C 345258 STREET ADDRESS, CITY, STATE, ZIP CODE TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 000 Initial Comments E 000 An unannounced Recertification survey was conducted on 9/3-6/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GVW611. F 000 F 000 INITIAL COMMENTS F 000 An unannounced recertification and compliant survey were conducted from 9/3/2019 through 9/6/2019, event # GVW611. F 000 7 of the 38 complaint allegations were substantiated resulting in deficiencies F561, F626, F693, F755, F759, and F842. I		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER Image: constraint of the co			345258			_	
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS KANNAPOLIS, NC 2883 (M) D PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (RCAC) DEFICIENCY MUST BE REFCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IP PREFX TAG PROVIDENCE OF CORRECTIVE ACTION SHOULD BE (RCACS REFERENCED TO THE APPROPRIATE DEFICIENCY) C E 000 Initial Comments E 000 Initial Comments E 000 An unannounced Recertification survey was conducted on 9/3-6/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GVW611. F 000 F 000 INITIAL COMMENTS F 000 An unannounced recertification and compliant survey were conducted from 9/3/2019 through 9/6/2019, event # GVW611. F 561 SS=G CFR(s): 483.10(f)(1)-(3)(8) F 561 SS=G CFR(s): 483.10(f)(1)-(3)(8) S483.10(f)(1) for resident has a right to choose activities, schedules (including blut not limited to the rights specified in paragraphs (f) (1) through 11) of this section. F 561 S483.10(f)(2) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his part. S483.10(f)(2) The resident has a right to make choices about aspects of his or her inferents, aspects of this part. S483.10(f)(2) The resident has a right to make choices about aspects of his or her inferents, aspects of this part.	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		9/10/2019
PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE (REGULATORY OR LS: DENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSSREETRENCED TO THE APPROPRIATE DEFICIENCY) E 000 Initial Comments E 000 An unannounced Recertification survey was conducted on 9/3-6/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GVW611. F 000 F 000 INITIAL COMMENTS F 000 An unannounced recertification and compliant survey were conducted from 9/3/2019 through 9/6/2019, event # GVW611. F 000 7 of the 38 complaint allegations were substantiated resulting in deficiencies F561, F561 F 561 Self-Determination F 561 Self-Determination. F 561 The resident has the right to and the facility must promote and facilitate resident has the right to and the facility must promote and facilitate resident has a right to choose activities, schedules (including but not limited to the right specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS				
An unannounced Recertification survey was conducted on 9/3-6/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GVW611. F 000 F 000 INITIAL COMMENTS F 000 An unannounced recertification and compliant survey were conducted from 9/3/2019 through 9/6/2019, event # GVW611. F 000 7 of the 38 complaint allegations were substantiated resulting in deficiencies F561, F626, F693, F755, F759, and F842. F 561 S = G CFR(s): 483.10(f)(1)-(3)(8) F 561 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident hocie, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETIO DATE
conducted on 9/3-6/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GVW611. F 000 F 000 INITIAL COMMENTS F 000 An unannounced recertification and compliant survey were conducted from 9/3/2019 through 9/6/2019, event # GVW611. F 000 7 of the 38 complaint allegations were substantiated resulting in deficiencies F561, F626, F693, F755, F759, and F842. F 561 Self-Determination F 561 Self-Determination. F 561 Sysec CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	E 000	Initial Comments		E 00	00		
survey were conducted from 9/3/2019 through 9/6/2019, event # GVW611. 7 of the 38 complaint allegations were substantiated resulting in deficiencies F561, F626, F693, F755, F759, and F842. Self-Determination SS=G CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 000	conducted on 9/3-6/2 in compliance with the Emergency Prepared	019. The facility was found e requirement CFR 483.73, ness. Event ID #GVW611.	F 00	00		
substantiated resulting in deficiencies F561, F626, F693, F755, F759, and F842. F 561 Self-Determination F 561 SS=G CFR(s): 483.10(f)(1)-(3)(8) F 561 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the		survey were conducte	ed from 9/3/2019 through				
The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the		substantiated resultin F626, F693, F755, F Self-Determination	g in deficiencies F561, 759, and F842.	F 56	31		10/8/19
activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the		The resident has the promote and facilitate through support of renot limited to the right	right to and the facility must e resident self-determination sident choice, including but ts specified in paragraphs (f)				
choices about aspects of his or her life in the		activities, schedules (waking times), health care services consist assessments, and pla	(including sleeping and care and providers of health ent with his or her interests, an of care and other				
		choices about aspect	s of his or her life in the				
§483.10(f)(3) The resident has a right to interact with members of the community and participate in			-				

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.

		ND HUMAN SERVICES				FOI	ED: 10/21/20 ⁷ RM APPROVE <u>IO. 0938-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED C
		345258	B. WING			0	9/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
TRANSITI	ONAL HEALTH SERVIC	ES OF KANNAPOLIS		181	0 CONCORD LAKE ROAD		
				KA	NNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 561	Continued From page	e 1	F 5	61			
1 001		both inside and outside the	F J				
	facility.						
	§483.10(f)(8) The res						
		ctivities, including social,					
	0	unity activities that do not its of other residents in the					
	facility.						
		Γ is not met as evidenced					
	by:						
		views, resident and staff			F 561		
	-	y failed to honor a resident ' s et instead of a bedpan for 1			1. There is no corrective action to		
		d for choices (Resident			perform at this time, resident #181 w	as	
	#181). The facility's	•			admitted and discharged on 9/29/20		
		ulted in the resident utilizing			2. Residents admitted to facility who		
		Services (EMS) for bathroom			need of assistance for transfers for		
		esident experienced bladder			toileting have the potential to be affe	cted	
	pain lasting more that	in one day.			by this practice.	6	
	Findings included:				3. Completed by 10-8-19 the Director Nursing/Assistant Director of Nursing		
	Findings included.				educated staff on the importance of		
	Review of the Level	of care screening tool (FL2)			all options for toileting, within safe a		
	completed by the prin	mary physician and dated			reasonable perimeters. Per education		
		ed Resident #181 was alert,			Nursing will perform a transfer		
		ely intact and without			assessment ,notify Medical Director		
	physical or verbal be	haviors.			offer resident appropriate options. (E		
	A hospital physician	discharge summery dated			pan, Bed side commode, Wheelchai 4. DON/Designee will audit new resi	,	
	· · ·	ed Resident #181 was alert			who need transfer assistance for toil		
		spital discharge instructions			regarding preferences 3 x weeks fo	-	
		cified that Resident #181			weeks, then 1 x week for 2 months a		
		earing on her right leg with			then 1 x monthly for 3 months. The		
	•	aring and ordered a skilled			findings will be reviewed monthly by	the	
	nursing nome physic	al therapy evaluation.			Quality Assurance Improvement	tod if	
	Resident #181 was a	admitted to the facility on			Committee monthly and audits upda changes are needed based on findir		
		oses to include hypertension			The Quality Assurance Improvement	-	
		hip replacement. Resident			Committee will meet monthly and as		

Facility ID: 923060

If continuation sheet Page 2 of 91

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 10/21/201 MAPPROVEI O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY IPLETED
		345258	B. WING			09	C 9/10/2019
NAME OF PI	AME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				18	10 CONCORD LAKE ROAD		
TRANSITI	ONAL HEALTH SERVIC	ES OF KANNAPOLIS		K	ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
		- 0					
F 561	Continued From pag		F 56	61			
	was not completed.	Data Set (MDS) assessment A nursing admission			needed. Date of Compliance Oct 8, 2019		
	assessment was not	completed.					
		dated 9/30/2018 noted discharged to the hospital.					
	-	n by Nurse #14 and dated					
		toilet on 9/29/2018 at 3:45 nented the nursing assistant					
		Resident #181 she could not					
		he bed to walk to the toilet					
	without a physical the Resident #181 was of	offered the use of a bedpan.					
		cumented Resident #181 was					
		ed to use the bedpan and					
		d "911" to request transfer					
	9/29/2018.	e hospital at 8:20 PM on					
		nterviewed by phone on and she reported she had					
	been able to ambula	te to the bathroom while					
	•	e-person assistance and the					
		ident #181 explained she felt ambulate to the bathroom					
		explained to Nurse #14 that					
		ident #181 reported she had					
	a lot of pain from her	surgery and that using a					
		omfortable for her and she					
	-	rse #14, but he would not					
		the toilet. The resident					
		ot been able to void her e had called 911 and the					
		transporters assisted her to					
		room. Resident #181					
		for transport back to the					

Facility ID: 923060

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
					С	
		345258	B. WING		09	/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	assistance she felt wa #181 reported she ha days after leaving tha unable to void her bla urge. Resident #181 to the hospital. Nurse #14 was interv at 1:57 PM. He repor Resident #181 and sl toilet after she was ac #14 reported he had bedpan and he would	was not provided with the as necessary. Resident id bladder pain for several it facility because she was adder when she first had the reported she was readmitted iewed by phone on 9/6/2019 ted he remembered he had requested to use the dmitted to the facility. Nurse instructed her to use the d assist her, but she refused. he had attempted to explain				
	to Resident #181 he of she needed to wait for evaluate her before s ambulate. Nurse #14 offered to transfer Re wheelchair or use of because Resident #1 weight on her right les stated he had not cal	did not want her to fall and or the physical therapist to he got out of bed to explained he had not sident #181 to the toilet by a a bed-side commode 81 would have had to bear g to transfer. The nurse led the physician to get d for Resident #181 and he				
	AM and she reported admitted to the facility the staff usually waite evaluated their activit gotten out of bed. Nu resident had discharg that specified they we	viewed on 9/6/2019 at 10:18 when a resident was y with orthopedic diagnoses, ed until physical therapy y level before they were rse #12 further explained if a ge orders from the hospital ere able to ambulate with ved those orders until able to complete the				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 10/21/2019 RM APPROVED NO: 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		DNSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345258	B. WING			0	9/10/2019
NAME OF PF	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITIO	ONAL HEALTH SERVICE	S OF KANNAPOLIS) CONCORD LAKE ROAD		
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRE		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 561	Continued From page	<u>а</u> Л		561			
1 001		rector (RD) was interviewed					
		AM and she reported that					
		e facility were evaluated by					
		n 24 hours of admission, but o get out of bed and the					
		ders stated they could get					
	out of bed with equipr						
		ent should be gotten up by					
		reported that the physical 0/29/2018 had left for the day					
	when Resident #181	-					
		had planned to perform her					
	assessment in the mo	orning on 9/30/2018.					
	The Director of Nursir	ng (DON) was interviewed					
		PM and she reported she					
		f to read the discharge ident. The DON further					
		ed the nursing staff to offer					
	•	issions who had not had a					
		uation, but if the resident dpan, she expected staff to					
	read the discharge or						
	•	ased on those orders.					
	The Administrator way	s interviewed on 9/6/2019 at					
		orted it was her expectation					
		ld call the facility physician					
		eeded on a new admission n their toileting preference.					
F 584		ble/Homelike Environment	F	584			10/8/19
SS=E	CFR(s): 483.10(i)(1)-((7)					
	§483.10(i) Safe Envir	onment.					
	The resident has a rig	ht to a safe, clean,					
		elike environment, including					
	but not limited to rece supports for daily livin	-					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/21/2019 // APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		LETED
		345258	B. WING				C 10/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				18	10 CONCORD LAKE ROAD		
IRANSIII	ONAL HEALTH SERVICE	S OF KANNAPOLIS		K	ANNAPOLIS, NC 28083		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIZ	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B)		(X5) COMPLETION DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	UE	
F 584	Continued From page	9 5	F	584			
	The facility must prov	ide-					
		clean, comfortable, and					
		t, allowing the resident to					
		al belongings to the extent					
	possible.	ring that the regident can					
		ring that the resident can rices safely and that the					
		facility maximizes resident					
		bes not pose a safety risk.					
	(ii) The facility shall ex	xercise reasonable care for					
	the protection of the root or theft.	esident's property from loss					
		eeping and maintenance maintain a sanitary, orderly, ior;					
	§483.10(i)(3) Clean b in good condition;	ed and bath linens that are					
	§483.10(i)(4) Private or resident room, as spe	closet space in each ecified in §483.90 (e)(2)(iv);					
	§483.10(i)(5) Adequa levels in all areas;	te and comfortable lighting					
	levels. Facilities initial	table and safe temperature Ily certified after October 1, a temperature range of 71 to					
	sound levels.	maintenance of comfortable					
	•	n and staff interviews the			F 584		
	facility failed to (1) rep	pair walls in resident rooms			1. Residents in rooms 303, 304, 310	ľ	
	to prevent areas of ex	posed plaster for 3 of 15			have had exposed plaster repaired.	ľ	

Facility ID: 923060

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		MEDICAID SERVICES						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· · ·	E SURVEY PLETED	
			A. BUILDING	G				
		345258	B. WING			С		
	ROVIDER OR SUPPLIER	0.0200			REET ADDRESS, CITY, STATE, ZIP CODE	09	/10/2019	
					10 CONCORD LAKE ROAD			
TRANSITI	ONAL HEALTH SERVICI	ES OF KANNAPOLIS			ANNAPOLIS, NC 28083			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETIO	
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE	
F 584	Continued From page	e 6	F 58	84				
	rooms (rooms 303, 3				Rooms 303 and 310 have had chipped	d		
		nt doors that were chipped			doors repaired. The bathroom door in			
		of 15 rooms (rooms 303, 309			Room 309 was repaired to close prope			
	· ·	n air/heat wall units for 2 of			The rusted bathroom door frame in Ro	-		
	15 rooms (rooms 304				310 has been repaired. The missing			
	residents built in clos	ets from chipping paint for 4			unit s control covers on the air/heat u	nits		
	of 15 rooms (rooms 3	304, 305, 314 and 316), (5)			in rooms 304, 310 will be replaced. Bu	ilt in		
	repair/replace loose f	aucet in residents bathroom			closets have been painted in rooms 30	04,		
	for 1 of 15 rooms (roo	om 309), (6) repair loose air			305, 314, 316. Loose faucet was repair			
		room for 1 of 15 rooms			in room 309. Repaired loose air vent in			
		rovide a proper fitting toilet			room 309. Replaced toilet tank cover i			
		i resident rooms (room 309).			room 309. These repairs were comple on 9-10-19.	ted		
	Findings included:							
		hear and an 0.2 40 at 1.40 pm			2. Center residents have the potential			
		bserved on 9-3-19 at 1:12pm			be affected by this deficient practice.			
	vent wall unit and by	f the wall above the heat/air			center was reviewed for repairs to plas doors, door closures, bathroom frames			
		rved again on 9-6-19 at			rust, control covers on air and heat un			
		ipping off the wall above the			built in closets for paint, loose faucets,			
		t and by the bathroom.			loose air vents, and toilet tank covers.			
					Areas were addressed at the time of the			
	1b. The walls located	l in room 304 were observed			review on 9-10-19 on going for additio			
		The walls were noted to			2 weeks.			
		hipped away exposing the						
		om and the main entrance			3. The Executive Director/ designee			
	into the room.				educated staff on the importance of			
		rved again on 9-6-19 at			CFR(s) 483.10(i)(1)-(7) Safe/ Clean/			
		alls were noted to have areas			Comfortable/ Homelike Environment			
	of paint chipped away	y exposing the plaster by the			specific to submitting maintenance rep	bair		
	bathroom and the ma	ain entrance into the room.			requests according to facility procedur 9-16-19 and 9-25-19. Line items have			
	1c. Room 310 was ol	bserved on 9-3-19 at			been added to TELS to monitor expos	ed		
		he bathroom was noted to			plaster, chipped doors, check on air/he			
	have chipped paint e	xposing the plaster.			units, built in closets for chipped paint,			
		of room 310 was made on			loose facets, loose air vents and toilets			
		e wall in the bathroom was			proper order. Mock Survey Round she			
	noted to have chippe	d paint exposing the plaster.			have had line items added to ensure the	hat		
	1				all areas of repair are noted daily for		1	

Facility ID: 923060

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DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE 8					FO	ED: 10/21/2019 RM APPROVED IO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		STRUCTION	(X3) DA	FE SURVEY MPLETED	
	345258	B. WING			C 09/10/2019		
NAME OF PROVIDER OR SUPPLIER			STREET	TADDRESS, CITY, STATE, ZIP CODE	•		
TRANSITIONAL HEALTH SERVIC			1810 C	ONCORD LAKE ROAD			
			KANN	APOLIS, NC 28083			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
supervisor on 9-6-19 supervisor stated he needed painted and frame or plan in place repaired. 2a. Room 303 was of 1:12pm. The resider their room was noted along the sides of th Room 303 was obse 9:50am. The resider their room was noted along the sides of th 2b. Room 309 was obse 9:50am. The resider their room was noted along the sides of th 2b. Room 309 was obse 9:56am. The resider to be hitting the door from shutting all the 2c. Room 310 was of 9:47am. The bathroot be rusted and paint the door. Another observation 9-6-19 at 9:54am. Th noted to be rusted a sides of the door. The maintenance su 9-6-19 at 10:00am. aware of the issues he had started in Au repairing the wooder	with the maintenance at 9:55am, the maintenance was aware the rooms that he did not have a time that he door leading into that have wood chipped off that he door. The door have a that he door that he door was noted that he	F 5	4. item me for rev As mc are Qu Co	going maintenance awareness or 25-19. Maintenance Director will bring L ms report from TELS to morning betting for Executive Directors ponitoring 3 x weeks for 4 weeks, th eek for 2 months and then 1x mon 3 months. The findings will be viewed monthly by the Quality surance Improvement Committee ponthly and audits updated if change is needed based on findings. The failty Assurance Improvement committee meets monthly and as eded.	ine hen 1x thly ges		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345258	B. WING				C 10/2019
NAME OF P	ROVIDER OR SUPPLIER			S	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 PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 584	 missing the cover for Room 304 was obser 9:52am. The heat/air missing the cover for 3b. Room 310 was ob 9:47am. The heat/air missing the cover for Another observation of 9-6-19 at 9:54am. The noted to be missing the controls. During an interview w supervisor on 9-6-19 supervisor stated he covers missing for the vent unit. He stated so the computer or hand place it in the mainter stated work orders ar and that he had not so missing covers. 4a. The built-in closed observed on 9-3-19 at the bottom of the close missing paint exposin Room 304 was obser 9:52am. The drawers were noted to be missi wood underneath. 4b. Room 305 was obser 	maybe started. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. ved again on 9-6-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at wall unit was noted to be the unit's controls. Deserved on 9-3-19 at was not made aware of the deserved on the heat/air taff could put a work order and hance box in the lobby. He deserved up 2 times a day deserved on 9-3-19 at the picked up 2 times a day deserved on 9-3-19 at the drawers on Deserved on 9-3-19 at the drawers on	F	584			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		345258	B. WING				0 /10/2019
NAME OF P	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			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 PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 584	Room 305 was obser 10:02am and was fou exposing the wood un closets. 4c. During an observa at 10:01am it was not had paint missing exp Room 314 was obser 10:04am with the buil exposing the wood un 4d. Room 316 was ob 10:04am. The built-in have missing paint ex- underneath. During another obser 9-6-19 at 10:06am it w closets were missing underneath. The maintenance sup 9-6-19 at 10:06am. T aware that painting w rooms and did not ha when the painting wo 5a. Room 309 was ob 2:49pm. The resident noted to be loose ma faucet on/off. Room 309 was obser 9:56am. The resident noted to be loose ma faucet on/off. The maintenance sup	of the built-in closets. ved again on 9-6-19 at and to have paint chipped off inderneath of the built-in ation of room 314 on 9-3-19 ted that the built-in closets bosing the wood underneath. ved again on 9-6-19 at tt-in closets paint missing inderneath. beserved on 9-3-19 at wall closets were noted to kposing the wood vation of room 316 on was noted that the built-in paint exposing the wood bervisor was interviewed on he supervisor stated he was ras needed in the resident ve a plan or time frame on uld be completed.	F	584			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 10/21/2019 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION		X3) DATE COMP	SURVEY LETED
		345258	B. WING			C 09/10/2019		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
TRANSITI	ONAL HEALTH SERVICE				1810 CONCORD LAKE ROAD			
Interiori	ONAL MEALIN CERTIC				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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	E	(X5) COMPLETION DATE
F 584	faucet. He stated staft the computer or hand place it in the mainter stated work orders ar and that he had not s loose faucet. 6a. Room 309 was ob 2:49pm. The resident was noted to have se causing it to hang from Room 309 was obser 9:56am. The resident was noted to have se causing it to hang from The maintenance sup 9-6-19 at 10:00am. T stated he was not ma vent in the bathroom few screws". He state order in the computer and place it in the ma He stated work orders day and that he had r loose air vent in the b 7a. Room 309 was ob 2:49pm. The back of not have a cover that and had a square cover 9:56am. The back of not have a cover that and had a square cover that and had a square cover that and had a square cover that and had a square cover that and had a square cover that	de aware of the loose f could put a work order in l write a work order and hance box in the lobby. He e picked up 2 times a day een a work order for the oserved on 9-3-19 at 's bathroom ceiling air vent veral missing screws m the ceiling. ved again on 9-6-19 at 's bathroom ceiling air vent veral missing screws m the ceiling. ver a missing screws m the ceiling. ver a missing screws m the ceiling. of the loose air and stated, "it's missing a ed, staff could put a work or hand write a work order intenance box in the lobby. s are picked up 2 times a hot seen a work order for the athroom. oserved on 9-3-19 at the resident's toilet tank did fit. The toilet tank was oval ver. ved again on 9-6-19 at the resident's toilet tank did fit. The toilet tank was oval ver.	F	584	4			
	not have a cover that and had a square cov The maintenance sup	fit. The toilet tank was oval						

