed					
		s the request was for urgent					

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/23/201 RM APPROVEI IO. 0938-039	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED	
		345258	B. WING 04		4/07/2017		
	ROVIDER OR SUPPLIER ONAL HEALTH SERVICE	ES OF KANNAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE	
F 281 F 309 SS=G	order received; order access to laboratory of placed in the nurses laboratory staff come blood or receive the s placed in E-lab; and a result is placed in the record. Nurse #2 sta three piece carbon ar reconciled each day f was followed. Nurse vendor provided lab s weekend, and the sta the vendor ' s website 483.24, 483.25(k)(I) F FOR HIGHEST WEL 483.24 Quality of life Quality of life is a fun applies to all care and residents. Each resid facility must provide t services to attain or r practicable physical, well-being, consisten comprehensive asses 483.25 Quality of care is a fun applies to all treatment facility residents. Bas assessment of a resid that residents receive accordance with profi- practice, the compref	ad the process as follows: placed in E-lab (electronic vendor); lab to be drawn is station lab log book; to the facility to draw the specimen; the lab result is a reminder to check for lab medication administration ted that all orders have a nd the gold piece is to ascertain that the order #2 also stated that the services and results on the aff retrieved the results from e. PROVIDE CARE/SERVICES L BEING damental principle that d services provided to facility dent must receive and the he necessary care and naintain the highest mental, and psychosocial t with the resident's asment and plan of care. e ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered sidents' choices, including	F 28			5/2/17	

Event ID: XH5C11

Facility ID: 923060

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/23/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345258	B. WING		C 04/07/2017
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
TRANSITI	ONAL HEALTH SERVIC	ES OF KANNAPOLIS	1	810 CONCORD LAKE ROAD	
			P	(ANNAPOLIS, NC 28083	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 309	Continued From page	e 16	F 309		
	(k) Pain Managemen				
		ure that pain management is			
		who require such services, ssional standards of practice,			
	-	erson-centered care plan,			
	and the residents' go	als and preferences.			
	(I) Dialysis. The facil	ity must ensure that			
		e dialysis receive such			
		with professional standards rehensive person-centered			
	care plan, and the re	-			
	preferences.				
		Γ is not met as evidenced			
	by: Based on record rev	iew, staff interviews and		F309 SS=G QOC r/t recognizi	ing and
	physician interviews,			assessing changes in condition r/t	
		ess for a change in condition		diarrhea	
		erienced daily diarrhea, f a diagnosis and treatment		1. Resident #1 was transferred to	the
		n (Clostridium difficile), for 1		1. Resident #1 was transferred to hospital and discharged from the fac	
	of 3 residents (Resid			on 3/10/17.	
				2. On 4/28/17, the Director of Clin	
	Findings include: Resident #1 was adn	nitted on 1/25/17 for		Services (DCS) and or Registered N designee completed a quality	Nurse
		nip fracture surgery. The		improvement monitoring of 93 curre	ent
		noses of femur fracture and		residents to identify residents with a	
	chronic kidney diseas	se stage III.		change in condition including any episodes of diarrhea/loose stools,	
		are plan dated 1/25/17 for		vomiting, decreased urinary output of	
		of nutrition and hydration.		decreased fluid intake to validate the	
		num data set dated 1/30/17 t was cognitively intact and		licensed nurse recognized and asse the change in condition and docume	
		ssistance of one staff		finding in the residents' medical reco	
	member with activitie			Any identified residents to be asses	sed by
				the licensed nurse until condition res	solves
		I movement log revealed naving diarrhea on 2/24/17		to maintain hydration and health. 3. By 5/2/17, the DCS and/or regis	stered
	I Starteur				SICICU

