STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitional Health Services of Kannapolis	1810 Concord Lake Road Kannapolis, NC 28083

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review, and Responsible Party and staff interviews the facility failed to protect the private health information of 1 of 1 resident (Resident #189) when her discharge summary and medication list was sent home with another resident. A reasonable person would not want their private medical information shared with another resident. Findings included: Resident #189 was admitted to the facility on [DATE]. Resident #189's admission Minimum Data Set assessment dated [DATE] indicated she was moderately cognitively impaired. Resident #189 discharged from the facility to home on 7/26/2024. A Complaint/Grievance Report form dated 7/31/2024 by Resident #188 indicated she received Resident #189's discharge summary and medication list when she discharged from the facility. During an interview with Nurse #1 on 1/8/2025 at 12:26 pm she stated there were two residents (Resident #189 and Resident #188) that were scheduled to discharge from the facility on 7/26/2024. She stated Resident #189's records were sent home with Resident #188 by mistake. Resident #188 returned to the facility with the incorrect records, reported the incident and received her own discharge summary and medication list. Resident #189's Responsible Party was interviewed by phone on 1/8/2025 at 1:02 pm and stated when Resident #189 was discharged from the facility she did not have her Discharge Summary or Medication List in the paperwork that was sent home with her and the Responsible Party returned to the facility on [DATE] to get the discharge summary and the medication list. During an interview with the Director of Nursing on 1/9/2025 at 1:37 pm she did not recall if Resident #189 was notified of the breach of privacy when her Discharge Summary and Medication List was sent home with Resident #188. The DON stated Nurse #1 should have ensured the correct packet was sent with Resident #189 and Resident #188. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/2025 at 2:10 pm the Administrator was interviewed and stated the staff should have notified Resident #189 or her Responsible of Party of the privacy breach when Resident #189's medical records were sent home with Resident #188. The Administrator stated Resident #189, or her Responsible Party should have been made aware of the potential risk to her personal health information.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review, and Nurse Practitioner (NP) and staff interviews the facility failed to provide 1 of 1 resident (Resident #190) with a Continuous Positive Airway Pressure (CPAP) machine (a CPAP machine provides constant and steady air pressure to help a resident breath while asleep) reviewed for respiratory services. Findings included: A Discharge Summary dated 6/6/2024 from the hospital was reviewed and stated Resident #190 required a CPAP machine when he was sleeping and napping. The Discharge Summary further stated Resident #190 had been noncompliant in the past with his CPAP but had been compliant during his hospitalization . Resident #190 was admitted to the facility on [DATE] with of respiratory disease and obstructive sleep apnea. A review of Resident #190's Physician's Orders revealed no orders for a CPAP were found. Nurse #2, who admitted Resident #190 on 6/6/2024, was interviewed by phone on 1/8/2025 at 1:07 pm and she stated she did not remember Resident #190 and was not able to say whether his hospital Discharge Summary stated he needed a CPAP machine. Resident #190's initial Care Plan dated 6/6/2024 specified he should have 4 liters of oxygen per minute and required a CPAP machine. A 5-day Minimum Data Set assessment dated [DATE] indicated Resident #190 was severely cognitively impaired. Resident #190's Medication Administration Record (MAR) for 6/2024 did not indicate he was provided a CPAP machine. The Respiratory Therapist was interviewed by phone on 1/8/2025 at 2:15 pm and she stated she did not have access to the records at the facility and did not remember Resident #190. The Respiratory Therapist stated when she evaluated and treated residents at the facility, she did a written note that was scanned and placed in the resident's electronic record. She stated if she saw Resident #190 after he was admitted there would be a note in his electronic record. A hospital Emergency Department Note dated 6/9/2024 at 1:17 pm indicated Resident #190 was seen in the Emergency Department but was not in respiratory distress. The note further indicated a chest x-ray showed pleural effusions and pulmonary edema and re-admission back to the hospital was recommended due to the pulmonary edema and his CPAP not being available. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Nurse Practitioner on 1/9/2025 at 1:15 pm and she stated Resident #190 was in very bad shape when he was admitted , and she felt that he should not have been discharged from the hospital. She further stated she saw him the day after he was admitted and did not remember if he had a CPAP or not. The Nurse Practitioner stated she did not know if the CPAP would have made a difference is his outcome since he was already so sick. On 1/9/2025 at 7:52 am the Director of Nursing (DON) was interviewed and stated Resident #190 was admitted to the facility on [DATE] and discharged on [DATE] when his Responsible Party called emergency services to have him sent to the hospital. The DON also stated Resident #190 did not have his CPAP during his stay. She stated he came from the hospital without CPAP supplies or a CPAP machine and usually when a resident is on a CPAP they are sent to the facility with the machine. The DON stated she did not know why the hospital had discharged him without the CPAP. The DON stated she called the Respiratory Therapist on the evening of 6/6/2024 when Resident #190 was admitted and again on the morning of 6/7/2024 but she did not try to reach her again. The DON stated she did not know why the Respiratory Therapist did not come to assess Resident #190 and set up his CPAP. The DON stated the Responsible Party came into the facility on [DATE] and called emergency services because he did not have his CPAP since he was admitted but Resident #190 was not in respiratory distress. The Director of Nursing also stated she was not able to find a progress note written by the Respiratory Therapist in the resident's record. The Administrator was interviewed on 1/9/2025 at 2:08 pm and stated the nursing staff should have ensured Resident #190's CPAP was in place when he was admitted and if they could not get the CPAP on admission, they should have sent him back to the hospital.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281 Based on record review, and Consultant Pharmacist, and Director of Nursing interviews the Consultant Pharmacist failed to recognize a medication error when the facility failed to follow admission orders for hydrocortisone used for adrenal insufficiency. This was for 1 of 9 residents reviewed for medication errors (Resident #137). The findings included: Review of the hospital discharge orders for Resident #137 dated 8/28/24 revealed an order hydrocortisone 10 milligrams (mg) tablet for adrenal insufficiency, (administer) 15 mg (1.5 tablets) in AM and 10 mg (1 tablet) in afternoon by mouth with food. Double or triple dose for illness for 3 days as directed (during illness, the body requires additional cortisol to regulate inflammation, blood pressure, and maintain blood volume.) Resident #137 was admitted to the facility on [DATE] with diagnoses including adrenocortical (adrenal) insufficiency. Adrenal insufficiency is a disorder in which the adrenal glands produce insufficient amounts of cortisol. A deficiency of cortisol can result in a life-threatening crisis characterized by low blood pressure. A physician's order transcribed from the hospital discharge summary by Unit Manager #1 dated 8/29/24 specified hydrocortisone 10mg give 1.5 tablets by mouth in the afternoon for inflammation for 3 days. The order concluded on 9/1/24. Review of Resident #137's medication administration record (MAR) documented that on 8/29/24 Resident #137 did not receive the hydrocortisone due to the medication not being available. Further review of the MAR documented hydrocortisone 10mg 1.5 tablets was administered on 8/30/24 and 8/31/24. Review of the medication administration record for September 2024 documented Resident #137 did not receive hydrocortisone 9/1/24 to 9/18/24. A pharmacist note written by Pharmacist #1 and dated 8/30/24 documented based upon the information available at the time of the review, and assuming the accuracy and completeness of such information it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities . A phone interview was conducted on 1/8/25 at 3:03 PM with Pharmacist #1 and Pharmacist #3, her clinical manager. Pharmacist #1 reported she conducted a remote review of the admission orders for Resident #137 on 8/30/24. Pharmacist #1 reported during the admission review of information for new residents, she reviewed the information that was available in the electronic documentation system, and if the hospital discharge orders were not uploaded into the system, she would have looked at only the orders in the electronic documentation system. Pharmacist #3 explained that the facilities are encouraged to upload all information into the electronic documentation system, so all information is available to the pharmacist, but she did not recall if the hospital discharge orders were available during her review. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up phone interview was conducted on 1/15/25 at 1:00 PM with Pharmacist #2 and Pharmacist #3. Pharmacist #2 performed a medication review for Resident #137 on 9/19/24 and reported she had not reviewed the hospital discharge orders, only the medication orders available in the electronic documentation system. Pharmacist #3 explained that after the interview on 1/8/25, she had investigated when the hospital discharge orders were available in the electronic documentation system and discovered that the facility had not scanned the orders in for 2 weeks. The Director of Nursing (DON) and Administrator were interviewed by phone on 1/16/25 at 11:09 AM. The DON reported the admission orders for Resident #137 were not uploaded into the electronic documentation system until 9/12/24 and the admission orders were not available for Pharmacist #1 to review on 8/30/24. The Administrator explained that typically the hospital discharge orders were put into the system by the corporate admissions team, but the orders for Resident #137 were emailed to the DON and that caused the delay loading the orders into the electronic documentation system.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281 Based on record reviews, and Nurse Practitioner (NP), Physician, Pharmacist, Endocrinologist, and staff interviews, the facility failed to prevent a significant medication error related to hydrocortisone prescribed for Resident #137 (hydrocortisone tablets are a steroid medication that works by decreasing inflammation, slowing down an overactive immune system or replacing the cortisol hormone that helps the body respond to stress) when Resident #137 missed a dose of hydrocortisone on ([DATE]), received the wrong dose of hydrocortisone for two days ([DATE] and [DATE]) and then the medication was abruptly stopped. Abrupt cessation of hydrocortisone for adrenal insufficiency can cause an adrenal crisis, where the body experiences a sudden drop in cortisol levels and can lead to life-threatening complications such as low blood pressure. Resident #137 went 18 days without receiving hydrocortisone. Resident #137 was scheduled to be seen by the Endocrinologist on [DATE] for the missed doses of hydrocortisone but she was transferred to the hospital on [DATE] at the request of family and admitted for weakness and low blood pressure ,d+[DATE] (normal blood pressure is ,d+[DATE]). This was for 1 of 9 residents reviewed for significant medication errors (Resident #137). The findings included: Review of the hospital discharge orders for Resident #137 dated [DATE] revealed an order hydrocortisone 10 milligrams (mg) tablet for adrenal insufficiency, (administer) 15 mg (1.5 tablets) in AM and 10 mg (1 tablet) in afternoon by mouth with food. Double or triple dose for illness for 3 days as directed (during illness, the body requires additional cortisol to regulate inflammation, blood pressure, and maintain blood volume.) Resident #137 was admitted to the facility on [DATE] with diagnoses including adrenocortical (adrenal) insufficiency. Adrenal insufficiency is a disorder in which the adrenal glands produce insufficient amounts of cortisol. A deficiency of cortisol can result in a life-threatening crisis characterized by low blood pressure. Additional diagnoses for Resident #137 included diabetes, malnutrition, high blood sodium levels, breast cancer, syncope and collapse (fainting), and abnormal gait. A physician's order transcribed from the hospital discharge summary by Unit Manager #1 dated [DATE] specified hydrocortisone 10mg give 1.5 tablets by mouth in the afternoon for inflammation for 3 days. The stop date for the order was [DATE]. A physician order dated [DATE] for midodrine (a medication that elevates blood pressure) 10 mg every 8 hours for low blood pressure, do not give fore blood pressure over ,d+[DATE]. An NP admission note written by NP #4 dated [DATE] was reviewed. NP #4 documented Resident #137 was to take hydrocortisone 10 mg 1.5 tablets every evening with a stop date of [DATE]. Review of Resident #137's medication administration record (MAR) documented by Nurse #1 that on [DATE] Resident #137 did not receive the hydrocortisone due to the medication not being available. Further review of the MAR documented hydrocortisone 10mg 1.5 tablets was administered on [DATE] and [DATE]. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medication administration record for [DATE] documented Resident #137 did not receive hydrocortisone from [DATE] to [DATE]. Review of the blood pressures for Resident #137 revealed the following: (normal blood pressure ,d+[DATE]) - [DATE] ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM - [DATE] ,d+[DATE] at 2:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM - [DATE] ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM; ,d+[DATE] at 2:00 PM; ,d+[DATE] at 10:00 PM - [DATE] ,d+[DATE] at 6:00 AM (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unit Manager #1 was interviewed on [DATE] at 8:47 AM. Unit Manager #1 reported she transcribed the discharge hospital orders for Resident #137 upon her admission to the facility on [DATE]. Unit Manager #1 explained she read the hydrocortisone order to be for 3 days only and transcribed the order as she understood it. Unit Manager #1 reported she had not clarified the order with the hospital, and she had not called the Endocrinologist to ask for clarification. Unit Manager #1 reported she was not certain if the NP or the physician had reviewed the orders for Resident #137. Unit Manager #1 reported after she transcribed the hospital discharge orders, she asked Unit Manager #2 to check the orders and Unit Manager #2 did not report any transcription mistakes to her. When asked how she understood the orders for hydrocortisone, Unit Manager #1 explained she thought that the medication was to be given for only 3 days, and it didn't occur to her to call the Endocrinologist for clarification or ask the physician or NP to review the order. Unit Manager #1 reported she was not aware Resident #137 did not receive the medication on [DATE]. Unit Manager #1 reported she was not aware she had not correctly transcribed the order for hydrocortisone. Unit Manager #2 was interviewed on [DATE] at 10:07 AM. Unit Manager #2 reported she reviewed Resident #137's hospital discharge orders and the orders in the electronic documentation system and she did not notice the hydrocortisone was ordered for only 3 days. Unit Manager #2 reported when she reviewed the hospital discharge orders, she thought the medication was supposed to be ordered for 3 days only and she did not notice the dose was not ordered correctly. Unit Manager #2 reported she did not call the physician, NP, or the Endocrinologist for clarification of the hydrocortisone order. NP #4 was interviewed by phone on [DATE] at 12:50 PM. NP #4 reported she saw Resident #137 for her admission assessment on [DATE]. NP #4 explained she reviewed the hospital discharge orders and the orders in the electronic documentation system, but she did not notice the hydrocortisone was transcribed incorrectly. NP #4 reported hydrocortisone should not have been stopped abruptly because it would cause the body to lose an essential hormone and could cause an adrenal crisis. A pharmacist note written by Pharmacist #1 and dated [DATE] documented based upon the information available at the time of the review, and assuming the accuracy and completeness of such information it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities . A follow-up phone interview was conducted on [DATE] at 1:00 PM with Pharmacist #2 and Pharmacist #3. Pharmacist #3 explained that hydrocortisone was used in adrenocortical insufficiency to replace the hormone cortisol the body made to maintain blood pressure and other functions. Pharmacist #3 reported she was unable to say if Resident #137 was affected adversely by the cessation of the hydrocortisone, as the Endocrinologist would have been responsible for managing the dosage of hydrocortisone. A physician history and physical note written by the Physician dated [DATE] documented hydrocortisone was to continue for adrenal insufficiency. The history and physical note did not document the hydrocortisone dose. A phone interview was conducted with the Physician on [DATE] at 1:03 PM. The Physician reported he had reviewed the hospital discharge orders but had not reviewed the orders transcribed into the electronic documentation system. The Physician reported the hydrocortisone was a significant medication error and the medication should not have been stopped abruptly. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The admission Minimum Data Set assessment dated [DATE] assessed Resident #137 to be cognitively intact. A NP progress note dated [DATE] was reviewed. NP #2 documented that on [DATE] Resident #137's family member asked about the hydrocortisone and NP #2 documented that the hydrocortisone appeared to not be ordered. NP #2 documented she discussed Resident #137's symptoms and labs with the Endocrinologist and it appears that (Resident #137) is supposed to be on hydrocortisone 15 mg in the morning and 10 mg in the evening, which is not currently ordered. (Resident #137) received 3 days of hydrocortisone since admission to the facility (per medication administration record). The note documented the Endocrinologist ordered hydrocortisone 20 mg to be given now and 10 mg in the evening for 3 days and then 15 mg in the morning and 10 mg in the evening. The note documented the endocrinologist wanted Resident #137 to come to the office to be seen on [DATE]. A physician order dated [DATE] to administer hydrocortisone 20 mg, give 1 tablet by mouth once per day for 2 days. Administer 10 mg tablet in the evening. Beginning [DATE] administer hydrocortisone 15 mg in the morning and 10 mg in the evening. NP #2 was interviewed