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	-	ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE 10. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING			E SURVEY IPLETED
		345258	B. WING		09	C 9/10/2019
	ROVIDER OR SUPPLIER ONAL HEALTH SERVICE	ES OF KANNAPOLIS	1810	EET ADDRESS, CITY, STATE, ZIP CODE) 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 584 F 623 SS=D	cover and after he ex "this is not the right c put a work order in th work order and place the lobby. He stated times a day and that order for the toilet tar The Administrator wa 12:20pm. The Admin maintenance supervis sweeps" weekly to m that needed to be con also stated she exper comfortable and hom Notice Requirements CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility trans resident, the facility n (i) Notify the resident representative(s) of the the reasons for the m language and manne facility must send a c representative of the Long-Term Care Oml (ii) Record the reason discharge in the resident (iii) Include in the not paragraph (c)(5) of the	ade aware of the toilet tank tamined the cover, he stated over". He stated staff could be computer or hand write a it in the maintenance box in work orders are picked up 2 he had not seen a work ak cover. It is interviewed on 9-6-19 at istrator stated the sor completed "room onitor and assess any work mpleted. The Administrator cted the environment to be helike for the residents. Before Transfer/Discharge -(6)(8) before transfer. fers or discharges a nust- and the resident's he transfer or discharge and hove in writing and in a er they understand. The opy of the notice to a Office of the State budsman. Ins for the transfer or dent's medical record in agraph (c)(2) of this section; ice the items described in his section.	F 584			10/8/19

Facility ID: 923060

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 10/21/2019 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345258	B. WING				(09/) 10/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS			1810 CONCORD LAKE ROA KANNAPOLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 623	discharge required un made by the facility at resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (B) The health of indiv be endangered, under this section; (C) The resident's hea allow a more immedia under paragraph (c)(1 (D) An immediate tran required by the reside under paragraph (c)(1 (E) A resident has not days. §483.15(c)(5) Conten notice specified in par must include the follow (i) The reason for tran (ii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such requess to obtain an appeal for completing the form a hearing request;	he notice of transfer or ider this section must be cleast 30 days before the or discharged. Ide as soon as practicable charge when- riduals in the facility would paragraph (c)(1)(i)(C) of riduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to the transfer or discharge,)(i)(B) of this section; hefer or discharge is ont's urgent medical needs,)(i)(A) of this section; or cresided in the facility for 30 ts of the notice. The written ragraph (c)(3) of this section wing: hefer or discharge; of transfer or discharge; of transfer or discharge; inch the resident is ged; e resident's appeal rights, ddress (mailing and email), or of the entity which ts; and information on how rm and assistance in nd submitting the appeal s (mailing and email) and the Office of the State	F	623				

Facility ID: 923060

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/21/2019 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345258	B. WING				0 10/2019
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 623	Continued From page	e 13	F	623			
	(vi) For nursing facility residents with intellectual and developmental disabilities or related						
		ng and email address and					
		the agency responsible for lvocacy of individuals with					
	-	ilities established under Part					
		tal Disabilities Assistance					
		of 2000 (Pub. L. 106-402,					
	codified at 42 U.S.C. (vii) For nursing facili	ty residents with a mental					
	- · · ·	sabilities, the mailing and					
		lephone number of the					
	agency responsible for	or the protection and als with a mental disorder					
	-	e Protection and Advocacy					
	for Mentally III Individ	-					
	§483.15(c)(6) Chang						
		ne notice changes prior to or discharge, the facility					
	-	pients of the notice as soon					
	as practicable once the	he updated information					
	becomes available.						
		in advance of facility closure					
		closure, the individual who is					
		he facility must provide ior to the impending closure					
		gency, the Office of the					
	State Long-Term Car	e Ombudsman, residents of					
		esident representatives, as					
		e transfer and adequate dents, as required at §					
	483.70(l).	iono, ao requirea ar y					
	This REQUIREMENT	Γ is not met as evidenced					
	by:						
		iews, family interview, and acility failed to notify the			F623 Notice Requirements Before Transfer/Discharge		
	i sidii iiiici views. life lä		1				1

Facility ID: 923060

If continuation sheet Page 14 of 91

JENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	· /	E SURVEY PLETED
		345258	B. WING			00	C /10/2019
	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	03	10/2013
					10 CONCORD LAKE ROAD		
RANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
F 623	Continued From page	e 14	F 62	23			
. 020	residents' discharge f		1 02		the facility. Resident #183 was		
	hospital for 1 of 3 res			transfer/discharged to acute setting or	า		
	discharge (Resident			11/30/18.			
				2) Current residents have the potent			
	Findings included:			be affected. Audit completed on 9/25/			
					of residents who have transfer/dischar		
		cal record revealed Resident			in the past 30 days from the facility to		
		the facility on 11/23/18 with			hospital. 4 residents were identified to		
		uded: Altered Mental Status,			not received the Transfer/Discharge le		
		generalized weakness, a, debility, and infection.			; the facility sent certified letters regard said Transfer/Discharge for all 4.	ung	
		a, debility, and mection.			3) The Assistant Director of		
	Review Resident #18	3's Minimum Data Set			Nursing/Nurse Management will education	ato	
	(MDS) revealed a discharge return not				licensed nurses and social workers or		
	anticipated (DRNA) a	-			Family Notification by 10/8/19. The		
		ce Date (ARD) of 11/30/18.			education will be included in Orientation	on	
		ment revealed the resident			for new hires. Nurses are responsible		
	was coded as having	been discharged to another			notifying the family by verbal exchang	е	
	nursing home as an u	unplanned discharge. A			when family member is present in the		
	cognitive assessmen	t was not completed, and			facility or by telephone calls. If the nu	rse	
		ed as having been rarely or			is unable to contact the family, the soc		
	never understood.				worker will initiate a written letter and	mail	
					to family.		
		note completed by Nurse			4) Executive Director/ Designee will		
		nd timed 8:50 PM, revealed			audit all transfers/discharges to hospit		
		een discharged to the cy Medical Services (EMS)			ensure notification to families in writing 3xweek for 4 weeks, then 1x weekly for		
		18. The resident was			months and then 1x monthly for 3 mor		
		ig been had a critically low			Nurses are responsible for notifying th		
		he part of the blood which			family by verbal exchange when family		
		2 (normal HGB is 13.5 to			member is present in the facility or by	,	
		loctor was made aware an			telephone calls. If the nurse is unable	to	
	-	o send the resident to the			contact the family, the social worker w		
	Emergency Room (E	R). Further review of the			initiate a written letter and mail to fami		
	documentation revea				The Director of Nursing will report on t	-	
	responsible party had	been notified via a			results of the quality monitoring (audits		
	-	esident being sent to the ER.			the Quality Assurance Performance		
		cumented as having been			Improvement committee. The findings	s will	
	alert, verbal, vital sign	ns stable at the time of the			be reviewed monthly by the Quality		

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 10/21/20 MAPPROVE D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345258	B. WING			/10/2019
	ROVIDER OR SUPPLIER	ES OF KANNAPOLIS	18	TREET ADDRESS, CITY, STATE, ZIP CODE 310 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 623 F 625 SS=D	transfer and did not a acute distress. An interview was con 9/6/19 at 10:28 AM. nurse who was assig 11/30/18 on the date hospital. She stated responsible party and message on an answ was being discharged An interview was con with Resident #183's responsible party stat written notification fro resident's discharge t she had not signed m regarding the residen Notice of Bed Hold P CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d)(1) Notice nursing facility transfe the resident or reside specifies- (i) The duration of the any, during which the return and resume re facility; (ii) The nursing facilit the nursing facility	ducted with Nurse #1 on Nurse #1 stated she was the ned to Resident #183 on of his discharge to the she called the resident's d notified them via a rering machine the resident d to the hospital. ducted on 9/6/19 at 1:36 PM responsible party. The ted she had not received im the facility regarding the to the hospital. She stated or received paperwork t's discharge to the hospital. olicy Before/Upon Trnsfr (2) bed-hold policy and return- before transfer. Before a ters a resident to a hospital or therapeutic leave, the provide written information to nt representative that e state bed-hold policy, if e resident is permitted to sidence in the nursing wayment policy in the state of this chapter, if any;	F 623	Assurance Improvement Committee monthly and audits updated if change are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.	25	10/8/19

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 10/21/201 RM APPROVE NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		TE SURVEY MPLETED
		345258	B. WING		0	C 9/10/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL)E	
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	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 625	resident to return; and (iv) The information s of this section. §483.15(d)(2) Bed-ho the time of transfer of hospitalization or the facility must provide t resident representation gescribed in paragrap This REQUIREMENT by: Based on record rev staff interviews, the fa written notification to party regarding bed h hospitalized for 1 of 3 discharge (Resident a Findings included: A review of the medic #183 was admitted to diagnoses which includ difficulty swallowing, inhalation pneumonia Review Resident #18 (MDS) revealed a dis	his section, permitting a d pecified in paragraph (e)(1) old notice upon transfer. At f a resident for rapeutic leave, a nursing o the resident and the ve written notice which of the bed-hold policy oh (d)(1) of this section. T is not met as evidenced iews, family interview, and acility failed to provide the resident's responsible hold when the resident was a residents reviewed for #183). cal record revealed Resident o the facility on 11/23/18 with uded: Altered Mental Status, generalized weakness, a, debility, and infection. c3's Minimum Data Set charge return not	F 62	F 625 1. There is no corrective action at this time this resident (who facility from 11/23/18 through no longer in facility. However admission the Bed Hold Polic Admission packet was discuss resident's wife. 2. Residents sent out to the h the potential to be affected by practice. A 100% audit was c all resident sent out within the days; 3 were identified and B were sent certified mail to the the Bed Hold Policy and Proo 3. Executive Director/ design	on to perform was in 11/30/18) is , upon cy and the seed with hospital has y this ompleted on e past 30 ed Holds e families with cedure. hee educated	
	Review of the assess was coded as having nursing home as an u cognitive assessmen	Issessment with an ce Date (ARD) of 11/30/18. Isment revealed the resident been discharged to another unplanned discharge. A t was not completed, and ed as having been rarely or		Department Heads on the im F625 Notice of Bed Hold Poli before/Upon Transfer. A line added to the Stand Up temple any resident sent out to hosp that Bed Hold was sent and t documentation of this action In-servicing by ADON will be	cy item was ate monitor ital; Verifying he was done.	

Facility ID: 923060

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/21/2019 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345258	B. WING				C /10/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE			18	810 CONCORD LAKE ROAD		
TRANSITI	UNAL HEALTH SERVICE	S OF RANNAFOLIS		ĸ	ANNAPOLIS, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	 #1, dated 11/30/18 ar Resident #183 had be hospital via Emergent at 4:00 PM on 11/30/7 documented as havin hemoglobin (HGB) (th carries oxygen) of 6.2 17.5) and when the d order was obtained to Emergency Room (El documentation reveal responsible party had message about the re The resident was doc alert, verbal, vital sign transfer and did not a acute distress. Review of a second n Nurse #1, dated 12/17 revealed resident #18 called the facility and 11/30/18. The family as having informed th want to give up the re An interview was con 9/6/19 at 10:28 AM. I discuss the possibility responsible party duri An interview was con AM with the Administin not aware if the resider a bed hold. She state 	note completed by Nurse and timed 8:50 PM, revealed een discharged to the cy Medical Services (EMS) 18. The resident was ig been had a critically low he part of the blood which 2 (normal HGB is 13.5 to octor was made aware an b send the resident to the R). Further review of the led the resident's 1 been notified via a esident being sent to the ER. cumented as having been his stable at the time of the ppear to have been in any hurses' note completed by (18 and timed 7:41 PM, 33's responsible party had spoke to the nurse on member was documented he staff member she did not esident's bed at the facility. ducted with Nurse #1 on Nurse #1 stated she did not y of a bed hold with the ing the phone conversation. ducted on 9/6/19 at 11:09 rator. She stated she was ent's responsible party e aware of the possibility of ed typically when a resident	F	625	 100% of the Nursing staff to ensure th Bed Hold and Documentation process followed. 4. Executive Director/Designee will monitor and reviewed in the daily Interdisciplinary Team Meeting for Bed Hold 3 x weeks for 4 weeks, then 1 x w for 2 months and then 1 x monthly for months. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assur Improvement Committee meets month and as needed. Date of Compliance Oct 8, 2019 	s is veek 3 I	
		ospital, the responsible					

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	-	ND HUMAN SERVICES				RM APPROVE NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345258	B. WING		0	C 9/10/2019
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP COD	DE	
TRANSIT	ONAL HEALTH SERVICI	ES OF KANNAPOLIS		OCONCORD LAKE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 625 F 626 SS=D	party and physician a information about the information is sent ou member will follow up the resident was goir contact the resident's a bed hold. An interview was cor- with Resident #183's responsible party sta written notification fro- bed hold information. received paperwork r hold. The responsibl of a bed hold was no members from the fa any written informatio a bed hold from the f Permitting Residents CFR(s): 483.15(e)(1) §483.15(e)(1) Permit facility. A facility must establi on permitting resident after they are hospita therapeutic leave. Th following. (i) A resident, whose leave exceeds the be State plan, returns to room if available or ir availability of a bed in resident-	are made aware, a packet of e resident with bed hold ut with the resident, a staff p with the hospital to clarify if ng to be admitted, and they a responsible party to discuss adducted on 9/6/19 at 1:36 PM responsible party. The ted she had not received om the facility regarding the . She stated she had not regarding the resident's bed to party stated the possibility t discussed with any staff cility nor did she received on regarding the possibility of acility. to Return to Facility (2) ting residents to return to ash and follow a written policy tts to return to the facility	F 625	DEFICIENCY		10/8/19

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/21/201 FORM APPROVE OMB NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		345258	B. WING		C 09/10/2019		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 626	Continued From page	e 19	F 626				
	services or Medicaid						
	nursing facility service						
		letermines that a resident					
		with an expectation of y, cannot return to the					
	facility, the facility mu						
		graph (c) as they apply to					
	discharges.						
		nission to a composite ne facility to which a resident					
		e distinct part (as defined in					
	-	t must be permitted to return					
		the particular location of the					
		rt in which he or she resided					
		not available in that location the resident must be given					
		that location upon the first					
	availability of a bed th						
	by:						
		iews, family interview, and		F 626			
		acility failed to permit a he facility from the hospital		1. There is no corrective action to perf	iorm		
	for 1 of 3 residents re			at this time; this resident (who was in			
	(Resident #183).			facility from 11/23/18 through 11/30/20			
				is no longer in facility. However, upon			
	Findings included:			admission the Bed Hold Policy was			
	A review of the modic	cal record revealed Resident		discussed with wife.2. Residents sent out to the hospital h			
		the facility on 11/23/18 with		the potential to be affected by this			
		uded: Altered Mental Status,		practice. Audit of all residents sent ou	it to		
	difficulty swallowing,	generalized weakness,		hospital in the past 30 days; 2 residen			
	inhalation pneumonia	a, debility, and infection.		identified and certified notification was sent to families, Bed Hold	;		
	Review Resident #18	33's Minimum Data Set		Policy/Readmission was provided at the	his		
	(MDS) revealed a dis	-		time.			
	anticipated (DRNA) a			3. Executive Director/ designee educa			
	Assessment Referen	ce Date (ARD) of 11/30/18.		Department Heads on the importance	OF		

Event ID: GVW611

Facility ID: 923060

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					OMB NO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
				~	с
		345258	B. WING		09/10/2019
NAME OF P	ROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIF	•
				1810 CONCORD LAKE ROAD	
TRANSITI	ONAL HEALTH SERVICI	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 A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLET D THE APPROPRIATE DATE
E 000					
F 626	10		F 62		
		sment revealed the resident		626 Notice of Bed Hold F	-
	-	been discharged to another		before/Upon Transfer. A	
		unplanned discharge. A		added to the Stand Up te	
	-	t was not completed, and		any resident sent out to h	
		ed as having been rarely or		that Bed Hold was sent a	
	never understood.			documentation of this act Per the North Carolina Be	
	A review of a purpos'	note completed by Nurse		applicable regarding the	
		note completed by Nurse nd timed 8:50 PM, revealed		bed Hold Policy during w	
		een discharged to the		is permitted to return and	
		icy Medical Services (EMS)		residence in the nursing	
		18. The resident was		reserve Bed Payment Po	-
		ng been had a critically low		Plan". In-servicing by AD	-
		he part of the blood which		for 100% of the Nursing s	
		2 (normal HGB is 13.5 to		that Bed Hold and Docum	
		loctor was made aware an		process is followed and r	
	, ,	o send the resident to the		appropriately returning fro	
		R). Further review of the		4. Executive Director /De	-
	documentation revea			monitor the readmissions	
	responsible party had			Hold/Readmission Policy	•
		esident being sent to the ER.		follow the North Carolina	
	-	cumented as having been		in accordance to each rea	-
		ns stable at the time of the		source (Private Pay, Mec	
		appear to have been in any		Medicaid) Residents will	
	acute distress.			the daily Interdisciplinary	Team Meeting
				for Bed Hold/Readmissio	n 3 x weeks for
		nurses' note completed by		4 weeks, then 1x week for	
		/18 and timed 7:41 PM,		then 1x monthly for 3 mo	
		83's responsible party had		findings will be reviewed	
		spoke to the nurse on		Quality Assurance Improv	
		documented the responsible		Committee monthly and a	
		urse the resident would be		changes are needed bas	
		ed to the facility on 12/1/18.		The Quality Assurance In	
		cumented she discussed		Committee meets month	y and as
		party the resident would not		needed.	
	be returning to the nu				
		been made for the resident			
		ifferent nursing home. The			
	responsible party wa	s documented as having			