Event ID: XH5C11

Facility ID: 923060

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			DICAID SERVICES				1	<u>O. 0938-03</u>
	OF DEFICIENCIES	(X1)) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	· /	E SURVEY PLETED
				A. BUILDING	з			
			345258	B. WING			С	
			545256			TREET ADDRESS, CITY, STATE, ZIP CODE	04	/07/2017
NAME OF P	ROVIDER OR SUPPL	JER						
TRANSIT	ONAL HEALTH S	ERVICES O	OF KANNAPOLIS			810 CONCORD LAKE ROAD ANNAPOLIS, NC 28083		
	0.111					<i>,</i>		
(X4) ID PREFIX TAG	(EACH DE	FICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
F 309	Continued From	m page 17	,	F 30	09			
			se bowel movements per			nurse designee completed reeducatio	n to	
			exception of 3/3/17 she			licensed nurses and nursing assistant		
			ere was a formed stool.			regulation 483.24, 483.25(k)(l) regard		
			ere loose and no other			providing the necessary care and serv	vices	
	description was	s provided	l.			to attain or maintain the highest		
						practicable physical, mental and		
	02/24/2017 8		BM large Loose			psychosocial well-being, consistent wi		
	02/25/2017 1		BM medium Formed			the residents' comprehensive assess		
	02/25/2017 9		BM small Loose BM large Loose			and plan of care. Education also inclu Consulate policy N-105 "Change in	ueu	
	02/26/2017 1		BM extra large Loose			Condition" and N-107 "Change of Shift	ŧ	
0	02/27/2017 1		BM large Loose			Report", Consulate Best Practices	L	
	02/27/2017 6		BM small Loose			"24-Hour Report" and "Daily Clinical		
	02/28/2017 8		BM large Loose			Meeting" and Interact tools "Stop and		
	02/28/2017 1	11:43 AM	BM extra large Loose			Watch", "SBAR" and "Care Path for		
	03/01/2017 1		BM large Loose			Dehydration" regarding the expectatio	n of	
	03/01/2017 8		BM small Loose			the licensed nurse to recognize and		
	03/02/2017 1		BM small Loose			assess a resident when he/she exhibi	ts a	
	03/02/2017 9		BM extra large Loose			change in condition including any	tina	
	03/02/2017 8		BM small Loose BM large Loose			episodes of diarrhea/loose stool, vomi decreased urinary output or decrease	-	
	03/03/2017 1		BM medium Formed			fluid intake to prevent dehydration. Ne		
	03/03/2017 9		BM small Loose			hired licensed nurses and nursing	wiy	
		11:23 PM	BM large Loose			assistants to be educated upon hire.		
	03/04/2017 9	9:01 PM	BM small Loose			The licensed nurse and nursing		
	03/05/2017 9	9:35 PM	BM large Loose			assistant will monitor residents for a		
		12:39 PM	BM extra large Loose			change in condition including any		
		5:03 PM	BM large Loose			episodes of diarrhea/loose stool, vomi	•	
		11:16 AM	BM medium Loose			decreased urinary output or decrease		
		4:46 PM	BM small Loose			fluid intake. The nursing assistant will		
		1:46 PM	BM extra large Loose BM small Loose			document observed changes in reside		
		6:24 PM 11:42 PM	BM small Loose BM large Loose			condition utilizing the "Stop and Watch tool and will document diarrhea episod		
		11:42 PM	BM extra large Loose			in Care Tracker as indicated and	100	
						communicate to the licensed nurse for	-	
	A progress not	te dated 2/2	27/17 revealed the			further assessment and intervention.		
			saw the resident for loose			licensed nurse to assess residents for		
			vely become more			changes in condition and dehydration	risk	
	frequent. The	note indica	ated the staff was			as appropriate, notify physician and/o	r NP	

Event ID: XH5C11

Facility ID: 923060

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		MEDICAID SERVICES				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · ·	ATE SURVEY
		245259	B. WING			С
		345258	B. WING			04/07/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	JDE	
RANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE A		ON SHOULD BE	(X5) COMPLETIC DATE	
IAG				DEFICIENCY		
F 309	Continued From page	e 18	F 30	19		
		cile infection. The NP noted	1.00		e new orders	
		Citrucel and Metamucil for		and RP, obtain and complet as indicated and continue to		
		ered C-Difficile stool culture		residents' response to treatr		
		rams (mg) every 6 hours as		resolved. The licensed nurs		
	needed for loose stools.			their initial clinical assessme		
				residents change in conditio		
2/ In di	A review of the nurse	practitioner 's order dated		SBAR (Situation Back grour		
		cool culture for C-Difficile and		Assessment and Review an		
		6 hours as needed for		tool in the residents' medica	,	
	diarrhea.			nurses notes within the med		
				until condition resolved. Cor		
	A review of the nurse	s 'notes from 2/27/17 to		be noted on the 24 hour rep		
		resident had no changes in		verbalized during change of		
		d, and there was no notation		ensure continued monitoring		
		movements or diarrhea.		assessment of residents' ch		
		ated the blood pressure and		condition. The licensed nurs	-	
	pulse were stable and	•		to review SBARs, Stop and		
				24 hour reports, Bowel and		
		cation administration record 3/10/17 revealed the 2/27/17		Tracker reports and nursing daily and the DCS and IDT		
		tool sample was added to		(Interdisciplinary Team) to m	onitor for	
		initials for being completed.		compliance during the morn		
		I Imodium on 2/27/17,		meeting Mondays-Fridays to	-	
		B/3/17 at 10:00 am, and		residents who exhibit chang		
	3/5/17. No documen	-		are recognized, assessed a		
		present on the MAR.		effectively to prevent dehydred 4. The DCS/registered nu	ration.	
		metabolic panel (BMP)		to conduct quality improvem	•	
		aled Resident #1 's average		monitoring of 5 residents' m		
		kidney function) dated 3/1/17		to ensure that residents with		
		le 0.6 - 1.3). The resident		condition including episodes	•	
	had a weekly BMP to			diarrhea/loose stool, vomitir		
	function, hydration, a	-		urinary output or decreased	-	
				are recognized, assessed a		
	A review of the labora	atory results of the resident '		effectively to prevent dehyd		
		7/17 revealed the creatinine		frequency of daily for 4 wee		
		the blood urea nitrogen		times a week for 8 weeks, th		
		ion] result was 33 (normal		month Frequency of quality		
	range 3-25).			be modified based on findin		