on [DATE] at 9:40 AM. The NP reported she was not working on [DATE] when Resident #137 was admitted to the facility and NP #4 did the admission assessment. NP #2 reported she had reviewed Resident #137's medications (she was uncertain of the exact date) and made a call to the Endocrinologist to clarify the hydrocortisone order. NP #2 reported on [DATE] Resident #137's family member inquired about the hydrocortisone and NP #2 was able to talk to the Endocrinologist and received clarification of the order. NP #2 explained Resident #137 should have continued hydrocortisone and it should not have been stopped abruptly because it could cause an adrenal crisis if stopped. A follow-up phone interview was conducted with NP #2 on [DATE] at 10:50 AM. NP #2 clarified that the Endocrinologist had ordered hydrocortisone to be given immediately, plus gave orders for the medication for the following days. A follow-up interview was conducted by phone with the Physician on [DATE] at 2:48 PM and he reported the hydrocortisone dose would have been determined by the Endocrinologist, and NP #2 did the right thing by contacting the Endocrinologist for orders on [DATE]. The Physician explained stopping hydrocortisone abruptly could cause an adrenal crisis. The Physician reported he would have expected the Unit Manager to call him, the NP, the hospital or the Endocrinologist for clarification of orders. A nursing note dated [DATE] at 12:15 PM documented Resident #137 was taken to her endocrinology appointment by her family member but returned to the facility without being seen by the Endocrinologist. The family member reported he was running late and was unable to get Resident #137 to the appointment on time, and he requested Resident #137 be sent to the emergency room . Hospital emergency room records dated [DATE] for Resident #137 documented she was admitted to the hospital for weakness and low blood pressure. Blood pressure on admission to the emergency room was , d+[DATE]. Resident #137 was a [AGE] year-old female with a past medical history significant for adrenal insufficiency. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A computed tomography (CT) scan was completed on [DATE] and a large volume pneumoperitoneum (a condition where air or gas was in the abdominal cavity) was revealed, leading to concerns for a large bowel perforation. The decision was made with Resident #137 and her family member to undergo a laparotomy. Resident #137 was taken urgently to the operating room at 9:00 PM on [DATE] for lysis of adhesions, resection of the colon with a colostomy. After the surgery, Resident #137 was transferred to ICU, and she developed worsening low blood pressure. Lab results showed severe acute blood loss anemia. Resident #137 lost pulses and her abdomen was reopened in the ICU where approximately 750 cubic centimeters of blood were discovered. Resident #137 received several rounds of cardiopulmonary resuscitation efforts, and she died at 5:10 AM on [DATE]. The Endocrinologist was interviewed by phone on [DATE] at 4:49 PM. The Endocrinologist reported she recalled talking to NP #2 and ordered Resident 137 to receive hydrocortisone 20 mg immediately. The Endocrinologist explained that stopping hydrocortisone abruptly would have caused an adrenal crisis and this crisis would have caused Resident #137 difficulties with controlling her blood pressure and caused fatigue, as well as other symptoms. The Endocrinologist explained that the adrenal crisis would not have contributed to the bleeding post-operatively. The Administrator was notified of immediate jeopardy on [DATE] at 10:45 AM. The facility submitted the following corrective action plan with a compliance date of [DATE]. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice On [DATE] Resident #137 was admitted to the facility. The hospital discharge summary orders for Resident #137 read: hydrocortisone 10mg tablet, (administer) 15mg (1.5 tablets) in AM and 10 mg (1 tablet) in afternoon by mouth with food, double or triple doses for illness for 3 days as directed. Resident #137 had a diagnosis of adrenal insufficiency and was prescribed hydrocortisone. The Unit Manager transcribed the order on [DATE]: hydrocortisone 10 milligrams (mg) give 1.5 tablet by mouth in the afternoon for inflammatory for 3 days until [DATE]. Resident #137's Medication Administration Record (MAR) was reviewed and there was no documentation of any doses of hydrocortisone administered from [DATE] - [DATE]. One 20mg Hydrocortisone was administered the morning of [DATE]. On [DATE], Resident #137 was transferred to the hospital, and she underwent a laparotomy for lysis of adhesions, resections of the sigmoid colon with end colostomy. Post surgery she was transferred to the Intensive Care Unit (ICU) and developed hypotension and was found to have experienced severe acute blood loss anemia and died on [DATE]. Address how the facility will identify other residents having the potential to be affected by the same deficient practice The facility recognizes that all newly admitted and readmitted residents have the potential to be affected from the prior noncompliance with significant medication errors All newly admitted and readmitted residents between [DATE] - [DATE] medication orders were audited by the Director of Nursing and or Unit Managers to ensure orders were transcribed correctly on [DATE]. 30 residents were audited with no discrepancies noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitional Health Services of Kannapolis	1810 Concord Lake Road Kannapolis, NC 28083