Facility ID: 923060

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/21/2019 MAPPROVED D. 0938-0391
STATEMENT (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345258	B. WING				C /10/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE			1	810 CONCORD LAKE ROAD		
INANOITI	SNAL HEALTH GERVICE			۲	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 626	give up the resident's A Hospital Discharge revealed Resident #1 Emergency Room (El remained in the ER u hospital on 12/2/18 w Anemia. A narrative Nurse (RN) of the Em 12/1/18 and timed 6:2 nursing report from th not allowed to return narrative note by an F 1:13 PM revealed the resident with a staff m she confirmed the par to the facility. The res 12/11/18. Review of a Social Se 12/4/18 and timed 10 documentation of a co Social Worker (SW) a Department of Social documented she infor Resident #183 was m readmitted to the facility was services for Resident	mber she did not want to bed at the facility. Summary dated 12/11/18 83 was seen in the R) on 11/30/18 and ntil he was admitted to the ith a principal diagnosis of note by the Registered hergency Room (ER) dated 26 PM documented per he facility the resident was to the facility. Review of a RN dated 12/3/18 and timed e RN had discussed the hember at the facility and tient was not going to return sident died at the hospital on ervice Progress note dated :03 AM revealed onversation between the and an employee of the Services (DSS). The SW rmed the DSS employee of going to be allowed to be lity per the Administrator. ducted with the Director of 5/19 at 4:26 PM. The DON is able to provide care and #183, but the resident's I been noncompliant with	F	626			
	9/6/19 at 10:28 AM.	ducted with Nurse #1 on Nurse #1 stated she was the ned to Resident #183 on					

Facility ID: 923060

If continuation sheet Page 22 of 91

		ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 10/21/201 M APPROVEI D. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COME	E SURVEY PLETED
		345258	B. WING			C / 10/2019
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
			18	10 CONCORD LAKE ROAD		
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS	ĸ	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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 626	11/30/18 on the date hospital. She stated family and notified the answering machine the discharged to the hose resident was being set had a critical lab value send him out to the E told the responsible p to be admitted to a di hospital and would not An interview was con AM with the Administ stated Resident #183 discharge notice. Sh sent to other facilities other facilities did not stated the facility had would not readmit the typically when a resid hospital, the family ar aware, a packet of int with bed hold informa resident, a staff mem hospital to clarify if th	of his discharge to the she called the resident's em via a message on an ne resident was being	F 626			
	with Resident #183's party stated someone her and told her the r readmitted to the faci further stated she had have been readmitted been told during phor	ducted on 9/6/19 at 1:36 PM family. The responsible e from the facility had called esident was not going to be lity. The responsible party d expected the resident to d to the facility, but she had he conversations the e able to be readmitted to the				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 10/21/2019 RM APPROVED NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED C	
		345258	B. WING		0	09/10/2019	
	ROVIDER OR SUPPLIER	ES OF KANNAPOLIS			00,10,2013		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility		F 63	37		10/8/19	
	there has been a sign resident's physical or purpose of this section means a major declin resident's status that itself without further in implementing standar interventions, that ha one area of the reside requires interdisciplin care plan, or both.) This REQUIREMENT by: Based on observation interviews, the facility significant change of (MDS) assessment for for significant change Findings included: Resident #1 was adm 12/22/2016. The annual MDS date #1 to eat a mechanic not have a gastrostor assessed Resident # one-person assistant transfers, and dressin eating. Resident #1 was read diagnoses to include	mental condition. (For n, a "significant change" le or improvement in the will not normally resolve htervention by staff or by rd disease-related clinical is an impact on more than ent's health status, and ary review or revision of the - is not met as evidenced n, record reviews and staff failed to complete a status Minimum Data Set or 1 of 2 residents reviewed is (Resident #1). hitted to the facility on ed 5/19/2019 noted Resident ally altered diet and she did ny tube in place. The MDS 1 to require extensive		 F637 1. On 9/6/19 resident #1□s S Change Assessment dated 8/1 completed by Dietary and the M Data Set nurse signed and con assessment for transmission. T assessment was transmitted at accepted on 9/9/19. 2. On 10/2/19, the Regional M Data Assessment Nurse perfor Quality Improvement monitorin current residents with assessm progress to identify any late as Any issues identified were add 3. On 10/2/19, the Interdiscip was re-educated by the Region Minimum Data Set nurse on tin Significant Change assessmen completion. The Director of Nu and/or Regional Minimum Data Assessment Nurse will perform Improvement Monitoring of MD 	9/19 was Minimum npleted the The and Minimum med g for all nents in sessments. ressed. Dinary Team nal neliness of at rsing a n Quality		

Facility ID: 923060

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STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) D	NO. 0938-039 ATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C	OMPLETED
		345258	B. WING			C 09/10/2019
NAME OF P	ROVIDER OR SUPPLIER			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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 637	Continued From page	e 24	F 63	7		
	in progress and not c the insertion of a gas hydration. The MDS require total two-pers mobility and transfers assistance for eating A care area summery MDS dated 8/19/2019 summery noted Resid the facility with a gas dysphagia (difficulty s vascular accident on Resident #1 was obs PM with a tube feedir tube. Resident #1 was be interviewed. MDS Nurse #2 was in 12:32 PM and she re Change MDS with a c have the completed b was not aware the as completed and report coordinator had move	and dressing. from the significant change was reviewed and the dent #1 was readmitted to trostomy tube due to swallowing) after a cerebral 8/4/2019. erved on 9/3/2019 at 3:21 ng infusing via a gastrostomy s non-verbal and unable to hterviewed on 9/6/2019 at ported the Significant date of 8/19/2019 should by 9/2/2019. MDS Nurse #2 sessment had not been		assessments for timeliness of o by reviewing the In Progress M daily for two weeks, then twice two weeks, then one time per v two months and then one time three months. Audits will begir 4. The Director of Nursing wi the results of the Quality Monit (Audits) to the Quality Assurance Performance Improvement Cor Findings will be reviewed by Qu Committee monthly and Quality Monitoring (Audit) updated if ch needed based on findings. The Assurance Performance Impro Committee meets monthly and at a minimum.	IDS list weekly for week for monthly for 10/3/19. Il report on oring ce mmittee. API y nanges are e Quality vement	
12:32 PM and the significant completed. MI reporting the a from another d	12:32 PM and she re the significant change completed. MDS Nu reporting the assessr	nterviewed on 9/6/2019 at ported she was not aware e assessment had not been rse #1 concluded by nent needed corrections nent and that was why the				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/21/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345258	B. WING		C 09/10/2019
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 637	The former MDS coo for interview. The Administrator wa	continued From page 25 he former MDS coordinator was not available or interview. he Administrator was interviewed on 9/6/2019 at			
F 641	to be completed in a Administrator went or coordinator had move	n to explain the MDS ed on to a corporate position d the significant change	F 641		10/8/19
SS=D	resident's status. This REQUIREMENT by: Based on observatio interview the facility fa Data Set (MDS) accu (Resident #30), disch bowel and bladder (R residents reviewed for Findings included: 1.Resident #30 was a 7-18-18 with multiple pneumonia, chronic of disease, shortness of hypertension.	at accurately reflect the is not met as evidenced n, record review and staff ailed to code the Minimum rately in the areas of oxygen arge (Resident #81) and tesident #80) for 3 of 24 or MDS accuracy. admitted to the facility on diagnosis that included obstructive pulmonary breath and pulmonary m Data Set (MDS) dated sident #30 was severely		F641 1. On 10/2/19, resident #30 s MDS 1 updated to accurately reflect the reside MDS Assessment for Oxygen by the Minimum Data Set nurse. On 7/19/19, resident #81 s MDS was updated to accurately reflect the residents MDS Assessment for Discharge by the Minimum Data Set nurse. On 10/2/19, resident #80 s MDS was updated to accurately reflect the residents MDS Assessment for Indwelling Catheter by Minimum Data Set nurse. 2. On 10/2/19, the Minimum Data Set nurses and the Regional Minimum Data Assessment nurse performed Quality Improvement monitoring of all assessments with an ARD of 9/10/19 a	the t
	7-13-19 revealed Res cognitively impaired.	sident #30 was severely The MDS also revealed the or shortness of breath but			ed

Event ID: GVW611

Facility ID: 923060

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	S FOR MEDICARE &		a		OMB NO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVEY COMPLETED
					С
		345258	B. WING		09/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
TRANSIT	ONAL HEALTH SERVICE	S OF KANNAPOLIS		1810 CONCORD LAKE ROAD	
	1			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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
F 641	Continued From page	26	F 64	1	
r 041	Resident #30's care p a goal that Resident # while breathing during listed for that goal in p reporting respiratory r oxygen as ordered. A review of the physic revealed an ongoing of have oxygen administ During an observation at 4:15pm, the resider bed with oxygen being canula at 2 liters per r Nurse #3 was intervie The nurse stated she Resident #30 since th had not seen the reside She also stated Residen portable oxygen when the oxygen concentrat laying down. A review of the nursin revealed Resident #3 oxygen via nasal can concentrator. During an interview w at 10:35am, the MDS her information from t and treatment admini- progress notes. She r	blan dated 7-15-19 revealed #30 would display comfort g activity. The interventions bart included; assessing and rate and administering cian orders dated 11-19-18 order for Resident #30 to tered at 2 liters per minute. In of Resident #30 on 9-4-19 nt was noted to be laying in g administered via nasal minute. Evend on 9-5-19 at 8:45am. had been working with he first of July 2019 and she dent without her oxygen. dent #30 would use her in she attended activities or itor in her room if she was	F 64	 issues identified were addressed 3. On 10/2/19, the Interdisciplin was re-educated by the Regional Minimum Data Set nurse on: a. O0100 □ Special Treatments Procedures, and Programs □ special Treatments Procedures, and Indwelling Catheters Protector of Nursing will retree monthly for three monthle Audits will be gin 10/3/19. Protector of Nursing will reviewed by QAF Committee monthly and Quality Monitoring (Audit) updated if chain needed based on findings. The Q	ary Team s, ecifically itatus, egional e will nitoring ey of Dxygen, ers □ on nree en one d then s. report on ng nittee. Pl nges are Quality ment

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345258	B. WING				C 10/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			10 CONCORD LAKE ROAD ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	MDS dated 7-13-19 a coded. MDS nurse #1 why she had not code guess I just missed it. The Administrator wa 12:20pm. The Admini the MDS to paint a pit their care needs. 2. Resident #81 was a 6-20-19 with multiple cerebral infarction, dia obstructive pulmonary A review of the social revealed Resident #8 home with home heal The discharge Minime 7-12-19 revealed the an acute care hospita The progress notes d and revealed Resider with family. During an interview w at 11:35am, the MDS information from the r staff and medical reco the nursing note writte reviewed the discharg did I get that all mixed she had "just made a The Administrator wa 12:20pm. The Admini the MDS to paint a pit	and did not see oxygen I stated she did not know ed oxygen use on the MDS "I "" s interviewed on 9-6-19 at strator stated she expected cture of the resident and admitted to the facility on diagnosis that included abetes and chronic y disease. work notes dated 7-11-19 1 was to be discharged th. um Data Set (MDS) dated resident was discharged to al. ated 7-12-19 were reviewed ht #81 was discharged home with MDS nurse #2 on 9-6-19 nurse stated she obtained hursing notes, talking with ord review. She reviewed en 7-12-19 and then ge MDS and stated, "How d up." The MDS nurse stated	F 6	641			

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345258	B. WING				C 10/2019
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			810 CONCORD LAKE ROAD ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	 wrong box. 3) Resident #80 was 7/28/19 with diagnose urine and neuromusc A physician's order da order for Resident #8 Review of the baselin revealed the resident Nursing notes dated 3 specified Resident #8 place. The admission Minim 8/4/19 revealed the re- impaired cognition. R always incontinent of an indwelling catheter During an interview w 9/6/19 at 11:02am, sh had an indwelling urin 08/04/19 MDS was con the MDS did not refle- indwelling catheter. An interview was con- with the Director of Na 	admitted to the facility on es that included retention of ular disorder of the bladder. ated 7/28/19 revealed an 0 to have a urinary catheter. ate care plan dated 7/28/19 had a urinary catheter. 7/28/19 through 8/4/19 00 had a urinary catheter in um Data Set (MDS) dated esident had moderately esident #80 was coded as bladder and as not having r. with the MDS Nurse #3 on he confirmed the resident hary catheter when the completed and it was an error ct the resident had an ducted on 9/6/19 at 11:45am ursing. She indicated it was	F	541			
F 656 SS=D	her expectation for th accurately. Develop/Implement C CFR(s): 483.21(b)(1)	e MDS to be coded	F6	656			10/8/19
	§483.21(b) Comprehe	ensive Care Plans					

Event ID: GVW611

Facility ID: 923060

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 10/21/2019 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE COMP	SURVEY LETED
		345258	B. WING		_		C 10/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS		810 CONCORD LAKE ROA ANNAPOLIS, 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	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re- under §483.10, include treatment under §483.3 (iii) Any specialized se rehabilitative services provide as a result of recommendations. If a findings of the PASAF rationale in the reside (iv)In consultation with resident's representat (A) The resident's goa desired outcomes. (B) The resident's pre- future discharge. Fact whether the resident's community was asses local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, i	cility must develop and ensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ed in the comprehensive aprehensive care plan must - re to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse .10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its nt's medical record. In the resident and the ive(s)- als for admission and ference and potential for lities must document a desire to return to the seed and any referrals to a and/or other appropriate	F 656				

If continuation sheet Page 30 of 91

		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 10/21/2019 RM APPROVED NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		DNSTRUCTION	(X3) DA	TE SURVEY
		345258	B. WING				C)9/10/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	•	
				1810	CONCORD LAKE ROAD		
TRANSITI	ONAL HEALTH SERVICI	ES OF KANNAPOLIS		KAN	INAPOLIS, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page	e 30	F 6	56			
	section.						
		Γ is not met as evidenced					
	by:						
	-	iew and staff interviews the			F656		
	facility failed to devel				On 10/2/19, resident #36⊡s Care Pla		
		prehensive care plan to			was updated to accurately reflect the		
		ehaviors and diagnosis for 1			residents Care Plan for active diagno		
	of 5 residents review	•			and behaviors by the Minimum Data	Set	
	psychotropic medical	tions (Resident #36).			hurse and Social Worker.		
	Eindinge included:				On 10/2/19, the Minimum Data Set n and the Regional Minimum Data	urses	
	Findings included:				Assessment nurse performed Quality	,	
	Resident #36 was ad	lmitted to the facility on			mprovement monitoring of all		
		diagnosis that included			assessments with an ARD of 9/10/19	and	
		wer limb, atrial fibrillation,			forward that were completed, transm		
	dementia, major depi	ressive disorder psychotic			and accepted for Care Plan accuracy		
	disorder with delusion	ns and anxiety disorder.		i	ssues identified were addressed. On 10/2/19, the Interdisciplinary	Team	
	The quarterly Minimu	ım Data Set (MDS) dated		\	was re-educated by the Regional		
		sident #36 was severely			Vinimum Data Set nurse on Care		
	cognitively impaired a	and received antipsychotic		F	Planning of active Diagnoses and		
		days, antianxiety medication		l t	pehaviors to accurately reflect the		
		Intidepressant medication 7			resident.		
		DS also revealed Resident			3. The Director of Nursing and/or		
	#36 did not have any	mood or behaviors			Regional Minimum Data Assessment		
	exhibited.				Nurse will perform Quality Improvemon Monitoring of Care Plans for active	ent	
	Resident #36's caro	plan dated 8-14-19, that was			diagnoses and resident behaviors on	five	
		lid not reveal any goals or			and a manufacture and the side in behaviors on random MDS assessments three time		
		resident's mental health			per week for four weeks, then one tin		
	diagnosis or behavior				per week for two months and then or		
	-				ime monthly for three months. Audit		
	Resident #36 was ob				begin 10/3/19.		
		r wheelchair in the dinning			4. The Director of Nursing will repo	rt on	
		to be alert, looking around			the results of the Quality Monitoring		
	the room but not con	versing with her peers.			(Audits) to the Quality Assurance		
					Performance Improvement Committe	e.	
		ewed on 9-4-19 at 2:35pm.			Findings will be reviewed by QAPI		
	The nurse stated Res	Suent #30 nau been			Committee monthly and Quality		

Facility ID: 923060

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · · ·	SURVEY
	CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING			C
		345258	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
TRANSITI	ONAL HEALTH SERVIC	ES OF KANNAPOLIS		810 CONCORD LAKE ROAD (ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 656	Continued From pag	e 31	F 656			
	combative, confused at times. She also sta interventions were or help aide with the be walk away from the r minutes later. When #36's care plan she of	and refusing her medication ated she did not know what n the resident's care plan to haviors but that she would esident and return 5-10 Nurse #1 reviewed Resident		Monitoring (Audit) updated if needed based on findings. T Assurance Performance Impr Committee meets monthly an at a minimum.	he Quality ovement	
	9-4-19 at 2:40pm, the Resident #36's care know why there were her diagnosis or beha stated he would have diagnosis and her be would have been the	vith Social Worker #1 on e Social Worker reviewed plan and stated he did not e no goals or interventions for aviors. The Social Worker e to "look into" the resident's shaviors. He also stated he social Worker who should goals and interventions for				
	The Director of Nursing was interviewed on 9-4-19 at 4:30pm. The Director of Nursing stated the facility had changed social work staff "about 6 months ago" and felt Social Worker #1 had "just over looked care planning the resident for her behaviors". She was also able to state Resident #36 exhibited confusion, combativeness and refused her medication at times.					
F 657	12:20pm. The Admin the care plan to paint their needs.	as interviewed on 9-6-19 at istrator stated she expected t a picture of the resident and d Revision	F 657			10/8/19
SS=D	CFR(s): 483.21(b)(2)					

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/21/20 FORM APPROVE OMB NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345258	B. WING		09/10/2019		
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
FRANSITI	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
F 657	be- (i) Developed within 7 the comprehensive a	orehensive care plan must 7 days after completion of ssessment.	F 657				
	 includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prace 	vsician. e with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of					
	An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determ	staff or professionals in ined by the resident's needs					
	team after each asse comprehensive and o assessments. This REQUIREMENT by:	ised by the interdisciplinary ssment, including both the juarterly review					
	resident interviews, th and revise the care p care plans reviewed t (Resident #67).	cord review, staff and ne facility failed to review lan for one of twenty-four for care plan revisions		F657 1. On 9/17/19, resident #67 s Care Plan was updated to accurately reflect residents Care Plan for hallucinations the Social Worker. On 10/2/19, reside #67 s MDS was updated to accuratel	by nt y		
	The resident's cumula	: mitted to the facility 1/31/19. ative diagnoses included: ne, contracture, dementia,		 reflect the residents MDS Assessment hallucinations by the Social Worker. On 10/2/19, the Minimum Data Se nurses and the Regional Minimum Data Assessment nurse performed Quality 	et		