Facility ID: 923060

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/23/2017 RM APPROVED NO. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345258	B. WING			0	C 4/07/2017
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				18	810 CONCORD LAKE ROAD		
IRANSIII	ONAL HEALTH SERVICE	S OF KANNAPOLIS		к	ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From page	e 19	F	309			
	saw the resident for of C-Difficile stool cultur treated with Imodium needed for loose stood blood pressure of 122 temperature of 98 F a labs were reviewed a baseline. The reside and the NP planned of A review of the nurse 3/8/17 revealed a sto assess orthostatic blo and to discontinue the each day and the Me A review of the physic revealed normal salir (cubic centimeters) p A review of the physic stated to send the resi room to have an intra A progress note date saw the resident for a creatinine 5.85 (norm resident ' s blood pre 80. The same progre assessment was acu kidney disease from of was started on intrave centimeters (cc) per for ordered a stat (urgen and repeat the basic tomorrow.	and was in no distress. The ind the creatinine was at nt complained of dizziness orthostatic blood pressures. practitioner 's order dated ol culture for C-Difficile, to bod pressure for three days, e Citrucel 500 milligrams tamucil 6 grams each day. cian 's order dated 3/8/17 ne intravenous fluid at 125 cc			The results of quality improvement monitoring to be reported to the Qualit Assurance Performance Improvement Committee monthly by the Administra and/or DCS. The Quality Assurance Performance Improvement Committee evaluate the effectiveness of the monitoring/observation tools for makin changes to the corrective action if necessary to maintain substantial compliance and provide the necessar care and services to attain or maintain highest practicable physical, mental a psychosocial well-being, consistent w the residents' comprehensive assess and plan of care. The Quality Assurar Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director (quarterly a minimum) and at least three other members to include but not limited to direct care giver AOC date: 5/2/17	t tor e to ng y n the ind ith ment nce at a	