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A quality review was completed on [DATE] by the Director of Nursing and or Unit Manager of current residents with a diagnosis of adrenal insufficiency and with hydrocortisone orders to ensure medication is ordered, transcribed correctly, and being given as ordered, no discrepancies noted. On [DATE], a quality review of current residents admitted and readmitted within the past 30 days prior to [DATE] was conducted by the Director of Nursing and Unit Manager to ensure all other newly admitted or readmitted patients' medications are administered per physician orders and transcribed correctly on the Medication Admission Record (MAR). Address what measures will be put into place or systemic changes made to ensure the deficient practice will not recur. On [DATE], a Root Cause Analysis was completed by the Director of Clinical Services, and the Executive Director regarding omission of medication administration for resident #137. It was determined through root cause and analysis that the significant medication error was due to the oversight of transcribing the orders incorrectly and there was no verification conducted by a second nurse. The Director of Nursing and/or the nurse managers provided education on [DATE] to current nurses on the importance of transcribing all new orders from discharge summaries, verified by 2 nurses to ensure medications are transcribed and administered per physician orders to the residents. Newly hired nurses will be educated on hire during the orientation process. The Executive Director provides oversight for the education of nurses to ensure that 100% of all licensed staff were reeducated on the importance of administrating all ordered medications. Education was completed on [DATE]. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing and or Nurse Managers will conduct Quality Improvement Monitoring 5 times per week for 4 weeks, 1 time per week for 3 months and 1 time monthly for 3 months in clinical morning meeting to review the medication administration records of all new residents when admitted or readmitted to ensure all medications are transcribed correctly and medications are administered as ordered per physician starting [DATE]. Upon receiving hospital discharge summaries medication orders are verified with the provider, 2 nurse verification system; 1 Nurse transcribes all orders, then 1 Nurse verifies/confirms that orders were transcribed correctly. They also review the previous days admissions during the morning meeting and verify during the meeting. On [DATE], when the deficient practice of transcribing orders that resulted in a significant medication error was identified the center Executive Director conducted an ADHOC Quality Assurance Performance Improvement (QAPI) meeting to determine the root cause analysis of the deficient practice. The QAPI committee put a plan of action in place to include quality improvement monitoring and the frequency of monitoring beginning on [DATE] to ensure medication administration orders were transcribed correctly and medications were administered as ordered. The QAPI committee included the Executive Director, Medical Director, Director of Nursing, the Manager of Social Services, a Unit Manager, Wound Care Nurse, and two floor Nurses. The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement meeting monthly to ensure ongoing compliance for 4 months. Quality Improvement schedule will be modified based on findings of the monitoring. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Center Executive Director alleges compliance on [DATE]. The corrective action plan was validated on [DATE]. Education for all nurses was reviewed, and interviews were conducted with the Unit Managers and the staff nurses to confirm receipt of the education. Initial audits of new admissions from [DATE] to [DATE] were reviewed and no significant medication errors were identified. Quality reviews of current residents and new admissions were reviewed, and no issues were identified. Morning meeting and QAPI meeting notes were reviewed with the DON and Administrator. The immediate jeopardy removal date of [DATE] and the compliance date of [DATE] was validated.