Event ID: GVW611

Facility ID: 923060

If continuation sheet Page 33 of 91

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				MPLETED
						С
		345258	B. WING		0	9/10/2019
NAME OF P	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	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 657	Continued From page	e 33	F 65	7		
		ent disorder, anxiety,		Improvement monitoring of a assessments with an ARD o		
				forward that were completed	, transmitted	
		of the Minimum Data Set for Resident #67 revealed		and accepted for MDS asses Care Plan accuracy. Any iss		
		pleted assessment was a		were addressed.		
		t with an Assessment		3. On 10/2/19, the Interdis		
		D) of 8/10/19. Review of the the the coded as		was re-educated by the Reg Minimum Data Set nurse on		
		ive loss. The resident was		Planning and coding of hallu		
		hallucinations or delusions		delusions to accurately refle		
	during the assessme			resident. The Director of Nur	sing and/or	
		tod of Docidont #67's core		Regional Minimum Data Ass		
		eted of Resident #67's care realed the care plan had		Nurse will perform Quality In Monitoring of Care Plans for		
		n 8/22/19, revealed there		diagnoses and resident beha		
		address hallucinations.		random MDS assessments t	hree times	
	The progress notes f	or Resident #67 had a		per week for two months and		
		te dated 3/5/19 and timed		time monthly for three month	ns. Audits will	
		mented the resident stated		begin 10/3/19.		
		saw a man with a dog in the door. The resident's door		4. The Director of Nursing		
		having been closed. The		the results of the Quality Mo (Audits) to the Quality Assur-		
		he was unable to corroborate		Performance Improvement (
		nrough interviews with other		Findings will be reviewed by		
	residents.			Committee monthly and Qua	-	
	-			Monitoring (Audit) updated if		
		or Resident #67 had a timed 3/25/19 and timed		needed based on findings. Assurance Performance Imp	•	
		mented the resident thought		Committee meets monthly a		
		playing instruments just to		at a minimum.		
		entation was ineffective.				
	Further review of Res	sident #67's physician				
	progress notes revea					
		locumented on 3/8/19,				
	3/21/19, 3/26/19, 4/5	/19, 4/9/19, and 4/15/19.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345258	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	1	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
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 657	Review of the progres revealed a Nursing Pl and timed 6:41 AM w resident rang multiple hallucinating with con- seeing a man. The re- having had a history of During an interview cr on 9/3/19 at 11:39 AM had been a resident, played a flute or a reo further stated the resi while he was at the fa- the man returned to the dog and played the flad door of the facility. An interview was con- PM with Nursing Assi Resident #67 did hav there was a dog who area which had been An interview was con- with Nurse #5. She si hallucinations includir facility whose name w flute, and he had a do An interview was con- AM with Nurse #11. Si Manager and she was hallucinations. She si was working with the An interview was con- AM with MDS Nurse #	As notes for Resident #67 rogress Note dated 6/30/19 hich documented the e times through the night inplaints of a dog barking and esident was documented as of hallucinating. onducted with Resident #67 A the resident stated there a man, at the facility who corder at night. The resident dent had a dog with him acility. The resident stated he facility at night with his ute or recorder at the back ducted on 9/4/19 at 12:05 stant (NA) #5. She stated e hallucinations including slept under the facility in an cleared out. ducted on 9/4/19 at 2:53 PM tated Resident #67 did have ng there was a person at the was Kevin, who plays the og. ducted on 9/5/19 at 11:21 She stated she was the Unit s aware of Resident #67's tated psychiatric services	F	657			

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						O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		345258	B. WING		09	9/10/2019	
NAME OF PF	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	Ξ		
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS) 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	An interview was con AM with Social Worke Resident #67 was foll services and he was hallucinations such as who had a dog. He s information regarding	ons and she had not heard hallucinations. ducted on 9/5/19 at 11:49 er (SW) #1. He stated lowed by psychiatric aware she had s a boy playing a flute and tated he did not put the the hallucinations in the	F 657				
F 693 SS=D	having started to work An interview was con- with the Director of Ne stated she was aware hallucinations. She s hallucinations is a bel addressed on the Car An interview was con- AM with the Administr stated it was her expe as hallucinations to be Tube Feeding Mgmt/f CFR(s): 483.25(g)(4)(§483.25(g)(4)-(5) Ent (Includes naso-gastric both percutaneous er percutaneous endosc enteral fluids). Based	en occurring prior to him k at the facility. ducted on 9/5/19 at 4:41 PM ursing (DON). The DON e Resident #67 had tated the resident having havior which should be re Plan. ducted on 9/6/19 at 11:43 rator. The Administrator ectation for behaviors such e in the resident's care plan. Restore Eating Skills (5) eral Nutrition c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and on a resident's ssment, the facility must t-	F 693			10/8/19	

Facility ID: 923060

If continuation sheet Page 36 of 91

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/21/2 FORM APPROV OMB NO. 0938-03	
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345258	B. WING		C 09/10/2019	
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	·	
			1	1810 CONCORD LAKE ROAD		
IRANSIII	ONAL HEALTH SERVICE	ES OF KANNAPOLIS	1	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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC	
F 693	enteral methods unle condition demonstrat	e 36 ss the resident's clinical es that enteral feeding was d consented to by the	F 693			
	means receives the a services to restore, if and to prevent compl including but not limit diarrhea, vomiting, de abnormalities, and na This REQUIREMENT by: Based on record rev interviews, the facility feeding according to 2 residents reviewed #196). The tube feed the daytime 12-hour 12 hour period and the administered manual Findings included:	asal-pharyngeal ulcers. is not met as evidenced iew, observations and staff failed to administer tube the physician orders for 1 of for tube feeding (Resident ing was administered during period instead of nighttime he hourly water flush was not		F693 Tube feeding Mgmt/Restore Skills 1) On 9/6/19 once staff was mad tube feeding for resident #196 was stopped, no concerns noted. Nurs Practitioner and Registered Dietici in facility at the time and were mad aware. No new orders received ho orders were updated to include: "o "off" on medication administration 2) Current residents who receive feeding have the potential to be aff	le aware se an both de wever n" and record. e enteral	
	8/23/2019 with diagneric encephalopathy, dyspand diabetes. The action (MDS) assessment displeted. The MDS be severely cognitive behaviors. The MDS received more than 5 gastrostomy tube (G-501 milliliters (ml) of the first order with the fir	oses to include ohagia (difficulty swallowing) dmission Minimum Data Set ated 8/30/2019 was not assessed Resident #196 to ly impaired without documented Resident #196 1% of her calories by tube) feeding and more than		 Note the potential to be all On 9/25/19 an audit on all 3 resider receiving tube feeding was completensure tube feeding and water flust being administered according to plorders. All 3 residents were found zero adjustments for their orders for feeding. 3) The Assistant Director of Nursing/Nurse Management will reeducate licensed nurses on enterfeeding management by 10/8/19. education will be included in Orient for new hires. 	ents eted to shes are hysician to need or tube eral The	

Event ID: GVW611

Facility ID: 923060

		MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		<u>3 NO. 0938-039</u> DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:		G	· · · ·	COMPLETED	
						С	
		345258	B. WING			09/10/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 693	8:00 PM to 8:00 AM a for 12 hours every sh AM until 8:00 PM.	e 37 and water flush of 60 ml/hour ift for hydration from 8:00 bserved on 9/3/2019 at	F 69	 93 4) Nurse Management/A Nursing will audit residents enteral feeding to ensure to and water flushes are bein 	receiving ube feeding		
	12:07 PM and the tub infusing via G-tube at was not interviewable	be feeding Jevity was t 80 ml/hour. Resident #196 e.		per physician orders 3x we then 1x weekly for 2 month monthly for 3 months. The Nursing will report on the r	eek for 4 weeks, ns and then 1x Director of esults of the		
	revealed that Nurse # "Jevity 1.5 80 ml/hour flush 60 ml/hour for 1	cation administration record #11 had initialed the order r for 12 hours and water 2 hours" on 9/3/2019, 9 indicating the task was		quality monitoring (audits) Assurance Performance In committee. The findings w monthly by the Quality Ass Improvement Committee n audits updated if changes	nprovement vill be reviewed surance nonthly and		
				based on findings. The Qu Improvement Committee n and as needed.	uality Assurance		
	AM and she reported Resident #196 had or feeding to infuse from water to be administer until 8:00 PM. Nurse not have a pump that deliver water and the administer the water by her G-tube. Nurse administered the water	iewed on 9/5/2019 at 10:30 she was not aware that rders for Jevity G-tube n 8:00 PM until 8:00 AM and ered by G-tube from 8:00 AM #11 reported the facility did t could be programed to nurse would have to manually to Resident #196 e #11 reported she had not er to Resident #196 but had o her with her medication					
	AM and she reported a G-tube feeding pun administration of wate	ewed on 9/6/2019 at 10:48 that the facility did not have np that allowed for the er flushes and if the order a resident with a G-tube, the administer the water					

		ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE 10. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C 09/10/2019	
		345258	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP CO		
	ONAL HEALTH SERVIC			1810 CONCORD LAKE ROAD		
IRANSIII	UNAL HEALTH SERVICI	ES OF KANNAFOLIS		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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 693	Continued From page	e 38	F 693			
1 000	manually.		1 03			
		2 was interviewed on				
		1 and she reported she was				
		eding for Resident #196 was nd end at 8:00 AM with water				
		rted the order should be				
	clarified by the facility					
		es (DON) was interviewed on				
		I and she reported the order				
		feeding for Resident #196 should have been clarified				
		ON reported the facility				
		fies the physician orders for				
	tube feeding and the	order appeared to have				
	been entered into the	e system incorrectly.				
	The facility registered	d dietician (RD) was				
)19 at 1:36 PM and she				
		sor performed the admission				
	assessment on Resid					
		not in the hard chart or the				
		RD reported the physician				
		arified by the nurse. The RD				
		ng that Resident #196 was				
		s of meals and this was why				
		to be stopped from 8:00 AM				
		her the opportunity to eat.				
	The Administrator wa	is interviewed on 9/6/2019 at				
		orted she expected the				
	orders to be entered	correctly for all resident with				
	-	those residents to receive				
	nutrition correctly.					40/0/10
F 727	, , , , , , , , , , , , , , , , , , ,		F 72			10/8/19
SS=B	CFR(s): 483.35(b)(1)	-(3)	1			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/21/20 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED	
		345258	B. WING		C 09/10/2019
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO
F 727	Continued From page	ə 39	F 727		
	must use the services least 8 consecutive h §483.35(b)(2) Except paragraph (e) or (f) o must designate a reg director of nursing on §483.35(b)(3) The dir as a charge nurse on average daily occupa This REQUIREMENT by: Based on record rev facility failed to staff F coverage for 8 conse days reviewed for RN	when waived under f this section, the facility s of a registered nurse for at ours a day, 7 days a week. when waived under f this section, the facility istered nurse to serve as the		F727 1. The facility daily schedule sheets of indicate RN hours for the following da 6/29/19, 6/30/19, 7/13/19, 7/20/19, 7/21/19, 7/27/19, and 7/28/19.	
	from June 2019 to Au was not scheduled for hours a day on the for 6/30/19, 7/13/19, 7/20 7/28/19. An interview was com Nursing (DON) and A (ADON) on 9/6/19 at acknowledged there facility had no hours of indicated the RN unit	y's daily schedule sheets igust 2019 indicated a RN r at least 8 consecutive llowing dates: 6/29/19, 0/19, 7/21/19, 7/27/19 and ducted with the Director of sssistant Director of Nursing 2:00pm. They both were some days when the		 2. On 9/26/19, a review of RN coverations for the last 30 days was completed to verify RN coverage with no concerns noted. 3. On 9/25/19 Director of Nursing, Assistant Director of Nursing, Unit Managers, Executive Director, Schedand Human Resource Coordinator reeducated by Regional Director of Clinical Services on RN Staffing Requirements. Beginning 9/30/19 th weekly schedule will be reviewed and approved by the facility Executive Director of Director of Nursing to ensure adec RN coverage. Any RN calling out will 	duler, duler, d rector quate

Facility ID: 923060

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245050		С	
		345258			09/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FRANSITI	ONAL HEALTH SERVIC	ES OF KANNAPOLIS		1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIO
F 727	Continued From pag	e 40	F 727	,	
	stated) to provide 8 h Saturdays and Sund	nours of RN coverage on ays. The DON indicated it for a RN to be scheduled 8		referred to Executive Director/Director	
	with the facility's nurs stated the RN unit m weekends on August of RN coverage on w was unaware of the R Executive Director ar attention at the end of			Coordinator will audit schedules 3x for 4 weeks, then 1x weekly for 2 m and then 1x monthly for 3 months t ensure RN coverage. The Director Nursing will report on the results of quality monitoring (audits) to the Q Assurance Performance Improvem committee. The findings will be rev monthly by the Quality Assurance Improvement Committee monthly a audits updated if changes are need based on findings. The Quality Ass Improvement Committee meets mo and as needed.	nonths o of the uality ent viewed and ded surance
F 755 SS=E		cedures/Pharmacist/Records i(1)-(3)	F 755	5	10/8/19
	drugs and biologicals them under an agree §483.70(g). The faci personnel to adminis	vide routine and emergency to its residents, or obtain ement described in lity may permit unlicensed			
	pharmaceutical servi that assure the accur dispensing, and adm	es. A facility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and he needs of each resident.			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM): 10/21/2019 1 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345258	B. WING _				」 10/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			310 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 PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	pharmacist who- §483.45(b)(1) Provide aspects of the provisi the facility. §483.45(b)(2) Establi receipt and dispositio sufficient detail to ena reconciliation; and §483.45(b)(3) Determ order and that an acc is maintained and per This REQUIREMENT by: Based on observation record reviews, the far established procedur administering medical documentation) to me sampled residents (R #282) observed durind observations and for unnecessary medical The findings included 1) Resident #24 was facility on 7/5/16 with 9/8/16. Her cumulativ depression.	n the services of a licensed es consultation on all ion of pharmacy services in shes a system of records of on of all controlled drugs in able an accurate nines that drug records are in count of all controlled drugs riodically reconciled. T is not met as evidenced ons, staff interviews, and acility failed to follow es for acquiring and titons (including eet the needs for 2 of 7 tesident #24 and Resident ag medication pass 1 of 7 residents reviewed for tions (Resident #39).	F 7	755	F755 1. Nurse #11 was educated by Director Nursing 9/3/19 on checking emergency for resident #24 medication that was no available. Nurse #8 administered medications (Amlodipine and Losartan) late to resident #282 after emergency k was brought to her attention. Nurse #8 no longer employed at facility. Resider #39 s medication (Donepezil) was ordered from pharmacy and delivered. Medication Error Reports were complet for each incident with notification to Physician. 2. Medications carts audited to ensure medications are available for residents 9/27/19. Issues identified were addressed.	/ kit bt) kit is ht ted	
	9/3/19 at 10:19 AM w prepared medications Resident #24. The m				3. The Assistant Director of Nursing/Nu Management will reeducate licensed nurses on Medication Availability (Ordering/Reordering Process, Receivi		

Event ID: GVW611

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						NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	· · /	ATE SURVEY DMPLETED	
			A. BUILDING		С		
		345258	B. WING			09/10/2019	
	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP CODE		09/10/2019	
				1810 CONCORD LAKE ROAD			
TRANSITI	ONAL HEALTH SERVICI	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 OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE	
F 755	Continued From page	a 42	F 75	5			
1755	1.0		F / 3	Medications in, Emergency Me	diaction		
		aline (an antidepressant). nis medication was not on		Kit, and Back-up Pharmacy) by			
		e would need to call the		All new nurse hires will be edu			
	pharmacy to have it s			during orientation by ADON.			
				4. Nurse Management/Adminis			
		#24 's physician 's orders		Nursing will audit medication c			
		edication order for 50 mg		3 x weekly for 4 weeks, then 1			
		as one tablet by mouth one lication was scheduled to be		for 2 months and then 1x mont months to ensure medications	•		
	administered at 9:00			The Director of Nursing will rep			
				results of the quality monitoring			
	An observation was o	conducted on 9/4/19 at 11:35		the Quality Assurance Perform			
	AM of the med cart u	sed for Resident #24. The		Improvement committee. The	findings will		
		there was no sertraline		be reviewed monthly by the Qu	-		
		cart for administration to the		Assurance Improvement Com			
		the resident ' s Medication d (MAR revealed Resident		monthly and audits updated if are needed based on findings.			
		dose of sertraline at any		Quality Assurance Improveme			
	time on 9/3/19.			Committee meets monthly and needed.			
	An interview was con	ducted on 9/4/19 at 4:25 PM					
		ng the interview, the med					
	pass administration f	rom 9/3/19 was discussed					
		Nurse #11 reported she did					
		ecked the facility 's e-kit to					
		aline for Resident #24 on dged she did not administer					
		to the resident on 9/3/19.					
		e facility 's procedure					
		do if a medication was not					
		nistered to a resident at the					
		d, Nurse #11 reported she					
		e-kit to see if the med was					
		was not there, she would go n to check if the medication					
		cond e-kit stored there.					
		e would also need to call the					
		to inform him/her if the					
		currently available, then call					

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		MEDICAID SERVICES				NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING	<u> </u>			
						С	
		345258	B. WING		0	9/10/2019	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD		DE		
IRANSIII	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		KANNAPOLIS, NC 28083			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLETION	
F 755	Continued From page	e 43	F 75	55			
			175				
		nem know the resident was n asked if she had taken					
		e reported she had not. ated she understood the 2nd					
		orking on 9/3/19 and 9/4/19					
		e requests for the sertraline					
		armacy reported they couldn't					
		t. She confirmed Resident					
		ne sertraline as ordered on					
	9/3/19.	le sellanne as ordered on					
	5/5/15.						
	An observation and in	nterview were conducted on					
	9/4/19 at 2:00 PM wit	h Nurse #8. Nurse #8 was					
	the 1st shift nurse as	signed to Resident #24 ' s					
	med cart. Upon requ	est, the nurse reviewed the					
	medications stored of	n the cart for Resident #24.					
	Nurse #8 confirmed r	no sertraline was stored on					
	the med cart for this r	resident. She reported the					
	resident 's electronic	medical record indicated					
	the medication was o	rdered from the pharmacy					
	on 9/4/19 (this date).	The nurse reported she					
	administered Resider	nt #24 's medications earlier					
		did not include sertraline).					
		Nurse #8 stated the facility					
		edications in an emergency					
		known as an e-kit) stored in					
	the medication room.						
	reported she did not						
		aline was scheduled for					
	administration at 9:00						
	-	went to the med room. A					
		d list of medications stored in					
		ontained both 25 mg and 50					
		ne. The 50 mg sertraline					
		d to be stored in the e-kit at					
	that time. The nurse						
		ered and was observed as					
	she administered the	prescribed sertraline to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/21/2019 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345258	B. WING				10/2019
NAME OF P	ROVIDER OR SUPPLIER			5	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 LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 755	Continued From page	2 44	F	755	5		
	3:52 PM with a disper worked for the facility During the interview, 30-day supply (30 tab last dispensed from th #24 on 7/19/19. She mg sertraline was rep from the facility 's e-H at 2:20 PM) within the pharmacist also report on 9/4/19 for a refill o and stated the med w pharmacy around 9:0 asked, the pharmaciss made to the facility tw pharmacy around 12: delivery shipment left Upon inquiry, the phar resident ran out of a r before a scheduled d contact the pharmacy obtain the medication (a local retail pharma An observation of Re was conducted on 9/5 observation, it was no sertraline had been d on 9/4/19 and was sto An interview was con with Nurse #10 to dis procedures to acquire needed for a resident a hall nurse assigned interview, the nurse ref	00 PM and the second the pharmacy at 9:00 PM. Irmacist reported if a medication that was needed elivery, the facility could v and they would arrange to of from a back-up pharmacy cy). sident #24 ' s hall med cart 5/19 at 8:58 AM. During the bted 30 tablets of 50 mg ispensed for Resident #24 ored on the medication cart. ducted on 9/5/19 at 3:35 PM cuss the facility ' s e or refill medications . Nurse #10 was working as to a med cart. During the					