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	
		345258	B. WING				07/2017
	ROVIDER OR SUPPLIER ONAL HEALTH SERVICE	S OF KANNAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
F 309	revealed an additional intravenous fluid at 12 and to repeat the BM A review of Resident stool culture of C-diffi revealed the stool wa 3/13/17. Laboratory of creatinine (kidney fun 9.61 (normal range 0. nitrogen (BUN) [show on 3/10/17 (normal range 0. atted to send Resider room for an evaluation and BUN. The NP indicated in a 3/10/17 she saw the r blood cell count (WB0 pressure was 106/60 assessment was wors elevated WBC. The I creatinine of 9.61 and was had acute kidney NP sent the resident the evaluation. Resident #1 was adm 3/10/17 and the hosp reviewed. The hospit Resident #1 had C-D failure in the setting of state and moderate m was seen by her neph with Flagyl (antibiotics resident had a two-was	I order for normal saline 25 cc per hour for one liter P lab. #1 ' s laboratory results for a cile collected on 3/9/17 s positive for C-difficile on results of the resident ' s ction) dated 3/10/17 was 6 - 1.3). The blood urea rs hydration] result was 55 inge 3-25). cian ' s order dated 3/10/17 ent #1 to the emergency n of the elevated creatinine progress note dated resident for elevated white C). The resident ' s blood and pulse 62. The sening kidney function and ab result showed a 1 a BUN 55. The resident r injury due to diarrhea. The to the emergency room for hitted to the hospital on ital history and physical was al course documented ifficile colitis and acute renal f a generalized debilitated halnutrition. The resident prologist and was treated	F	309			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-039			
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	, ,	G	· · ·	PLETED			
						С			
		345258	B. WING		04	/07/2017			
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE				
TRANSITI	ONAL HEALTH SERVIC	ES OF KANNAPOLIS		1810 CONCORD LAKE ROAD					
	ONAL NEALIN CENTO			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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE			
F 309	Continued From page	e 21	F 30	9					
	to 9.7. The discharge		1 30						
		bliguric (non-urine sparing),							
	•	n chronic kidney disease,							
		cocytosis (elevated white							
		hypocalcemia (low calcium),							
	and metabolic acidos	sis. The resident received							
	aggressive IV fluid re								
		ime of the hospital discharge							
		ent 's creatinine returned to							
	baseline at 1.6.								
	On 4/3/17 at 4:50 pm	an interview was conducted							
	with the NP. The NF	stated that on 2/27/17 she							
	was informed by staf	f Resident #1 was having							
		every day. The NP stated							
		esident about her diarrhea							
		e diarrhea was every day.							
		C-Difficile stool culture on							
		ent 's diarrhea. When the r the results of the C-difficile							
		P was informed the results							
		NP stated she did not write							
		mplete a stool for C-Difficile,							
	-	ne C-Difficile results from							
	2/27/17. The NP sta	ted she was not aware until							
		culture had not been done.							
		he contacted the resident 's							
		7 regarding the resident 's							
		and the nephrologist ordered							
		tra sound of the kidneys.							
		ne physician ordered on nt to go to the ER. The NP							
	thought that the resider	-							
		vated creatinine of 5.85, but							
		went to the ER to have an IV							
		ed that her expectation was							
	for staff to follow orde	-							

Facility ID: 923060

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 05/23/2017 DRM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION		ATE SURVEY OMPLETED
		345258	B. WING			C 04/07/2017	
NAME OF PI	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE	•	
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		181	0 CONCORD LAKE ROAD		
	ONAL MEALIN OLIVIOL			KA	NNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	from dehydration sec stated that another or completed on 3/10/17 and it had not improv received intravenous sent to the emergence referred to her nephro hospitalized. On 4/4/17 at 8:40 am with the Director of N stated that she expect s orders. On 4/4/17 at 9:00 am with Nursing Assistant the resident had 4 to on day shift for over a hospitalization. NA # aware of a stool cultur obtained the stool sat NA #1 stated she rep Resident #1 had mult On 4/4/17 at 9:10 am with Nurse #1. Nurse leave when the first o 2/27/17 was written. second order for C-dit Nurse #1 stated she of from the 24-hour nurs was no diarrhea on h	acute injury to the kidney ondary to diarrhea. The NP reatinine lab level was 7 and it had increased to 9.6, ed after Resident #1 fluids. The resident was by room on 3/10/17 and was ologist while she was an interview was conducted ursing (DON). The DON the d staff to follow physician ' an interview was conducted to (NA) #1. NA #1 stated that 6 loose bowel movements a week leading up to the efficient stated she was not irre order for 2/27/17, but mple on 3/8/17 for the nurse. orted to the nurse that tiple bowel movements. an interview was conducted e #1 stated she was out on order for stool culture on Nurse #1 processed the ifficile stool culture on 3/8/17. was aware of the diarrhea sing shift report, but there	F	309			
	was conducted with t root cause analysis w C-difficile lab order da	he DON. The DON stated a vas conducted for the missed ated 2/27/17. She explained the C-Difficile lab had					

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		MEDICAID SERVICES				O. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	E SURVEY IPLETED	
						С	
		345258	B. WING		04	4/07/2017	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
TRANSITI	ONAL HEALTH SERVIC	ES OF KANNAPOLIS		810 CONCORD LAKE ROAD (ANNAPOLIS, 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 309	F 309 Continued From page 23		F 309				
		7 was three days before the					
	-	he DON felt that the nurse ne incident was isolated.					
at 2:02 pm via tele stated that the dia day and frequency she did not have the resident care. NA		ew was conducted on 4/6/17					
		none with NA #1. NA #1					
		as not documented because					
	she did not have time	e to document and provide					
		1 stated that the diarrhea was					
		nd foul smelling. She n duty at least once a shift					
		ident had diarrhea. NA #1					
		ent was tired and commented					
		eats goes right through her. d a decrease in appetite. NA					
		scussed the resident 's					
		and a culture was ordered,					
	and NA #1 collected remember the date.	that specimen. She cannot					
		ew was conducted on 4/6/17					
		none with Nurse #1. Nurse Ny had Resident #1 for one					
		t did not have lose stools and					
		dium. She was aware that a					
	stool culture was ord aware that it had not	lered 2/27/17, but was not been collected					
		nducted on 4/6/17 at 2:10 pm					
		urse #2. Nurse #2 stated contact with Resident #1, but					
		the resident had an order to					
	receive intravenous f						
		stated that the laboratory or retrieve a specimen the day					
		and placed in their system,					
	unless the request w	as for urgent (stat). Nurse					
	#2 stated that the pro	a a a a fan a annalatin a lah		1		1	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/23/2017 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345258	B. WING		_		C 07/2017
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS				810 CONCORD LAKE ROA KANNAPOLIS, NC 2808			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	and results on the we retrieved the results fi An interview was con- via telephone with Nu that the resident did n night shift on 3/8/17, a Imodium. Nurse #3 s by telephone of the re- increase to 5.85. She inquire about the resu #3 stated giving Imod contraindicated. She staff was moved arou could not remember in because of the diarrho An interview was con- via telephone with the physician stated he re- had reviewed the reco was missed as part of physician explained h facility that the order f on 2/27/27 was missed was informed by his N loose stool a day. Th with a C-Difficile infect staff informed the NP bowel movement a da will review the record intravenous fluids (IV) the creatinine increas physician stated his u resident needed IV ac	endor provided lab services ekend, and the staff rom the vendor 's website. ducted on 4/6/17 at 3:40 pm rse #3. Nurse #3 stated not have diarrhea on her and she did not administer tated she informed the NP esident 's creatinine explained the NP did not alts of the C-Difficile. Nurse ium with C-Difficile was also stated that the nursing nd the facility, and she f Resident #1 had a decline ea. ducted on 4/6/17 at 3:40 pm e resident 's physician. The emembered Resident #1 and ords when the stool culture f quality review. The e was informed by the for C-Difficile stool sample ed. The physician stated he NP that the resident had one e resident did not present tion because the facility that Resident #1 had one ay. The physician stated he to evaluate when the o were started in response to e of 5.85 on 3/8/19. The inderstanding was that the ccess and received IV the fluids were started on	F 309				

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FORM	D: 05/23/2017 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345258	B. WING		C 04/07/2017	
NAME OF PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
			1810 CONCORD LAKE ROAD		
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			KANNAPOLIS, NC 28083		
PREFIX (EACH DEFICIENC	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
again with the reside physician stated that metabolic panel lab (BMP result was repo pm. The physician s resident 's status: vit overall condition. Th resident remained at Intravenous fluids we s nephrologist was m he was paged at 7:55 were unable to place 7:55 pm the physicia resident to the emerg had an intravenous of emergency room at 9 returned to the facility started at 10:29 pm at The resident received The physician stated 3/9/17 in the morning of fluid. The physicia delay of C-Difficile re The physician was in the lab vendor and th 5 days to complete. Imodium could be giv was no confirmation standard practice. T resident had diarrheat On 4/7/17 at 11:40 at conducted via teleph #4 stated that she rei was on duty 3/3/17 fo two loose stools on d assistant assisted the	an interview was conducted nt 's physician. The on 3/7/19 the weekly basic BMP) was ordered. The rted to him on 3/8/17 at 6:41 tated he asked staff for the sal signs, mentation, and e physician stated the baseline according to staff. ere ordered and the resident ' otified. The physician stated 3 pm on 3/8/17 because staff an intravenous catheter. At n responded to send the gency room. The resident atheter placed at the 0:06 pm. The resident y and intravenous fluids were at 125 milliliters per hour. d a liter of fluid overnight. the NP saw the resident on g and ordered a second liter in stated he discussed the sults with the facility DON. formed that the DON called he C-Difficile could take 3 to The physician stated that ven by nursing when there of C-Difficile, which was he NP was informed that the a once a day.	F 30			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		345258	B. WING		C 04/07/2017
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CO	ODE
RANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		0 CONCORD LAKE ROAD NNAPOLIS, NC 28083	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 309	Continued From page	26	F 309		
F 327 SS=G	loose consistency, wi of moderate amount. Imodium at 10:00 am the resident. The resident. The resident. The resident. The resident and the reviewing the chart. If resident was drinking on her shift. Nurse # reviewing the chart. If resident was drinking on her shift. Nurse # report at start of shift diarrhea. Nurse #4 s concern for dehydrati was drinking fluids ar diarrhea. Nurse #4 s physician if a residen as needed medication diarrhea. 483.25(g)(2) SUFFIC HYDRATION (g) Assisted nutrition (Includes naso-gastri- both percutaneous endosc enteral fluids). Based comprehensive asses ensure that a residen (2) Is offered sufficier proper hydration and This REQUIREMENT by: Based on record rev	c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and on a resident's assment, the facility must t- tt fluid intake to maintain	F 327	F327 SS=G Sufficient hydration	t fluid to maintain