Facility ID: 923060

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			0.00	E CONSTRUCTION			
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY PLETED	
			A. BOILDING			с	
		345258	B. WING		09	/10/2019	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		10/2010	
				1810 CONCORD LAKE ROAD			
TRANSITIC	ONAL HEALTH SERVIC	ES OF KANNAPOLIS		KANNAPOLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 755	Continued From pag	e 45	F 75	5			
			175				
	doses left in the resident 's bubble pack card. She stated some medications could be						
		ally but if they were, the					
		get sent out from the					
		To improve the chances of					
	• •	that night, Nurse #10					
	•	to write out the refill request					
		macy before 5:00 PM. Upon					
		e would do if a resident was nedication when it was					
		istration, the nurse reported					
		the facility 's e-kit. If the					
		here, she would call the					
	pharmacy and see if	it could be sent out STAT					
		nately 2 hours to receive). If					
		not be received by the					
		inner, the pharmacy would					
	pharmacy.	pharmacy as their back-up					
	pharmacy.						
	An interview was cor	nducted on 9/5/19 at 4:16 PM					
		cuss the facility 's procedures					
		edications needed for a					
	resident. Nurse #9 v	vas working as a hall nurse					
		art. Upon inquiry, the nurse					
		ng issues with this." Nurse					
	#9 reported she wou	-					
		re were 8 doses or so left in le pack card. If a resident					
		tion that was scheduled for					
		urse stated she could check					
		erring to the e-kit) that carried					
	quite a bit of basic m						
		available in-house, Nurse #9					
		all their contracted pharmacy					
	and tell them she ne	eded the medication. She					
		e					
		ne facility would receive the lot. If the med was ordered					

Facility ID: 923060

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE SURVEY COMPLETED	
		345258	B. WING			C 09/10/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
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 .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	understood it was sup but noted that was not asked if there was an the medication if it wa hours, Nurse #9 repo a local retail pharmace back-up pharmacy. An interview was com AM with the facility's I During the interview, acquiring a medicatio were discussed. The was out of an over-the member of the staff w retail store. If the me medication, she would check the e-kits to se medication was availa nursing staff would be resident 's physician order on hold or obtail appropriate alternativ prescribed medication appropriate alternativ needed to call the pha medication to be sent once). 2-a) Resident #282 w 8/16/19. Her cumulati hypertension (high bla A medication pass ob 9/4/19 at 11:20 AM w prepared medications Resident #282. The n administration to Res	poposed to arrive in 4 hours at always the case. When other alternative to acquire as needed sooner than 4 rted the pharmacy did have by they could use as a ducted on 9/6/19 at 11:00 Director of Nursing (DON). the facility 's procedures for n needed for a resident DON reported if a resident e-counter medication, a yould go and pick it up at a dication was a prescription d expect the nursing staff to e if that particular able in-house. If not, e expected to notify the to either put the medication n an order for an e available in-house until the n could be obtained. If no e was available, staff armacy and ask for the to out to the facility "STAT" (at the servation was conducted on ith Nurse #8 as she to for administration to medications scheduled for	F	75	5		

Facility ID: 923060

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME				F	FORM APPROVED B NO. 0938-0391
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED C
	345258	B. WING		09/10/2019	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
TRANSITIONAL HEALTH SERVICES		1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES /UST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
 dose of 7.5 mg). The nut t enough amlodipine left tablets that remained in pack card. Nurse #8 stat call the pharmacy to havout. Upon further inquir medication would come sometime today. Howe the medication would core afternoon or evening. A review of Resident #2 included a current medication would a current medication would core at tablets (total dose of 7.5 day. The medication was administered at 9:00 AM A follow-up interview was 2:00 PM with Nurse #8. stated the facility had so in an emergency (ER) m an e-kit) stored in the m was accompanied as sh A review of the itemized in the e-kit revealed it in of amlodipine. When the list included amlodipine, medication could have p Resident #282 during the Nurse #8 reported she w dosage and administer amlodipine ordered for factors. 	as 1 and ½ tablets (total urse reported there wasn ' t on the cart with the ½ the resident ' s bubble ated she would need to ve the medication sent ry, the nurse stated the e from the pharmacy ever, she was not sure if ome in to the facility that 282 ' s physician ' s orders cation order for 5 mg as one and one-half 5 mg) by mouth one time a as scheduled to be A each day. as conducted on 9/4/19 at Upon inquiry, Nurse #8 ome back up medications nedication room. Nurse #8 ne went to the med room. d list of medications stored heluded 4 - 2.5 mg tablets ne nurse was shown the , she was asked if this possibly been used for ne morning med pass. would double check the the medication since the Resident #282 had not yet	F 7	755		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345258	B. WING				C 1 0/2019
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
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 SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 755	During the interview, 15-day supply of amount the pharmacy for Ress supply included 1 but - 5 mg tablets of amount card containing 15 - 1 (to yield 2.5 mg). She of 2 - 2.5 mg amlodip s e-kit was reported for 2:50 PM) within the p also reported a reque and was being process resident ' s amlodiping pharmacist reported of facility twice daily; on 12:00 PM and the sec at 9:00 PM. Upon indor reported if a resident was needed before a facility could contact to would arrange to get retail pharmacy. An observation of Res was conducted on 9/5 observation revealed - ½ tablets of 5 mg am 9/4/19 had come in fr Resident #282. Upor the med cart further a tablets of 5 mg amlod med cart for this reside A follow-up telephone 9/5/19 at 2:42 PM wit the facility 's contract	the pharmacist reported a polipine was dispensed from sident #282 on 8/16/19. This pole pack card containing 15 polipine and 1 bubble pack 4 tablets of 5 mg amlodipine e noted only one withdrawal ine tablets from the facility ' or this resident (on 9/4/19 at ast month. The pharmacist st was received on 9/4/19 seed for a refill of the e. When asked, the deliveries were made to the e left the pharmacy around cond delivery shipment left quiry, the pharmacist ran out of a medication that scheduled delivery, the the pharmacy and they the medication at a local sident #282 ' s hall med cart 5/19 at 8:58 AM. The only one card containing 15 nlodipine (each ½ tablet lodipine) dispensed on om the pharmacy for n inquiry, Nurse #3 reviewed ind reported no whole lipine were stored on the lent.	F	755	5		

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	S FOR MEDICARE &					IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	· · ·	TE SURVEY MPLETED
					С	
		345258	B. WING		09/10/2019	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		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 PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 755	Continued From page	e 49	F 755			
	and 1 card containing amlodipine) were sen	ontaining whole 5 mg tablets g ½ tablets of 5 mg at out on 9/4/19 and would by the facility the evening of				
	with Nurse #10 to dis procedures to acquire needed for a resident a hall nurse assigned interview, the nurse re- re-ordered a medicat doses left in the resid She stated some med re-ordered electronica medications may not pharmacy that night. getting a medication for reported she tended and fax it to the pharm inquiry as to what she completely out of a m scheduled for adminis she would first check medication was not the pharmacy and see if (which took approxim the medication could facility in a timely mat	e or refill medications t. Nurse #10 was working as I to a med cart. During the eported she usually ion when there were 7 to 8 lent ' s bubble pack card. dications could be ally but if they were, the get sent out from the To improve the chances of				
	with Nurse #9 to disc to acquire or refill me resident. Nurse #9 w	ducted on 9/5/19 at 4:16 PM uss the facility ' s procedures dications needed for a vas working as a hall nurse art. Upon inquiry, the nurse				

Facility ID: 923060

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 10/21/2019 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		DNSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		345258	B. WING _				C 09/10/2019
NAME OF PI	ROVIDER OR SUPPLIER	•	-	STR	EET ADDRESS, CITY, STATE, ZIP CODE	-	
TRANGITI				1810	CONCORD LAKE ROAD		
TRANSIT	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		KAN	NAPOLIS, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 755	the resident 's bubble was out of a medicati administration, the nu a "back up box" (refer quite a bit of basic me medication wasn 't a reported she could ca and tell them she need reported how soon th medication varied a la from the pharmacy of understood it was sup but noted that was no asked if there was an the medication if it wa hours, Nurse #9 repor a local retail pharmacy. An interview was con AM with the facility's During the interview, acquiring a medication were discussed. The was out of an over-th member of the staff w retail store. If the me medication was availan ursing staff would be resident 's physician order on hold or obta appropriate alternativ prescribed medication	d try to re-order a re were 8 doses or so left in e pack card. If a resident ion that was scheduled for urse stated she could check rring to the e-kit) that carried edications. If the vailable in-house, Nurse #9 all their contracted pharmacy eded the medication. She e facility would receive the ot. If the med was ordered in a STAT basis, she oposed to arrive in 4 hours ot always the case. When nother alternative to acquire as needed sooner than 4 rted the pharmacy did have by they could use as a ducted on 9/6/19 at 11:00 Director of Nursing (DON). the facility 's procedures for in needed for a resident e-counter medication, a vould go and pick it up at a dication was a prescription d expect the nursing staff to e if that particular able in-house. If not, e expected to notify the to either put the medication in an order for an e available in-house until the in could be obtained. If no re was available, staff	F7	755			
	order on hold or obta appropriate alternativ prescribed medication appropriate alternativ	in an order for an re available in-house until the n could be obtained. If no					

Facility ID: 923060

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/21/2019 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345258	B. WING				C 10/2019
NAME OF PI	ROVIDER OR SUPPLIER	L		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS		-	10 CONCORD LAKE ROAD		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	medication to be sent once). 2-b) Resident #282 w 8/16/19. Her cumulat hypertension (high bl A medication pass ob 9/4/19 at 11:20 AM w prepared medications Resident #282. The administration to Res milligrams (mg) losar medication) to be give mouth one time a day resident was out of th to be ordered from th stated she would nee have the medication a inquiry, the nurse star come from the pharm However, she was no would come in to the evening. A review of Resident included a current me losartan to be given a mouth one time a day scheduled to be adm day. A follow-up interview 2:00 PM with Nurse # stated the facility had in an emergency (ER an e-kit) stored in the was accompanied as	tout to the facility "STAT" (at as admitted to the facility on ive diagnoses included bood pressure). servation was conducted on ith Nurse #8 as she s for administration to medications scheduled for ident #282 included 50 tan (an antihypertensive en as 100 mg (2 tablets) by 7. The nurse reported the is medication so it needed e pharmacy. Nurse #8 d to call the pharmacy to sent out. Upon further ted the medication would	F	755			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/21/2019 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COMF	SURVEY PLETED
		345258	B. WING				C / 10/2019
NAME OF PF	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
TRANSITI	ONAL HEALTH SERVICE			1	810 CONCORD LAKE ROAD		
				ĸ	CANNAPOLIS, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	losartan. When the included losartan, she medication could hav Resident #282 during Nurse #8 reported sh dosage and administe losartan ordered for F come in to the facility A telephone interview 3:52 PM with a disper worked for the facility During the interview, 15-day supply of losa pharmacy for Resider noted only one withdr the facility 's e-kit wa (on 9/4/19 at 2:50 PM The pharmacist also received on 9/4/19 ar a refill of the resident the pharmacist report the facility twice daily around 12:00 PM and shipment left at 9:00 pharmacist reported i medication that was r delivery, the facility co and they would arran- local retail pharmacy. An observation of Re was conducted on 9/8 observation revealed the medication cart fo inquiry, Nurse #3 revi	t included4 - 25 mg tablets of e nurse was shown the list e was asked if this e possibly been used for the morning med pass. e would double check the er the medication since the Resident #282 had not yet was conducted on 9/4/19 at nsing pharmacist who 's contracted pharmacy. the pharmacist reported a rtan was dispensed from the nt #282 on 8/16/19. She rawal of losartan tablets from s reported for this resident 1) within the past month. reported a request was nd was being processed for 's losartan. When asked, ted deliveries were made to ; one left the pharmacy d the second delivery PM. Upon inquiry, the f a resident ran out of a needed before a scheduled ould contact the pharmacy ge to get the medication at a sident #282 's hall med cart 5/19 at 8:58 AM. The no losartan was stored on or Resident #282. Upon iewed the med cart further	F	755			
	and confirmed no los	artan was stored on the med					

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345258	B. WING				C 10/2019
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		K	ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 755	Continued From page	9 53	F	755			
	A follow-up telephone 9/5/19 at 2:42 PM wit the facility 's contract the pharmacy manag s losartan had not yet Upon inquiry as to wh and delivered to the far manager reported sho the medication order adjudication (referring submitting a claim to An interview was con- with Nurse #10 to dis- procedures to acquire needed for a resident a hall nurse assigned interview, the nurse for re-ordered a medication She stated some medication she stated some medication interview that night. getting a medication to reported she tended to and fax it to the pharm inquiry as to what she completely out of a m scheduled for adminis she would first check medication was not th pharmacy and see if if (which took approxim the medication could facility in a timely mark	e interview was conducted on h a pharmacy manager at ted pharmacy. When asked, er reported Resident #282 ' t been sent out to the facility. by it had not been dispensed acility, the pharmacy e was unsure, but thought may have been held up in g to the process of insurance). ducted on 9/5/19 at 3:35 PM cuss the facility ' s e or refill medications . Nurse #10 was working as to a med cart. During the eported she usually on when there were 7 to 8 ent ' s bubble pack card. dications could be ally but if they were, the get sent out from the To improve the chances of					

Facility ID: 923060

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			FOR	M APPROVED D. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	E SURVEY PLETED C
345258	B. WING			/10/2019
		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CES OF KANNAPOLIS		1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
ge 54	F 75	55		
scuss the facility 's procedures hedications needed for a was working as a hall nurse cart. Upon inquiry, the nurse ring issues with this." Nurse uld try to re-order a ere were 8 doses or so left in ble pack card. If a resident ation that was scheduled for nurse stated she could check ferring to the e-kit) that carried medications. If the available in-house, Nurse #9 call their contracted pharmacy eeded the medication. She the facility would receive the lot. If the med was ordered on a STAT basis, she upposed to arrive in 4 hours not always the case. When another alternative to acquire was needed sooner than 4 borted the pharmacy did have acy they could use as a onducted on 9/6/19 at 11:00 s Director of Nursing (DON). <i>A</i> , the facility 's procedures for ion needed for a resident the CON reported if a resident the counter medication, a would go and pick it up at a nedication was a prescription uld expect the nursing staff to				
	IDENTIFICATION NUMBER:	& MEDICAID SERVICES (X1) PROVIDERSUPPLIEN/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 345258 B. WING CES OF KANNAPOLIS ID PREFIX STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL WR LSC IDENTIFYING INFORMATION) ID PREFIX TAG age 54 F 75 onducted on 9/5/19 at 4:16 PM scuss the facility 's procedures nedications needed for a was working as a hall nurse cart. Upon inquiry, the nurse ving issues with this." Nurse uid try to re-order a nere were 8 doses or so left in ble pack card. If a resident ation that was scheduled for nurse stated she could check ferring to the e-kit) that carried medications. If the : available in-house, Nurse #9 call their contracted pharmacy eeded the medication. She the facility would receive the a lot. If the med was ordered on a STAT basis, she supposed to arrive in 4 hours not always the case. When another alternative to acquire was needed sconer than 4 ported the pharmacy did have acy they could use as a onducted on 9/6/19 at 11:00 's Director of Nursing (DON). w, the facility 's procedures for ton needed for a resident the DON reported if a resident the-counter medication, a f would go and pick it up at a needication was a prescription puld expect the nursing staff to see if that particular	& MEDICAID SERVICES (x1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 345258 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD KANNAPOLIS STREET ADDRESS, CITY, STATE, ZIP CODE 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083 STREEMENT OF DEFICIENCIES WEY MUST BE PRECEDED BY FULL RES DEPARTIENTS INFORMATION) R LSC DEPARTIENTS INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE APP DEFICIENCY) ID PREFIX TAG PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE APP DEFICIENCY) IS PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE APP DEFICIENCY) IS PROVIDERS PLAN OF CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE APP DEFICIENCY) IS PROVIDERS PLAN OF CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE APP DEFICIENCY) IS PROVIDERS PLAN OF CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE APP DEFICIENCY) IS PROVIDERS PLAN OF CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE APP DEFICIENCY) IS PROVIDERS ON OF CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE APP DEFICIENCY) IS PROVIDERS ON OF CORRECTIVE ACTION SH (CROSS-REFERENCED TO THE APP DEFICIENCY) the COUNT ACTIS	AND HUMAN SERVICES OMB N MEDICAID SERVICES OMB N (x1) PROVDERSUPPLENCUL USINTERCATION NUMBER: 345258 B VINC CCM 345258 B VINC CCS OF KANNAPOLIS STRTEMENT OF DEFICIENCIES STRTEMENT OF DEFICIENCIES STRTEMENT OF DEFICIENCIES STRTEMENT OF DEFICIENCIES STRTEMENT OF DEFICIENCIES RULDING STRTEMENT OF DEFICIENCIES STRTEMENT OF DEFICIENCIES RULDING STRTEMENT OF DEFICIENCIES STRTEMENT OF DEFICIENCY STRTEMENT OF DEFICIENCY STRTE

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/21/2019 MAPPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345258	B. WING				C 10/2019
	ROVIDER OR SUPPLIER ONAL HEALTH SERVICI	ES OF KANNAPOLIS		18	IREET ADDRESS, CITY, STATE, ZIP CODE 310 CONCORD LAKE ROAD ANNAPOLIS, NC 28083	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	resident 's physician order on hold or obta appropriate alternativ prescribed medicatio appropriate alternativ needed to call the ph medication to be sen once). 3) Resident #39 was 5/4/17 with a cumular included dementia ar A review of Resident included a current me milligrams (mg) done by mouth at bedtime Donepezil is a medic treatment of mild to s It is also used for der Parkinson 's disease A review of Resident Administration Recor present was conduct MARs indicated the f March 2019: 10 mg as administered once 4/23/19; May 2019: 10 mg of as administered once 5/4/19, 5/10/19, and June 2019: 10 mg of as administered once 5/4/19, 5/10/19, and June 2019: 10 mg of as administered once 5/4/19, 5/10/19, and June 2019: 10 mg of as administered once July 2019: 10 mg of	e expected to notify the to either put the medication in an order for an re available in-house until the n could be obtained. If no re was available, staff armacy and ask for the t out to the facility "STAT" (at admitted to the facility on tive diagnoses which nd Parkinson 's disease. #39 's physician 's order edication order for 10 pezil to be given as 1 tablet (start date 9/25/17). ation indicated for the evere Alzheimer 's disease. mentia associated with a. #39 's Medication ds (MARs) from 3/1/19 to ed. Documentation on the ollowing: g donepezil was documented a daily from 3/1/19-3/31/19; donepezil was documented a daily except on 4/22/19 and donepezil was documented a daily except on 5/1/19,	F	755			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	ED: 10/21/2019 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345258	B. WING		a	C 9/10/2019
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COL		
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	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 755	on 8/30/19; and, September 2019: 1 documented as admi on 9/2/19. A telephone interview 3:52 PM with a dispe worked for the facility During the interview, one month supply (30 was dispensed for Ref following dates during 5/22/19, 7/2/19, and 3 pharmacist reported of facility twice daily; on 12:00 PM and the set at 9:00 PM. Upon ind reported if a resident was needed before a facility could contact f would arrange to get retail pharmacy. A review of the facility medications stored in kit (known as an e-kit indicated the e-kit ind donepezil. A follow-up telephone 9/5/19 at 2:42 PM with the facility 's contract request, the pharmaco Resident #39's medic determined there wer	g donepezil was nistered once daily except 0 mg donepezil was nistered once daily except 2 was conducted on 9/4/19 at nsing pharmacist who 2's contracted pharmacy. the pharmacist reported a 0-count) of 10 mg donepezil esident #39 on each of the g the last 6 months: 2/21/19, 8/4/19. When asked, the deliveries were made to the e left the pharmacy around cond delivery shipment left quiry, the pharmacist ran out of a medication that scheduled delivery, the the pharmacy and they the medication at a local y ' s itemized list of a n emergency medication t) was conducted. The list eluded 4 - 5 mg tablets of the apharmacy. Upon cy manager reviewed	F 75	5		