Event ID: XH5C11

Facility ID: 923060

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345258	B. WING	C 04/07/2017		
	ROVIDER OR SUPPLIER	0.10200		STREET ADDRESS, CITY, STATE, Z		
	NOVIDER OR SOLT EIER			1810 CONCORD LAKE ROAD		
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE	
F 327	Continued From page	- 07		07		
F 321	Continued From page		F 32			
		h resulted in the resident 's		1. Resident #1 was tra		
		e on chronic renal failure		hospital and discharged	from the facility	
	(Resident #1).	on for 1 of 3 residents		on 3/10/17. 2. On 4/28/17, the Dire	ector of Clinical	
				Services (DCS) and or F		
	Findings included:			designee completed a q	-	
	Resident #1 was adm	nitted on 1/25/17 for		improvement monitoring		
	rehabilitation after a h	nip fracture surgery. The		residents to identify resi		
	resident had the diag	noses of femur fracture and		change in condition inclu	uding any	
	chronic kidney diseas	se stage III.		episodes of diarrhea/loo		
				vomiting, decreased urir		
		are plan dated 1/25/17 for		decreased fluid intake to		
	potential imbalance o	f nutrition and hydration.		licensed nurse recognize		
	The admission minim	um data set dated 1/30/17		provided treatments as maintain hydration and h		
		was cognitively intact and		documented finding in th		
	required extensive as			medical record. Any ide		
	member with activities			were assessed by the lid		
		nt of bowel and occasionally		treatments provided per		
	incontinent of urine.	,		with continued nursing a		
	A review of the bowel movement log revealed Resident #1 started having diarrhea on 2/24/17			condition resolved to ma	aintain hydration	
				and health.		
		loose bowel movements per		3. By 5/2/17, the DCS	-	
		the exception of 3/3/17 she		nurse designee complet		
		d there was a formed stool.		licensed nurses and nur	-	
		ts were loose and no other		regulation 483.25(g)(2)		
	description was provi	ucu.		maintaining hydration ar consistent with the resid		
	A progress note dated	d 2/27/17 revealed the		comprehensive assessn		
		P) saw Resident #1 for		care. Education also inc	-	
		progressively become more		policy N-105 "Change in		
	frequent. The note in	dicated the staff was		N-107 "Change of Shift		
		cile infection (infection of the		Consulate Best Practice		
		. The NP noted the resident		Report" and "Daily Clinic		
		Metamucil for constipation		Interact tools "Stop and		
		e stool culture and Imodium		and "Care Path for Dehy		
		hours as needed for loose		the expectation of the lic		
	stools.			recognize, assess and p		
				as ordered by the physic	cian and/or NP	