Facility ID: 923060

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	<u>0. 0938-039</u> E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i		PLETED
		345258	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER	040200		STREET ADDRESS, CITY, STATE, ZIP CO		/10/2019
TDANSITI	ONAL HEALTH SERVICI			1810 CONCORD LAKE ROAD		
INANGIN				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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 755	Continued From page	e 57	F 75	5		
		#39 during the past 6	170			
	months. An interview was conducted on 9/6/19 at					
		lity 's Director of Nursing				
		ce of Corporate Consultant				
	-	lid not have any additional				
		ithdrawals of donepezil were				
	made from an e-kit fo	or Resident #39.				
	In the presence of Nu	urse #12, an observation of				
	•	med cart was conducted on				
		he observation revealed				
	there were 11 tablets	of 10 mg donepezil ble pack card dispensed				
		or Resident #39 on 8/4/19.				
	Nurse #12 confirmed	the number of donepezil				
	tablets remaining in t	he bubble pack card.				
		nducted on 9/6/19 at 11:00				
		Director of Nursing (DON).				
	•	the facility 's procedures for on needed for a resident				
		e DON reported if a resident				
		tion medication, she would				
	expect the nursing st if that particular medi	aff to check the e-kits to see				
		sing staff would be expected				
		's physician to either put the				
		hold or obtain an order for an				
		e available in-house until the n could be obtained. If no				
		ve was available, staff				
	needed to call the ph	armacy and ask for the				
		t out to the facility "STAT" (at				
		erview, the DON also expect documentation on the				
		t with the dispensing records				
	from the pharmacy.					1

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			MPLETED
						С
		345258	B. WING		09/10/2019	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICI	ES OF KANNAPOLIS		0 CONCORD LAKE ROAD NNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	Continued From page	e 58	F 758			
F 758	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)		F 758			10/8/19
	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compreh resident, the facility n §483.45(e)(1) Reside psychotropic drugs a unless the medication	hotropic drug is any drug that s associated with mental vior. These drugs include, drugs in the following ensive assessment of a				
	in the clinical record; §483.45(e)(2) Reside drugs receive gradua behavioral interventio	ents who use psychotropic al dose reductions, and				
	unless that medicatio	ursuant to a PRN order on is necessary to treat a ondition that is documented				
	are limited to 14 days	rders for psychotropic drugs s. Except as provided in attending physician or				

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/21/201 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345258	B. WING		09/10/2019	
NAME OF P	ROVIDER OR SUPPLIER	I	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
TDANGITI	ONAL HEALTH SERVICE		1	1810 CONCORD LAKE ROAD		
INANGIII	ONAL HEALTH SERVICE		I	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 758	beyond 14 days, he of rationale in the reside indicate the duration f §483.45(e)(5) PRN of drugs are limited to 14 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on medical re resident interviews, th monitoring for side ef medications for two of unnecessary medicat Resident #36). The findings included Resident #67 was ad The resident's cumula Chronic pain syndrom heart failure, adjustm depression, and psyce Resident #67 had a N 3/5/19 and timed 2:36	er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order. rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. T is not met as evidenced cord review, staff, and he facility failed to document fects of psychotropic of five residents reviewed for tions (Resident #67 and time tagnoses included: he, contracture, dementia, ent disorder, anxiety,	F 758	 F758 Resident #67 and #36 both received psychotropic medications. On 9/5/19 orders received for behavior monitori for both residents. Current residents who receive psychotropic medications have the potential to be affected. On 9/25/19 residents receiving psychotropic where reviewed to ensure behavior monitoring/side effects monitoring is place. Issues identified were addres The Assistant Director of Nursing and/or Nurse Management will educations for the station of the statio) ing ere in sed. ate	
	resident's door was d closed. The nurse do to corroborate the res interviews with other Review of Resident #			 residents who receive psychotropic medications by 10/8/19. The education will be included in Orientation for new hires. 4. Nurse Management/Administrative Nursing will audit behavior monitoring effect monitoring 3x week for 4 week 	v g/side	

Facility ID: 923060

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S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURV	<u>38-039</u> /EY
CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETE	
				С	
	345258			09/10/20	019
ROVIDER OR SUPPLIER				DDE	
ONAL HEALTH SERVICE	ES OF KANNAPOLIS				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE COM TE APPROPRIATE	(X5) MPLETION DATE
Continued From page	e 60	F 758	3		
documented on 3/8/1 4/9/19, and 4/15/19.	9, 3/21/19, 3/26/19, 4/5/19,		monthly for 3 months. The E	Director of	
3/25/19 and timed 5: the resident thought t	06 AM which documented there was someone playing		quality monitoring (audits) to Assurance Performance Im committee. The findings will monthly by the Quality Assu Improvement Committee mo	o the Quality provement I be reviewed rance pothly and	
9/4/19 revealed no di monitoring of potentia	scovery of recorded al side effects from		-	-	
revealed a Nursing P and timed 6:41 AM w resident rang multiple hallucinating with cor seeing a man. The r	rogress Note dated 6/30/19 /hich documented the e times through the night nplaints of a dog barking and esident was documented as				
A review completed of the Minimum Data Set (MDS) assessments for Resident #67 revealed the most recent completed assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 8/10/19. Review of the assessment revealed the resident was coded as having had no cognitive loss. The resident was coded as not having hallucinations or delusions during the assessment period. The resident was coded for a diagnosis of dementia. Further review revealed the resident was documented as having had received antipsychotic medications, antianxiety medications, and antidepressant medications					
	Continued From page documented on 3/8/1 4/9/19, and 4/15/19. Review of the progre 9/4/19 revealed no di monitoring of potentia psychotropic medicat Review of the progre 9/4/19 revealed no di monitoring of potentia psychotropic medicat Review of the progre nevealed a Nursing P and timed 6:41 AM w resident rang multiple hallucinating with cor seeing a man. The r having had a history A review completed of (MDS) assessments the most recent comp quarterly assessmen Reference Date (ARI assessment revealed having had no cognit coded as not having during the assessme coded for a diagnosis review revealed the r having had received	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345258 ROVIDER ONAL HEALTH SERVICES OF KANNAPOLIS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 60 documented on 3/8/19, 3/21/19, 3/26/19, 4/5/19, 4/9/19, and 4/15/19. Resident #67 had a Nursing Progress Note dated 3/25/19 and timed 5:06 AM which documented the resident thought there was someone playing instruments just to annoy her, and reorientation was ineffective. Review of the progress notes from 6/1/19 through 9/4/19 revealed no discovery of recorded monitoring of potential side effects from psychotropic medications. Review of the progress notes for Resident #67 revealed a Nursing Progress Note dated 6/30/19 and timed 6:41 AM which documented the resident rang multiple times through the night hallucinating with complaints of a dog barking and seeing a man. The resident was documented as having had a history of hallucinating. A review completed of the Minimum Data Set (MDS) assessments for Resident #67 revealed the most recent completed assessment Reference Date (ARD) of 8/10/19. Review of the assessment revealed the resident was coded as having had no cognitive loss. The resident was coded for a diagnosis of dementia. Further review revealed the resident was documented as having had no cognitive loss. The resident was coded for a diagnosis of dementia. Further review revealed the resident was documented as having had received antipsychotic medications, antianxiety medications, and antidepressant <td>IDENTIFICATION NUMBER: A BUILDING 345258 B. WING</td> <td>CORRECTION DENTIFICATION NUMBER: A BUILDING ABUILDING B WING STREET ADDRESS, CITY, STATE, 2P OC 180 CONCORD LAKE ROAD CONAL HEALTH SERVICES OF KANNAPOLIS STREET ADDRESS, CITY, STATE, 2P OC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 60 D PREFIX TAG PROVIDER'S PLAN OF C (EACH ORRECIVE ACTI CROSS-REFERENCE) TO TO DEFICIENCE Continued From page 60 F 758 then 1x weekly for 2 months monthly for 3 months. The E Quality months just to annoy her, and reorientation was ineffective. F 758 Review of the progress notes from 6/1/19 through 9/4/19 revealed no discovery of recorded monitoring of potential side effects from psychotropic medications. F 758 Review of the progress notes for Resident #67 revealed a Nursing Progress Note dated 6/30/19 and timed 6/41 AM which documented the resident rang multiple times through the night hallucinating with complaints of a dog barking and seeing a man. The resident was documented as having had a history of hallucinating. A review completed of the Minimum Data Set (MDS) assessment for Resident was a quarterly assessment time and sassesment Reference Date (ARD) of 8/10/19. Review of the assessment revealed the resident was coded as having had no cognitive loss. The resident was coded as not having hallucinations or delusions during the assessment period. The resident was coded as not having hallucinations, and antidepressant Herin Antice Preformance antinaxiey medications,</td> <td>predencies connection (x1) PROVIDERSUPPLEXCUA DENTIFICATION NUMBER: 345258 (x2) MULTIPLE CONSTRUCTION A BULDING BUDDING (x3) DENTIFICATION NUMBER: A BULDING (x3) DENTIFICATION NUMBER: BUDDING (x4) DENTIFICATION NUMBER: BUDDING <t< td=""></t<></td>	IDENTIFICATION NUMBER: A BUILDING 345258 B. WING	CORRECTION DENTIFICATION NUMBER: A BUILDING ABUILDING B WING STREET ADDRESS, CITY, STATE, 2P OC 180 CONCORD LAKE ROAD CONAL HEALTH SERVICES OF KANNAPOLIS STREET ADDRESS, CITY, STATE, 2P OC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Continued From page 60 D PREFIX TAG PROVIDER'S PLAN OF C (EACH ORRECIVE ACTI CROSS-REFERENCE) TO TO DEFICIENCE Continued From page 60 F 758 then 1x weekly for 2 months monthly for 3 months. The E Quality months just to annoy her, and reorientation was ineffective. F 758 Review of the progress notes from 6/1/19 through 9/4/19 revealed no discovery of recorded monitoring of potential side effects from psychotropic medications. F 758 Review of the progress notes for Resident #67 revealed a Nursing Progress Note dated 6/30/19 and timed 6/41 AM which documented the resident rang multiple times through the night hallucinating with complaints of a dog barking and seeing a man. The resident was documented as having had a history of hallucinating. A review completed of the Minimum Data Set (MDS) assessment for Resident was a quarterly assessment time and sassesment Reference Date (ARD) of 8/10/19. Review of the assessment revealed the resident was coded as having had no cognitive loss. The resident was coded as not having hallucinations or delusions during the assessment period. The resident was coded as not having hallucinations, and antidepressant Herin Antice Preformance antinaxiey medications,	predencies connection (x1) PROVIDERSUPPLEXCUA DENTIFICATION NUMBER: 345258 (x2) MULTIPLE CONSTRUCTION A BULDING BUDDING (x3) DENTIFICATION NUMBER: A BULDING (x3) DENTIFICATION NUMBER: BUDDING (x4) DENTIFICATION NUMBER: BUDDING <t< td=""></t<>

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		345258	B. WING				_ 10/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 758	(MAR) from 8/1/19 the discovery of recorded of hallucinations or po- psychotropic medicat Review of Resident # Administration Record revealed the resident received the following tablet (an antidepress orally once daily, at 9 date of 2/1/19, Quetia antipsychotic) tablet 5 bedtime each night, a psychosis-order date Hydrochloride (HCI) (Extended Release (E two times a day, at 9: depression-order date (an anti-anxiety medic three times a tay, at 9: depression-order date (an anti-anxiety medic three times	rough 9/4/19 provided no I monitoring or observations obtential side effects from ions. 67's Medication d from 9/1/19 through 9/4/19 was prescribed and g: Escitalopram Oxalate sant) 20 milligrams (mg) :00 AM, for depression-order upine Fumarate (an 50 mg one tablet orally at it 9:00 PM, for of 6/18/19, Bupropion an antidepressant) R) 100 mg one tablet orally 00 AM and 5:00 PM, for e of 1/31/19, and Alprazolam cation) 1 mg one tablet orally 9:00 AM, 1:00 PM, and 8:00 date of 1/31/19.	F	758			

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	-	D HUMAN SERVICES			FOR	D: 10/21/2019 M APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	D. 0938-0391 E SURVEY PLETED
		345258	B. WING			C / 10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1810 CONCORD LAKE ROAD		
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS	1	KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 758	with Nurse #5. She s hallucinations includir facility whose name w flute, and he had a do During an interview of AM Nurse #13 she sta was assigned to Resi shift (7:00 AM to 3:00 not observed Resider effects from psychotro nurse stated the resid psychotropic medicati would not document p effects. She further s the MAR or the TAR t hallucinations the resi basically chart them in An interview was cond AM with Nurse #11. S	ducted on 9/4/19 at 2:53 PM tated Resident #67 did have ong there was a person at the vas Kevin, who plays the org. onducted on 9/5/19 at 10:35 ated she was the nurse who dent #67 and worked first PM). She stated she had of #67 to have had any side opic medications. The lent did not receive any ions during her shift, so she osychotropic medication side tated there was no area in o document the ident had and she would just in the nurses' notes. ducted on 9/5/19 at 11:21 She stated she was the Unit is aware of Resident #67's	F 758			
	was working with the there should be an ar- document the residen and side effects of ps She further stated sor were doing orders the of medications or beh She said at one time a resident's MAR but it current MAR. The nu the monitoring for psy effects on to the reside An interview was con-	tated psychiatric services resident. The nurse stated ea in her TAR or MAR to t's hallucinations behaviors ychotropic medications. metimes when the nurses e monitoring for side effects aviors will "fall off" the MAR. she thought it was on the was not on the resident's rse stated she would add chotropic medication side ent's MAR. ducted on 9/5/19 at 4:41 PM ursing (DON). The DON				

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		345258	B. WING				_ 10/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 000	
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 SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	stated she was aware hallucinations. She a such as hallucinations MAR to be monitored resident was on psych should be monitoring MAR. The DON revie and stated there was resident's MAR for ha of psychotropic medic sure why the monitoring MAR. The DON state is entered into the MA side effects of psycho monitoring may have was not entered initia her expectation for be hallucinations and mo effects of psychotropi resident's active and An interview was con AM with the Administi was her expectation f monitor for side effect medications. 2. Resident #36 was 4-2-19 with multiple d cellulitis of the left low dementia, major depr disorder with delusior The quarterly Minimu 7-10-19 revealed Res cognitively impaired a medication 7 out of 7	e Resident #67 had lso stated usually a behavior s would be on the resident's . The DON stated when a hotropic medications there recorded in the resident's ewed Resident #67's MAR no monitoring on the illucinations or side effects cations and she was not ng was not on the resident's ed sometimes when an item AR such as monitoring for otropic medications the an expiration date and the come off or the monitoring Ily. The DON stated it was ehavior monitoring for onitoring of potential side c medications to on the current MAR.	F	758	8		

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 10/21/2019 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345258	B. WING					C 10/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP C	ODE		
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS			810 CONCORD LAKE ROAD ANNAPOLIS, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD B		(X5) COMPLETION DATE
F 758	Continued From page	9 64	F	758				
	9-3-19 did not reveal	ess notes dated 7-13-19 to any monitoring of behaviors esident #36's medication.						
	(MAR) was reviewed revealed no monitorin	ation Administration Record from 7-1-19 to 9-4-19 which og of the resident's acts from her medication.						
	a goal that the resider psychotropic drug rela interventions for that a monitor for side effect effectiveness every sl	ated complications. The goal included in part;						
	revealed an order for	cians' orders dated 8-20-19 Seroquel (antipsychotic illigrams) in the morning and for anxiety.						
	2:35pm, the nurse sta combative, confused times. She also stated resident's behavior an were on the medicatio (MAR) and that a brie medical records. Nurs the last time she docu effects on the MAR as record. When asked,	with nurse #1 on 9-4-19 at ated Resident #36 had been and refusing medication at d the monitoring of the nd side effects to medication on administration record of narrative should be in the se #1 was unable to state umented behaviors or side s well as in the medical the nurse stated she had Resident #36's behaviors or medication.						
	Nurse #4 was intervie	ewed on 9-4-19 at 4:20pm.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345258	B. WING				C 10/2019
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	The nurse stated Res effects and behaviors MAR. She reviewed F stated, "she doesn't h she should." When as did not remember mo effects form her medi last few times I worke The Director of Nursir on 9-4-19 at 4:30pm. resident had behavior medication, the nurse physician's communic nurses should be more assessment tool that stated she did not knot have the assessment During an interview w on 9-5-19 at 3:30pm, saw the resident mone staff to be monitoring #36's behaviors and s medication on the MA review the monitoring reviewed the assess report any irregularities The Psychiatrist assis 9-5-19 at 4:20pm. The the MAR of the resider there was a monitoring resident side effects a stated she reviewed t	ident #36's medication side were documented on the Resident #36's MAR and ave it on there to assess but sked, Nurse #4 stated she nitoring the residents side cation or her behaviors "the ad." ng (DON) was interviewed The DON stated if a rs or side effects from their rs would leave a note in the cation notebook, but the nitoring every shift with the was on the MAR. She also by why Resident #36 did not on her MAR. with the facility's Psychiatrist the Psychiatrist stated he thly and that he expected and assessing Resident side effects of her R. He also stated he did not tool but that his assistant nent on the MAR and would es to him. stant was interviewed on e assistant denied reviewing ents and denied knowing ig tool on the MAR for and behaviors. The assistant he physician's orders but did oring of side effects from ors. She also stated she had mation from staff that	F	758			

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		ID HUMAN SERVICES MEDICAID SERVICES		(FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345258	B. WING		C 09/10/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		810 CONCORD LAKE ROAD	
(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 APPROPRIA DEFICIENCY)	
F 758	Continued From page	€ 66	F 758		
F 759 SS=E	 9-10-19 at 3:40pm. T had diagnosed Resid disorder with delusion resident seeing family middle of the night ar trying to find objects to The Administrator wa 12:20pm. The Admini know why some resid for side effects from r and other residents d residents' behaviors a medication to be mor Free of Medication Eff CFR(s): 483.45(f)(1) §483.45(f) Medication The facility must ensu §483.45(f)(1) Medication The facility must ensu §483.45(f)(1) Medication The facility must ensu §483.45(f)(1) Medication record reviews, the fa medication error rate evidenced by 5 medic medication opportuni medication error rate 	s interviewed on 9-6-19 at istrator stated she did not dents had the monitoring tool medication and behaviors id not but that she expected and side effects from their nitored. rror Rts 5 Prent or More n Errors. ure that its- tion error rates are not 5 T is not met as evidenced ans, staff interviews, and acility failed to have a of less than 5% as cation errors out of 26 ties, resulting in a of 19.2% for 3 of 7 residents ent #282, and Resident ag medication pass.	F 759	F759 1. Nurse #11 educated by Director of Nursing 9/3/19 on checking emergency for resident #24 medication that was no available and on the differences betwee Senna vs Senna S. Nurse #8 is no long employed at facility. Nurse #2 educated by Director of Nursing regarding administration of medication within one hour of scheduled time. Medication Error Reports completed for each incident wit notification to Physician.	t ger ger gor

Event ID: GVW611

Facility ID: 923060

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	F DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					с
		345258	B. WING		09/10/2019
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	
				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 OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIC
F 759	Continued From page	<u>- 67</u>	F 75	0	
1 100		pared medications for	175	5	
		ident #24. The medications		2. Current residents have the pote	ential to
		stration to Resident #24		be affected. On 9/30/19 medication	
	included 50 milligram			audited to current residents med	
antidepr medicat	antidepressant). The			record to ensure medications avai	lable.
	medication was not o	n the med cart and she		Issues identified were addressed.	
	would need to call the	e pharmacy to have the		Standardized Medication Pass tim	
	sertraline sent out.			established based on location (roc	
				number) to ensure timely administ	
in		#24 's physician 's orders		residents□ medication times upda	ited.
		edication order for 50 mg		2. The Assistant Director of Nursin	
	-	aline to be given as one tablet by mouth one a day. The medication was scheduled to be		3. The Assistant Director of Nursin and/or Nurse Management will ed	-
	administered at 9:00			licensed nurses on Medication	
	Review of the resider	at ' a Madiantian		Administration, Medication Pass T and Medication Availability	imes,
		d (MAR) conducted on		(Ordering/Reordering Process,	
		evealed Resident #24 did not		Emergency Medication Kit, and Ba	ack-up
		traline at any time on 9/3/19.		Pharmacy) by 10/8/19. The educa be included in Orientation for new	ation will
	On 9/4/19 at 2:00 PM	l, a review of an itemized list			
	of medications stored			4. Nurse Management will observe	e 2
		l kit (known as an e-kit) in		nurses pass medications for 5 res	
		ge room was conducted.		during medication administration p	
		e-kit contained 4 - 50 mg		on random shifts to include all shif	
		e 50 mg sertraline tablets		weekends 3x week for 4 weeks, th	
	that time.	o be stored in the e-kit at		weekly for 2 months and then 1x r for 3 months.	nonuniy
				The Director of Nursing will report	on the
	An interview was con	ducted on 9/4/19 at 4:25 PM		results of the quality monitoring (a	
		ng the interview, the med		the Quality Assurance Performance	-
		observed on 9/3/19 (which		Improvement committee. The find	
	omitted Resident #24			be reviewed monthly by the Qualit	-
	-	oon inquiry, Nurse #11		Assurance Improvement Committe	
		think she had checked the		monthly and audits updated if cha	-
	-	availability of sertraline on		are needed based on findings. Th	ie
		knowledged she did not		Quality Assurance Improvement	
		line doses to Resident #24 and what the facility ' s		Committee meets monthly and as needed.	

Facility ID: 923060

			FOF	ED: 10/21/2019 RM APPROVED O. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DAT	E SURVEY IPLETED
345258	B. WING		09	C 9/10/2019
	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	18	10 CONCORD LAKE ROAD		
	ĸ	ANNAPOLIS, NC 28083		
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
she should do if a medication the med cart to be ident at the time it was 1 reported she should first go he med was available. If not, other med room to check if e in a second e-kit stored f she had taken these steps, he did not. She confirmed receive the sertraline as ducted on 9/6/19 at 11:00 Director of Nursing (DON). observations from the med vere discussed. The DON tion medication was not ed cart, she would expect the take e-kits to see if that was available in-house. If uld notify the resident 's at the medication order on er for an appropriate n-house until the prescribed obtained. If no appropriate able, staff needed to call the r the medication to be sent AT" (at once). 9 AM, Nurse #11 was bared medications for ident #24. The medications ontaining 8.6 milligrams (mg) stimulant) taken from a the stored on the med cart.	F 759			
	IDENTIFICATION NUMBER: 345258 ES OF KANNAPOLIS ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 68 she should do if a medication the med cart to be ident at the time it was 1 reported she should first go he med was available. If not, other med room to check if le in a second e-kit stored f she had taken these steps, he did not. She confirmed receive the sertraline as aducted on 9/6/19 at 11:00 Director of Nursing (DON). observations from the med vere discussed. The DON tion medication was not ed cart, she would expect the a the e-kits to see if that was available in-house. If uld notify the resident 's at the medication order on er for an appropriate in-house until the prescribed obtained. If no appropriate able, staff needed to call the r the medication to be sent AT" (at once). 9 AM, Nurse #11 was bared medications for sident #24. The medications ontaining 8.6 milligrams (mg) stimulant) taken from a the stored on the med cart. #24 's physician 's orders	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING	MEDICAID SERVICES (x1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 345258 B. WING STREET ADDRESS, CITY, STATE, 2IP CODE 1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORT (EACH CORRECTIVE ACTIONS CROSS-REFERENCED TO THE DEFICIENCY) e 68 F 759 F 759 e 68 F 759 F 759 e dodd to if a medication the med cart to be ident at the time it was 1 reported she should first go he med was available. If not, there medication for the med vere discussed. The DON toon medication was not ed cart, she would expect the the medication order on er for an appropriate able, staff needed to call the r the medication to propriate able, staff needed to call the r the medication to for ident #24. The medications fortaining 8.6 milligrams (mg) stimulant) taken from a lie stored on the med cart. #24 's physician 's orders	UD HUMAN SERVICES OMB N MEDICAID SERVICES OMB N (1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (2) MULTIPLE CONSTRUCTION A BUILDING (2) (2) OMD 345258 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1310 CONCORD LAKE ROAD KANNAPOLIS 1310 CONCORD LAKE ROAD KANNAPOLIS, NC 20083 0 ATEMENT OF DEFICIENCIES SC DEMTIPYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION BHOLD BE (EACH CORRECTIVE ACTION BEFICIENCY) a 68 F 759 be add taken these steps, he did not. She confirmed receive the sertraline as adducted on 9/6/19 at 11:00 Director of Nursing (DON), observations from the med vere discussed. The DON tion medication was not ad cart, she would expect the the e-kits to see if that was available in-house. If ult the medication so prestile able, staff needed to call the r the medications for ident #24. The medications ontaining 8.6 milligrams (mg) stimulant) taken from a the stored on the med cart. #24 's physician 's orders

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		UILDING COMP		(X3) DATE COMP	E SURVEY PLETED
		345258	B. WING				C /10/2019
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 759	 day for constipation (if combination medication included two active in docusate (a stool soft of sennosides. An interview was con AM with Nurse #11. If reviewed the labeling containing the medicates well as the order of Administration Record the stock bottle, only identified as an active labeling on another stimed cart revealed this medication which con and 8.6 mg of sennos acknowledged she did combination medicati physician. An interview was con AM with the facility's I During the interview, administration observed observed as she prepadministration to Res medications schedule Resident #282 include amlodipine (an antihy given as 1 and ½ table 	nitiated on 5/29/19). The on ordered for Resident #24 gredients, including 50 mg ener) in addition to 8.6 mg ducted on 9/3/19 at 11:48 Jpon inquiry, the nurse on the stock bottle ation given to the resident, in Resident #24's Medication d (MAR). Upon review of 8.6 mg sennosides was e ingredient. Review of the tock bottle located on the s was a combination itained both 50 mg docusate sides. The nurse d not give the resident the on as ordered by the ducted on 9/6/19 at 11:00 Director of Nursing (DON). the medication ations were discussed. The puld expect nursing staff to edication, dose, patient and ere observed during med AM, Nurse #8 was pared medications for ident #282. The ed for administration to	F	759	9		

Facility ID: 923060

If continuation sheet Page 70 of 91

		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · · ·	E SURVEY IPLETED
		345258	B. WING		C 09/10/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
TRANSITI	IONAL 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	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 759	amlodipine available resident (only the ½ t #8 stated she would r have the medication s inquiry, the nurse stat come from the pharm However, she was no would come in to the evening. On 9/4/19 a observed as she adm Resident #282. Amlo to the resident at that resident ' s Septembe Administration Record administered. A review of Resident included a current me amlodipine to be give tablets (total dose of day. The medication administered at 9:00 A follow-up interview 2:00 PM with Nurse # Nurse #8 stated the f	on the med cart for the ablet was available). Nurse need to call the pharmacy to sent out. Upon further ted the medication would hacy sometime today. It sure if the medication facility that afternoon or at 11:30 AM, Nurse #8 was hinistered the medications to oblipine was not administered time; documentation on the er 2019 Medication d (MAR) indicated it was not #282 's physician 's orders edication order for 5 mg in as one and one-half 7.5 mg) by mouth one time a was scheduled to be	F 759			
	conducted; the list inc amlodipine. When th included amlodipine, medication could hav Resident #282 during reported she would d dose ordered for the	se #8, a review of the ations stored in the e-kit was cluded 4 - 5 mg tablets of e nurse was shown the list she was asked if this e possibly been used for the med pass. Nurse #8 ouble check the amlodipine resident and could use this amlodipine had not yet				

Facility ID: 923060

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 10/21/2019 MAPPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		345258	B. WING			C / 10/2019	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
			1	810 CONCORD LAKE ROAD			
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS	н	ANNAPOLIS, NC 28083			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 759	Continued From page	271	F 759				
	MAR revealed a seco by Nurse #8 to indicat administered on 9/4/1 An interview was com AM with the facility's ID During the interview, or administration pass were ported if a prescript available from the me nursing staff to check particular medication not, nursing staff should physician to either pur hold or obtain an order alternative available in medication could be or alternative was availad pharmacy and ask for out to the facility "STA 4) On 9/4/19 at 11:20 observed as she prep administration to Resi	9. ducted on 9/6/19 at 11:00 Director of Nursing (DON). observations from the med ere discussed. The DON ion medication was not d cart, she would expect the the e-kits to see if that was available in-house. If uld notify the resident ' s t the medication order on er for an appropriate n-house until the prescribed obtained. If no appropriate ble, staff needed to call the the medication to be sent xT" (at once). AM, Nurse #8 was ared medications for ident #282. The d for administration to					
	losartan (an antihyper given as 100 mg (2 ta day. The nurse repor this medication so it n the pharmacy. Upon stated the medication pharmacy sometime t not sure if the medica	tensive medication) to be blets) by mouth one time a ted the resident was out of eeded to be ordered from further inquiry, the nurse would come from the oday. However, she was tion would come in to the or evening. On 9/4/19 at					
	administered the prep						

Facility ID: 923060

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/21/2019 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345258	B. WING _				C 10/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			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	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 759	Resident #282. Losartan was not administered to			759			
	the resident at that tir	ne; documentation on the n Administration Record					
	included a current me milligrams (mg) losar medication) to be give mouth one time a day	#282 ' s physician ' s orders edication order for 50 tan (an antihypertensive en as 100 mg (2 tablets) by /. The medication was inistered at 9:00 AM each					
	2:00 PM with Nurse # Nurse #8 stated the fill medications in the en an e-kit) stored in the Accompanied by Nur- itemized list of medica conducted; the list inc losartan. When the n included losartan, she medication could hav Resident #282 during reported she would cl ordered for the resider	se #8, a review of the ations stored in the e-kit was cluded 4 - 25 mg tablets of surse was shown the list e was asked if this e possibly been used for the med pass. Nurse #8 heck the losartan dose					
	AM with the facility's During the interview,	ducted on 9/6/19 at 11:00 Director of Nursing (DON). observations from the med vere discussed. The DON					

Facility ID: 923060

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345258	B. WING				C / 10/2019
NAME OF P	ROVIDER OR SUPPLIER				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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 759	reported if a prescript available from the me nursing staff to check particular medication not, nursing staff shou physician to either pu hold or obtain an orde alternative available in medication could be of alternative was availa pharmacy and ask for out to the facility "STA 5) On 9/4/19 at 11:40 observed as she prep administration to Res medications schedule Resident #283 include milligrams (mg) cefpor medication was admi 9/4/19 at 11:41 AM. A review of Resident included a current me cefpodoxime to be giv every 12 hours. The to be administered at day. According to Lexi-Con electronic medication professionals, cefpod is approximately 2-3 h half-life). A drug 's h for the concentration to decrease by half. An interview was con	ion medication was not ed cart, she would expect the the e-kits to see if that was available in-house. If uld notify the resident 's t the medication order on er for an appropriate n-house until the prescribed obtained. If no appropriate able, staff needed to call the r the medication to be sent AT" (at once). AM, Nurse #2 was bared medications for ident #283. The ed for administration to ed one tablet of 200 bdoxime (an antibiotic). The nistered to the resident on #283 's physician 's orders edication order for 200 mg ven as one tablet by mouth medication was scheduled 9:00 AM and 9:00 PM each	F	759	Ξ		

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 10/21/2019 MAPPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		PLETED
		345258	B. WING			C / 10/2019
NAME OF PF	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS		1810 CONCORD LAKE ROAD		
				KANNAPOLIS, NC 28083		1
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 759	Continued From page	e 74	F 75	59		
	time versus the actual observed for the reside (particularly the cefpor responded by saying, morning."	dent's medications				
F 761 SS=D	AM with the facility's During the interview, during the medication discussed. The DON an antibiotic such as	-	F 76	51		10/8/19
	§483.45(g) Labeling of Drugs and biologicals	of Drugs and Biologicals s used in the facility must be with currently accepted s, and include the y and cautionary				
	§483.45(h) Storage o	f Drugs and Biologicals				
	Federal laws, the fact biologicals in locked of	ordance with State and ility must store all drugs and compartments under proper and permit only authorized cess to the keys.				
	locked, permanently storage of controlled the Comprehensive E	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to				

Facility ID: 923060

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · · ·	ATE SURVEY OMPLETED
		345258	B. WING			C 09/10/2019
NAME OF P	ROVIDER OR SUPPLIER			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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 761	Continued From page	e 75	F 76	61		
	package drug distribu quantity stored is min be readily detected. This REQUIREMENT by: Based on observation facility failed to discar of 3 medication carts Cart and 600 Hall Me medications with a sh Hall Med Cart). The findings included 1) In the presence of was conducted of the 9/4/19 at 2:25 PM. The observation reve Solostar (insulin) pen on 5/9/19 and labeled was stored on the me pen was dated as ha 6/30/19 and was date date of 7/27/19. The placed on the insulin opened. Discard unu days." At the time of reported the opened needed to be discard A review of the manu instructions indicated that have been punct within 28 days.	Nurse #8, an observation a 300 Hall Med Cart on ealed an opened Lantus dispensed by the pharmacy d for use by Resident #22 edication cart. The insulin ving been opened on ed also with an expiration pharmacy auxiliary sticker pen read, "Refrigerate until used medication aft (after) 28 the observation, Nurse #8 insulin pen was expired and led. facturer 's storage that Lantus prefilled pens stured (in use) should be used		 F761 Expired medications (irresident #22, resident #42 discarded and reordered Current residents who have the potential to be a completed on 9/25/19 of rinsulin orders to ensure irrexpired and labeled correcarts checked on 9/25/19 medications. Issues iden addressed. The Assistant Director Management will reeducat nurses by 10/8/19 on Medand Expiration Dating of Neducation will be included for new hires. Nurse Management/Act Nursing will audit 2 medic week for 4 weeks, then 12 months and then 1x month The Director of Nursing wiresults of the quality monit the Quality Assurance Pe Improvement committee. be reviewed monthly by the section of the sectio	2, and #44 were from pharmacy. receive insulin ffected. Audit residents with nsulin on cart not ectly. Medication for expired tified were of Nursing/Nurse ate licensed dication Storage Medications. The d in Orientation diministrative cation carts 3x x weekly for 2 thly for 3 months. vill report on the itoring (audits) to rformance The findings will he Quality	
		ent's physician orders 22 had a current order for the		Assurance Improvement monthly and audits updat are needed based on find	ed if changes	

Facility ID: 923060

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		O. 0938-039 E SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · /	PLETED		
						С		
		345258	B. WING		09	/10/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 761	Continued From page	e 76	F 761					
	AM with the facility 's Upon inquiry, the DO expected to mark insu- they were opened to insulin was opened o expiration date; and, discarded. 2) In the presence of was conducted of the 9/3/19 at 3:50 PM. The observation reve (insulin) pen dispense 6/24/19 and labeled f stored on the medica was dated as having The pharmacy auxilia bag containing the insu- until opened. Discard (after) 28 days." The was calculated to be observation, Nurse #8 insulin pen was expired discarded. A review of Resident the resident had a cu A review of the manur- instructions indicated that have been punct within 28 days. A review of the resider	#42's MD orders revealed rrent order for Basaglar. facturer ' s storage that Basaglar prefilled pens ured (in use) should be used		Quality Assurance Improvement Committee meets monthly and a needed.				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED C
		345258	B. WING				/10/2019
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
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 SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	AM with the facility 's Upon inquiry, the DO expected to mark insu- they were opened to insulin was opened of expiration date; and, of discarded. 3) In the presence of was conducted of the 9/4/19 at 2:25 PM. The observation reve Humalog insulin disper 7/9/19 and labeled for stored on the medicar Humalog insulin was been opened. At the Nurse #8 reported sh of insulin had been op A review of the manu- instructions indicated use), vials should be A review of Resident revealed the resident order for Humalog insu- An interview was con AM with the facility 's Upon inquiry, the DO were expected to man- when they were open- the insulin was opene- expiration date. 4) In the presence of	ducted on 9/6/19 at 11:00 a Director of Nursing (DON). N reported nursing staff was ulin pens and vials when indicate either the date the r the insulin 's shortened expired insulin should be Nurse #8, an observation 300 Hall Med Cart on aled an opened vial of ensed by the pharmacy on r use by Resident #44 was tion cart. The opened vial of not dated as to when it had time of the observation, e did not know when the vial bened. facturer 's storage that once punctured (in used within 28 days. #44's physician orders had a current medication	F	761			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/21/2019 M APPROVEE D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		NSTRUCTION	СОМ	E SURVEY PLETED C
		345258	B. WING _				/10/2019
	ROVIDER OR SUPPLIER ONAL HEALTH SERVICE	ES OF KANNAPOLIS		1810	ET ADDRESS, CITY, STATE, ZIP CODE CONCORD LAKE ROAD NAPOLIS, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 761 F 806 SS=B	Humalog insulin disper 7/31/19 was stored of opened vial of Humal to when it had been of observation, Nurse # when the vial of insul A review of the manu- instructions indicated use), vials should be A review of Resident revealed the resident order for Humalog ins An interview was con AM with the facility 's Upon inquiry, the DO were expected to ma when they were open the insulin was opene expiration date. Resident Allergies, PI CFR(s): 483.60(d)(4) §483.60(d) Food and Each resident received §483.60(d)(5) Appeal nutritive value to reside food that is initially se different meal choice	aled an opened vial of ensed for Resident #44 on in the medication cart. The og insulin was not dated as opened. At the time of the 8 reported she did not know in had been opened. facturer 's storage that once punctured (in used within 28 days. #44's physician orders had a current medication sulin. ducted on 9/6/19 at 11:00 b Director of Nursing (DON). N reported nursing staff rk insulin pens and vials ted to indicate either the date ed or the insulin 's shortened references, Substitutes (5) drink es and the facility provides- nat accommodates resident s, and preferences; ling options of similar dents who choose not to eat erved or who request a		306			10/8/19