Facility ID: 923060

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						NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	ATE SURVEY OMPLETED
	-		A. BUILDING			
		345258	B. WING			С
		545256	B. WING			04/07/2017
NAME OF PH	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
TRANSITI	ONAL HEALTH SERVICI	ES OF KANNAPOLIS		1810 CONCORD LAKE ROAD		
				KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE
F 327	Continued From page	e 28	F 32	.7		
		e practitioner 's order dated		when a resident exhibits a c	hange in	
		tool culture for C-Difficile and		condition including any episo	-	
		6 hours as needed for		diarrhea/loose stool, vomitin		
	diarrhea.			urinary output or decreased		
				maintain hydration and healt		
	A review of the medic	cation administration record		hired licensed nurses and nu	•	
	(MAR) for 2/27/17 to	3/10/17 revealed the 2/27/17		assistants will be educated u	•	
	order for C-Difficile st	tool sample was added to		The licensed nurse and		
	the MAR, but had no	initials for being completed.		assistant to monitor resident	s for a	
		-		change in condition including	g any	
	A review of the laboration	atory results of the resident '		episodes of diarrhea/loose s	tools,	
	s creatinine dated 3/7	7/17 revealed the creatinine		vomiting, decreased urinary	output or	
	(kidney function) resu	ult was 5.85 (normal range		decreased fluid intake. The	nursing	
	0.6 - 1.3) and the blo	od urea nitrogen (BUN)		assistant to document obser	ved changes	
	[shows hydration] res	sult was 33 (normal range		in resident condition utilizing	the "Stop and	
		s baseline creatinine was		Watch" tool and to documen	t	
	1.6 on March 1, 2017	7.		diarrhea/loose stool episode	s in Care	
				Tracker as indicated and con	mmunicate to	
	1 0	d 3/8/17 revealed the NP		the licensed nurse for furthe		
	saw the resident for o	diarrhea. The NP re-ordered		and intervention. The license	ed nurse to	
		re and the resident was		assess residents for change		
		4 mg every 6 hours as		and dehydration risk as app	•	
	needed for loose stor			physician and/or NP and RP		
		ess and the NP planned		complete new orders as indi		
	orthostatic blood pres	ssures.		continue to monitor resident		
				treatment until resolved. The		
		practitioner 's order dated		nurse to document their initia		
		ol culture for C-Difficile, to		assessment of residents cha	-	
		ood pressure for three days,		condition on the SBAR (Situ		
		e Citrucel 500 milligrams		ground Assessment and Rev		
	each day and the Me	tamucil 6 grams each day.		notification) tool in the reside		
	A prograde pate data	d 2/0/17 indicated the ND		record and in nurses notes w		
		d 3/9/17 indicated the NP an abnormal lab result of		medical record until conditio		
				Communicate will be noted or report and verbalized during		
		hal range 0.6 - 1.3). The		report and verbalized during		
		ssure was 140/70 and pulse		shift report to ensure continu		
		ess note further revealed the		and assessment of residents	-	
	assessment Showed	an acute kidney injury on	1	condition. The licensed nurs	e supervisor	

Facility ID: 923060

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				PLE CONSTRUCTION		D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	G		E SURVEY PLETED
						С
		345258	B. WING			/07/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS				1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 327	Continued From page	29	F 3	27		
F 327	resident was started of cubic centimeters (cc ordered a stat (urgent and repeat the basic tomorrow. A review of the physio revealed an additional intravenous fluid at 12 and to repeat the BM A review of Resident stool culture of C-diffi the stool was positive Laboratory results of (kidney function) date range 0.6 - 1.3). The [shows hydration] res (normal range 3-25). creatinine was 1.6. A review of the physio stated to send Resider room for an evaluatio of elevated creatinine tests). Resident #1 was adm 3/10/17 and the hospit Resident #1 had C-D failure in the setting o	on intravenous fluids at 125) per hour. The nephrologist t) renal ultrasound for today metabolic panel (BMP) cian ' s order dated 3/9/17 Il order for normal saline 25 cc per hour for one liter	F 3	 24 hour reports, Bowe Tracker reports and nu daily and the DCS and (Interdisciplinary Team compliance during the meeting Mondays-Frid residents who exhibit of are recognized, assess effectively to maintain health. 4. The DCS/register to conduct quality impr monitoring of 5 resider to ensure that resident condition including epi diarrhea/loose stool, vu urinary output or decre are recognized, assess effectively to maintain health at a frequency of then 3 times a week for time a month. Frequen monitoring to be modiffindings. The results of quality in monitoring to be report Assurance Performanto Committee monthly by and/or DCS. The Qua Performance Improver evaluate the effectiven monitoring/observatior 	I IDT I) to monitor for morning clinical lays to ensure changes in condition sed and treated hydration and ed nurse designee rovement nts' medical record is with a change in sodes of omiting, decreased eased fluid intake sed and treated hydration and of daily for 4 weeks, or 8 weeks, then 1 ncy of quality fied based on mprovement ted to the Quality ce Improvement ted to the Quality ce Improvement the Administrator lity Assurance ment Committee to uess of the	
	with Flagyl (antibiotic) had a two-week histo weakness. The disch diagnoses were nono	hrologist and was treated) and IV fluids. The resident ry of diarrhea with harge summary revealed liguric (body was unable to lehydrated), acute kidney		changes to the correct necessary to maintain compliance and ensure maintain hydration and with the residents' corr assessment and plan	substantial e that residents I health, consistent nprehensive	