Facility ID: 923060

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 10/21/2019 RM APPROVED IO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	PLE CONSTRUCTION	(X3) DA	E SURVEY IPLETED
		345258	B. WING _		0	C 9/10/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		
				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 OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 806	Continued From page	e 79	F 8	06		
	facility failed to honor from 2 of 5 tray carts preferences resulting tuna fish sandwiches a dislike on their tray and #63). Findings included: 1. Resident #13 was 6/6/17. Review of the Minimum Data Set (N with an Assessment N 7/4/19, revealed the r having had intact cog During an interview of an observation of the started at 4:49 PM, D dining room tray cart kitchen and be delive Resident #13's tray w fish sandwich on the #13's tray card, which revealed a preference During the observatio 4:49 PM, an interview Dietary Manager (DM card did identify the r	in three residents receiving despite having fish listed as cards (Residents #13, #27 admitted to the facility on e resident's most recent MDS), which was a quarterly Reference Date (ARD) of resident was coded as phition. conducted in conjunction with tray line on 9/4/19, which Dietary Aide #1 stated the was ready to leave the ored to the residents. vas observed to have a tuna plate. A review of Resident in was on the resident's tray,		F 806 1. Residents who had receive were immediately interviewed their preferences of fish/tuna Immediate changes were ma cards. 2. Residents who receive foo the kitchen have potential to A 100% audit of all residents 10-2/10-4 2019 by the Certifi Manager to review all resider preference food likes/dislikes completed for current resider updates were made as need residents will have preference within 24 hours of admit. 3. Executive Director/designed Healthcare Services Certified Manager on the importance of Resident Allergies, Preference Substitutes. In-servicing was Healthcare Services kitchen Certified Dietary Manager to preferences are completed w hours of admission for new m Also Healthcare Services sta in-serviced that if a meal tray reflect the tray card then it is changed/substituted. 4. Certified Dietary Manager	d to clarify fish. ade to the tray od trays from be affected. was done on red Dietary nts is it was nts and ed. All new res procured d Dietary fied Dietary of F 806 ces, and done with staff by ensure that vithin 24 esidents. aff was y does not	
	have received tuna fit information regarding no fish. The DM state the dietary staff to fol	ated the resident should not sh due to the tray card the resident's request for ed it was her expectation for low the information on the ng food for the residents.		copies of preference sheets admits to Executive Director/ who will monitored 3 x weeks then 1x week for 2 months a monthly for 3 months. The fi reviewed monthly by the Qua	/Designee s for 4 weeks, nd then 1x indings will be	

Facility ID: 923060

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				PLE CONSTRUCTION		10. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	G		IE SURVEY MPLETED
						С
		345258	B. WING		0	9/10/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
TRANSITI	ONAL HEALTH SERVIC	ES OF KANNAPOLIS		1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 806	Continued From pag	e 80	F 80	06		
	The DM further state	d sometimes a resident may		Assurance Improvement C	Committee	
		es not want other fish. She		monthly and audits update	-	
	stated she would pre the resident and ther	pare an alternate plate for		are needed based on findi Quality Assurance Improve	•	
	to verify her preferen	•		Committee meets monthly		
				needed.		
	•	conducted on 9/6/19 at 11:43				
e	AM the Administrator					
	-	ry staff and nursing staff to nd follow the resident's				
	-	ences. The Administrator				
		pected for clarification of				
		resident tray cards in the				
	to have tuna fish.	s not want fish but would like				
		s admitted to the facility on he resident's most recent				
		uarterly with an ARD of				
		e resident was coded as				
	having had intact coo	gnition.				
	During an interview o	conducted in conjunction with				
		e tray line on 9/4/19, which				
	started at 4:49 PM, E	Dietary Aide #1 stated the 300				
		ady to leave the kitchen and				
		esidents. Resident #27's tray e a tuna fish sandwich on				
		esident #27's tray card, which				
	-	s tray, revealed a fish was				
	listed as a dislike.					
	During the observation	on on 9/4/19, which started at				
	-	w was conducted with the				
		A). The DM stated the tray				
		resident did not want fish and				
		had been plated for the ated the resident should not				
	have received tuna fi					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345258	B. WING_				C 10/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS			810 CONCORD LAKE ROAD ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 806	 information regarding dislike of fish. The DI expectation for the did information on the tra for the residents. The sometimes a resident does not want other fi prepare an alternate of then follow up with Re preference. During an interview of AM the Administrator expectation for dietary read the tray cards an identified food prefere further stated she exp likes and dislikes on r event a resident does to have tuna fish. Resident #63 was facility on 3/11/19 and readmitted on 8/22/19 most recent MDS, wh ARD of 8/6/19, reveal as having had intact of During an interview of an observation of the started at 4:49 PM, D Hall tray cart was rea be delivered to the re was observed to have plate. A review of Re was on the resident's of no fish. 	the resident's identified M stated it was her etary staff to follow the y cards when plating food e DM further stated may want tuna fish but ish. She stated she would plate for the resident and esident #27 to verify her onducted on 9/6/19 at 11:43 stated it was her y staff and nursing staff to hd follow the resident's ences. The Administrator bected for clarification of resident tray cards in the s not want fish but would like originally admitted to the d was most recently 0. Review of the resident's hich was a quarterly with an led the resident was coded	F	306			

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TATEMENT OF DEFICIENCIES (ND PLAN OF CORRECTION		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	OMB NO. 093 (X3) DATE SURVE COMPLETED	
		345258	B. WING			C
NAME OF PF	ROVIDER OR SUPPLIER	010200		REET ADDRESS, CITY, STATE, ZIP CODE	0:	0/10/2019
				10 CONCORD LAKE ROAD		
FRANSITI	ONAL HEALTH SERVICE	ES OF KANNAPOLIS	КА	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 806	Continued From page	e 82	F 806			
	4:49 PM, an interview	v was conducted with the				
		1). The DM stated the tray				
		esident did not want fish and had been plated for the				
		ated the resident should not				
		sh due to the tray card				
	information regarding dislike of fish. The D	the resident's identified				
		etary staff to follow the				
	information on the tra	y cards when plating food				
	for the residents. The	e DM further stated t may want tuna fish but				
		ish. She stated she would				
		plate for the resident and				
	-	esident #63 to verify her				
	•	observation revealed a tray lent which identified a				
		but tuna OK. The DM				
	stated when she iden					
		a fish was OK, she would put e tray card in a similar				
	manner.					
	During an interview c	onducted on 9/6/19 at 11:43				
	AM the Administrator					
		y staff and nursing staff to nd follow the resident's				
	2	ences. The Administrator				
	further stated she exp	pected for clarification of				
		resident tray cards in the s not want fish but would like				
	to have tuna fish.	s not want lish but would like				
	Food Procurement,St	tore/Prepare/Serve-Sanitary 2)	F 812			10/8/19
	§483.60(i) Food safe	h roquiromonto				

Facility ID: 923060

If continuation sheet Page 83 of 91

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				OMB NC	MAPPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345258	B. WING				(10/2019
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSITI	ONAL HEALTH SERVIC	ES OF KANNAPOLIS			810 CONCORD LAKE ROAD ANNAPOLIS, NC 28083		
			ID		PROVIDER'S PLAN OF CORRECTION	1	(NE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 812	Continued From page	<u>- 83</u>	F	812			
1 012				012			
	§483.60(i)(1) - Procu	re food from sources red satisfactory by federal,					
	state or local authorit						
		ood items obtained directly					
		subject to applicable State					
	and local laws or reg	• • • •					
		es not prohibit or prevent					
		roduce grown in facility					
		ompliance with applicable					
	safe growing and foo	÷ .					
		es not preclude residents Is not procured by the facility.					
	\$483 60(i)(2) - Store	prepare, distribute and					
		ance with professional					
	standards for food se	-					
		is not met as evidenced					
	by:						
		on and staff interviews the			F 812		
	-	ve a build-up of dried debris					
		uipment. The facility failed to			1. The kitchen was immediately scrub	bed	
		es, knobs, or top surface on			and had dried debris cleaned off of		
	four of five pieces of for cleanliness.	kitchen equipment observed			handles, knobs, and top surfaces of kitchen equipment.		
	101 010011111033.				2. Residents who receive their nutritio	n	
	Findings Included:				from the kitchen have potential to be affected.		
	Observations of the k	kitchen conducted on 9/3/19			3. Executive Director/designee education	ted	
		4:49 PM, and 9/5/19 at 3:47			HSG Dietary CDM on the importance	of F	
	PM revealed the follo	-			812 Food Procurement,		
		es on the reach in cooler			Store/Prepare/Service-Sanitary. A we	-	
		ve a buildup of dried debris			cleaning audit tool was created to ens	ure	
	on the interior aspect				that the Kitchen knobs, surfaces and		
		es on the convection oven ve a buildup of dried debris			handles remain clean and free from debris.		
	on the interior aspect				4. The Dietary manager will utilize the		
		on the convection oven			Weekly Kitchen Audit tool to monitor e		
		ve a buildup of dried debris.			item (Handles, Knobs, and Surfaces)		
		knobs on the stove/oven/flat			cleanliness 3 x weeks for 4 weeks, the		

Facility ID: 923060

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING		
			5.14/11/0		С	
		345258	B. WING		09	/10/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 812	Continued From page	e 84	F 812			
	top grill were observed debris. e. The dish machine food debris residue o from the ware washin An interview and obs with the Dietary Mana PM. The observation of two handles on the observed to have a b interior aspect of eac on the convection over buildup of dried debri each handle, and one convection oven were of dried debris. The l expectation for the kr hand contact surface The dish machine wa debris residue on the ware washing cycles.	The dish machine was observed to have had nod debris residue on the top of the machine om the ware washing cycles. In interview and observation were conducted ith the Dietary Manager (DM) on 9/5/19 at 3:47 M. The observation revealed the following: two if two handles on the reach in cooler were observed to have a buildup of dried debris on the terior aspect of each handle, two of two handles in the convection oven were observed to have a uildup of dried debris on the interior aspect of ach handle, and one of two knobs on the onvection oven were observed to have a buildup if dried debris. The DM stated it was her expectation for the knobs, handles, and other and contact surfaces to be maintained clean. the dish machine was observed to have had food ebris residue on the top of the machine from the are washing cycles. The DM stated it was her expectation for the dish machine to be wiped		1x week for 2 months and then 1 monthly for 3 months. The findin brought to the Quality Assurance Improvement Committee and aud updated if changes are needed b findings. The Quality Assurance Improvement Committee meets r and as needed.	gs will be dits ased on	
F 842 SS=D	AM the Administrator expectation for handl such as knobs, and for kept clean. In addition was her expectation to be cleaned routinely cleaning schedule.	es, hand contact surfaces ood service equipment to be on, the Administrator stated it for the kitchen equipment to and kept clean as part of the dentifiable Information	F 842			10/8/19

Facility ID: 923060

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 09/10/2019		
	34		B. WING					
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS		1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083				
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
F 842	resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co- agrees not to use or of except to the extent th to do so. §483.70(i) Medical re- §483.70(i)(1) In accor- professional standard must maintain medica that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically or §483.70(i)(2) The faci- all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic v- activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to he by and in compliance	b the public. lease information that is the agent only in intract under which the agent disclose the information the facility itself is permitted cords. rdance with accepted ls and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential hed in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings,	F	842				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/21/2019 FORM APPROVED OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	345258		B. WING		C 09/10/2019	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
TRANSIT	ONAL HEALTH SERVICE	ES OF KANNAPOLIS		810 CONCORD LAKE ROAD ANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	DATE	
F 842	record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from th there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The me (i) Sufficient informati (ii) A record of the res (iii) The comprehensi provided; (iv) The results of any and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on observatio record reviews, the fa accurate medical recor testing (Resident #14 administration (Resid 33 residents reviewed records. The findings included 1) Resident #14 was 3/28/19 with diagnose	ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches e law. dical record must contain- on to identify the resident; sident's assessments; ve plan of care and services v preadmission screening evaluations and octed by the State; 's, and other licensed ss notes; and ogy and other diagnostic equired under §483.50. T is not met as evidenced ns, staff interviews and nords in the area of diabetic) and medication ent #24). This was for 2 of d for accurate medical : admitted to the facility on es that included diabetes, cular accident (CVA- a	F 842	F842 Resident Records 1) Resident #14 admitted to facility of 3/28/19 no accucheck documentation noted for 6 days (4/4/19 thru 4/9/19) accucheck order received on 4/10/19. 9/4/19 Nurse #8 documented inaccura on Medication Administration Record ti resident #24 receive her Sertraline. O nurse was made aware of the inaccura documentation, nurse retrieved the medication from emergency medicatio kit and administered medication to resident #24. Nurse #8 no longer employed at facility.	On tely hat nce ate	

Event ID: GVW611

Facility ID: 923060

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		MEDICAID SERVICES			OMB NO. 0938 (X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	345258		B. WING	C 09/10/201		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
				1810 CONCORD LAKE ROAD		
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS				KANNAPOLIS, NC 28083		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLI TO THE APPROPRIATE DAT	
F 842	Continued From pag	e 87	F 84	2		
				2) Current residents w	ho require diabetic	
	Review of the medica	al record revealed Resident		testing and residents wh	-	
		n the Emergency Room on		medications have the po		
		emic (low blood sugar)		affected. On admission		
	episode.			accuchecks for diabetic	residents and	
	-	2019 physician orders		record results on the me	edication	
	indicated orders date	ed 4/3/19 for accuchecks		administration record.	Medications carts	
	before meals and at	bedtime with no coverage.		audited to ensure medic	cations are	
				available for residents o	n 9/27/19. On	
	Review of the April 2	019 Medication		9/26/19 diabetic residen	ts were audited to	
	Administration Recor			ensure accucheck order		
		t documented as obtained by		being recorded accurate	ely in medication	
		by the resident for 6 out of		administration record. Is	sues identified	
	· ·	19, 4/6/19, 4/7/19, 4/8/19		were addressed.		
	and 4/9/19).			3) The Assistant Direc		
				Nursing/Nurse Manager		
		erly Minimum Data Set		reeducate licensed nurs		
		revealed Resident #14 to be		Documentation, Record	•	
		received extensive to total		Point Click Care, and er		
		for all Activities of Daily		medications availability	-	
	Living (ADLs).			education will be include	ed in Orientation	
				for new hires.		
		revealed a care plan for		4) Nurse Managemen		
		ntions that included blood		Nursing will audit 3 diab		
	sugar checks as orde	ereu.		requiring diabetic testing	-	
		ced to Nurse #5, who was		accuchecks are being re carts will be audited for		
		ced to Nurse #5, who was d shift on 4/6/19, on 9/6/19		week for 4 weeks, then	2	
		ge was left for a return call		months and then 1x mo		
		red during the survey.		Nurse Management/Adr		
		ee aannig the survey.		Nursing will observe 3 ra		
	A phone call was pla	ced to Nurse #6, who was		random shifts during me		
		d shift on 4/7/19, on 9/6/19		administration pass to e		
		ge was left for a return call		documentation 3x week		
	that was not received			1x weekly for 2 months		
		<u> </u>		monthly for 3 months. 1		
	On 9/6/19 at 8:39am	a telephone interview		Nursing will report on th		
		#7, who worked 3rd shift on		quality monitoring (audit		
	4/8/19 and 4/9/19. S		1		,	

Facility ID: 923060

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUITIPI	E CONSTRUCTION	(X3) DATE	E SURVEY	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	. ,		COMPLETE	
					С	
		345258	B. WING			/10/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
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	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 842	Continued From page	- 99	ГОЛ			
1 042		e oo ne facility and couldn't recall	F 842	committee. The findings w	ill be reviewed	
		were not documented on the		monthly by the Quality Ass		
	MAR or vital sign rec			Improvement Committee m	onthly and	
				audits updated if changes a		
	-	v was conducted with the e Practitioner (NP) on 9/6/19		based on findings. The Qu Improvement Committee m	-	
	at 9:28am. She indica	. ,		and as needed.		
	-	checks to be obtained as				
	ordered and docume	nted on the MAR.				
	An interview occurred	d with Nurse #2 on 9/6/19 at				
		d 1st shift on 4/5/19, 4/6/19				
		ed she had obtained the				
		ed but could not recall why ented on the MAR or vital				
	sign record.					
	On 9/6/19 at 10:41an	n an interview was held with				
		d 1st shift on 4/4/19, 4/8/19				
	and 4/9/19. She state	ed she obtained the ed but failed to document				
	them on the MAR or					
	An interview was con	npleted with the Director of				
	÷	11:45am and stated it was				
		ccuchecks to be obtained as				
	MAR.	cian and documented on the				
		admitted to the facility on				
	-	rom a hospital on 9/8/16. Her				
	cumulative diagnoses	s included depression.				
	A review of Resident	#24 ' s physician ' s orders				
	included a current me	edication order for 50				
		aline to be given as one				
	-	ime a day. The medication 4/17 and scheduled to be				
	administered at 9:00					

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		MEDICAID SERVICES				IO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	E SURVEY	
			A. BUILDING	A. BUILDING			
		345258	B. WING			С	
		545256				9/10/2019	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		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 IE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Continued From page	e 89	F 84	2			
		oservation was conducted on					
		vith Nurse #11 as she					
		s for administration to					
		redications scheduled for					
	administration to Res	ident #24 included 50					
	milligrams (mg) sertra	aline (an antidepressant).					
	The nurse reported th	nis medication was not on					
	the med cart and she	would need to call the					
		sent out. Nurse #11 correctly					
		esident 's Medication					
		d (MAR) the sertraline was					
	not administered at th	hat time.					
	An observation was (conducted on 9/4/19 at 11:35					
		sed for Resident #24. The					
		there was no sertraline					
		cart for administration to the					
	resident. However, a	review of Resident #24 's					
		R revealed sertraline was					
	documented as havir	ng been administered to the					
	resident the morning	of 9/4/19.					
		ducted on 9/4/19 at 2:00 PM					
		e #8 was the 1st shift nurse					
		#24 's med cart. Upon viewed both the medications					
	· ·	Resident #24 and the					
	resident 's MAR. Nu						
		on the med cart for this					
		the also confirmed she had					
		AR that sertraline was					
	administered to the re	esident the morning of					
		It was missed." Upon					
	· ·	#8 reported the facility had					
	-	ations in an emergency (ER)					
	,	n as an e-kit) stored in the					
		e nurse stated she did not					
	check the e-kit earlie	r mar dav when Resident				1	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/21/2019 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345258	B. WING				C 10/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
TRANSITI	ONAL HEALTH SERVICE	S OF KANNAPOLIS			810 CONCORD LAKE ROAD ANNAPOLIS, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	administration at 9:00 observed as she wen of the itemized list of e-kit revealed it conta tablets of sertraline. observed to obtain a from the e-kit and adr An interview was con- AM with the facility's I During the interview, f	AM. Nurse #8 was t to the med room. A review medications stored in the ined both 25 mg and 50 mg	F	842			

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