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ILTIPLE CONSTRUCTION DING DING (X3) DATE SURVEY COMPLETED C C 3 STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083 D PROVIDER'S PLAN OF CORRECTION (X5) D PROVIDER'S PLAN OF CORRECTION (X5) D D D D D D D D D D D D D D D D D D D
G 04/07/2017 STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083 0 PROVIDER'S PLAN OF CORRECTION (X5)
1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083 PROVIDER'S PLAN OF CORRECTION (X5)
KANNAPOLIS, NC 28083 PROVIDER'S PLAN OF CORRECTION (X5)
FIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC G CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
= 327 Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director (quarterly at a minimum) and at least three other members to include but not limited one direct care giver. AOC date: 5/2/17
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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/23/2017 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345258	B. WING			C 04/07/2017		
NAME OF PI	ROVIDER OR SUPPLIER	•		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
TRANSITIONAL HEALTH SERVICES OF KANNADOLIS				1	810 CONCORD LAKE ROAD			
TRANSITI	TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS			۲	KANNAPOLIS, NC 28083			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 327	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	327				
	that everything she ea The resident also had #1 stated that she dis diarrhea with the NP	nt was tired and commented ats goes right through her. d a decrease in appetite. NA scussed the resident ' s and a culture was ordered, that specimen. She could						

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	CARE &	ND HUMAN SERVICES MEDICAID SERVICES				O		05/23/2017 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE		LETED
		345258	B. WING					, 07/2017
NAME OF PROVIDER OR SUF	PLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS					1810 CONCORD LAKE ROAD			
					KANNAPOLIS, NC 28083			
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 327 Continued F	rom page	e 32	F	32 [.]	7			
not rememb	er the da	te.						
at 2:10 pm v #1 stated that shift and new shift. She w ordered 2/27 been collect An interview via telephon physician stathad reviewe was missed physician ex facility that th on 2/27/27 v was informe loose stool a review the re- intravenous diarrhea cau of 5.85 on 3 understandin access and fluids were s 3/9/17. On 4/7/17 at again with th physician sta- metabolic pa BMP result v	Continued From page 32 not remember the date. An additional interview was conducted on 4/6/17 at 2:10 pm via telephone with Nurse #1. Nurse #1 stated that she only had Resident #1 for one shift and never gave Imodium for diarrhea on her shift. She was aware that a stool culture was ordered 2/27/17, but was not aware that it had not been collected. An interview was conducted on 4/6/17 at 3:40 pm via telephone with the resident 's physician. The physician stated he remembered Resident #1 and had reviewed the records when the stool culture was missed as part of quality review. The physician explained he was informed by the facility that the order for C-Difficile stool sample on 2/27/27 was missed. The physician stated he was informed by his NP that the resident had one loose stool a day. The physician stated he would review the record to evaluate when the intravenous fluids (IV) were started in response to diarrhea caused dehydration creatinine increase of 5.85 on 3/8/19. The physician stated his understanding was that the resident needed IV access and received IV access on 3/8/17 and the fluids were started on that evening (3/8), not							

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM): 05/23/2017 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345258	B. WING			C 07/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· · · ·	
TRANSITIONAL HEALTH SERV	ICES OF KANNAPOLIS		1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
 he was paged at 7 were unable to plat 7:55 pm the physi resident to the emi- had an intravenous emergency room a returned to the fact started at 10:29 pm The resident recei The physician stat 3/9/17 in the morn of fluid. The physicial and the cause of of diarrhea. On 4/7/17 at 11:40 conducted via tele #4 stated that she was on duty 3/3/1 two loose stools of assistant assisted and Nurse #4 stated th loose consistency of moderate amou- lmodium at 10:00 the resident. The on her shift. Nurs provided an as ne how often previou cannot remember reviewing the char inform the physicia 	a notified. The physician stated (53 pm on 3/8/17 because staff ice an intravenous catheter. At cian responded to send the ergency room. The resident is catheter placed at the at 9:06 pm. The resident sility and intravenous fluids were m at 125 milliliters per hour. ved a liter of fluid overnight. ed the NP saw the resident on ing and ordered a second liter ician stated he discussed the results with the facility DON behydration was from the 0 am an interview was phone with Nurse #4. Nurse remembered Resident #1 and 7 for day shift. Resident #1 had n day shift. The nursing the resident for one episode sted for the second episode. tat the stool was brown, of , with no odor or mucous, and int. Nurse #4 administered am, which was requested by resident had no further stools e #4 stated that when she eded medication, she reviewed is doses were given. Nurse #4 the previous doses without t. Nurse #4 stated she would an if a resident had repeated eded medication or concerns	F 327			

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