

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Saturn Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 West Sugar Creek Road Charlotte, NC 28262	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934</p> <p>Based on observations, record review, and interviews with residents (Resident #88), family (Resident #74 and Resident #16), and staff, the facility failed to provide a dignified dining experience when three (3) residents who dined on the south unit did not receive assistance with their meal to allow them to eat with other residents who ate or were assisted to eat by staff. Resident #74 waited for staff to assist him with eating his meal, while his roommate, Resident #55 fed himself. Resident #88 and Resident #16 waited for staff to assist them with their meals while residents dining with them were assisted to eat by staff or fed themselves. This failure occurred for 3 of 3 residents sampled for dignity with dining (Residents #74, #88 and #16). The reasonable person concept was applied as individuals have the expectation of eating and to be served when dining at the same time as others.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Resident #74 was admitted to the facility on [DATE]. <p>The electronic medical record (EMR) for Resident #74 recorded a family member as his responsible party (RP).</p> <p>A 5/24/24 quarterly Minimum Data Set assessment, indicated Resident #74 had adequate hearing, rarely/never understood others, rarely/never understood by others, no speech, impaired short-term/long-term memory, severely impaired cognitive skills for daily decision making, and required substantial/maximal staff assistance with eating.</p> <p>On 6/17/24 a continuous observation of the lunch meal dining occurred on the south unit when the meal cart arrived on the unit at 12:08 PM until 12:48 PM.</p> <p>On 6/17/24 at 12:16 PM Resident #74 and Resident #55 were both observed in the same room. Resident #74 was in bed with the head of his bed elevated. The privacy curtain was observed open between the two Residents. Resident #55 was observed seated in his wheelchair with his lunch meal on his overbed table, he fed himself and at the time of the observation, he had eaten approximately 50% of his lunch. Resident #55 continued to feed himself until 12:21 PM and ate a total of approximately 75% of his lunch meal, while Resident #74 waited for staff to bring him lunch and assist him with his meal. The privacy curtain remained open between the two Residents while Resident #55 fed himself. NA #5 brought Resident #74 his lunch tray into his room at 12:25 PM, set up his meal tray, and fed him.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>NA #5 was interviewed on 6/17/24 at 1:18 PM, she stated that Resident #74 required staff assistance with his meals and when she brought him lunch, his roommate, Resident #55 had already eaten. NA #5 stated she was aware that residents should eat together, but further stated that the facility used to offer a feeding program in the dining room where six residents from the south unit who required staff assistance with meals ate together, but she had not seen this done for the last few weeks.</p> <p>NA #3 stated in an interview on 6/17/24 at 1:19 PM that Resident #74 was in the room in his bed when she took the lunch meal into the room for his roommate, Resident #55. She stated she set up the tray for Resident #55 and he fed himself. NA #3 stated that she did not take a lunch tray into the room for Resident #74, because he required staff assistance with eating, and NA #5 usually fed Resident #74 after all the trays were passed to residents who fed themselves. NA #5 stated Resident #74 only had to wait a few minutes to get his lunch until all the trays were passed. NA #3 further stated that the facility used to take residents to the dining room who required staff assistance with eating, but she had not seen that occur in the last week. She stated that she did not recall the exact time she took a lunch tray into the room for Resident #55, but that he was one of the first Residents on the unit to receive his tray. NA #3 stated that she did not consider it a dignity issue that Resident #74 waited in his room to receive his lunch and to be fed by NA #5.</p> <p>On 6/20/24 at 12:29 PM, a phone interview with the RP for Resident #74, she stated Resident #74 had to be fed in facility #1 where he lived before, he moved to the current facility. The RP stated that while Resident #74 lived at facility #1, he ate at the same time as all the other residents and that he was accustomed to eating with others. The RP stated that Resident #74 should not have to wait a long time to be fed and that she would not want him to wait too long to eat.</p> <p>The Director of Nursing (DON) was interviewed on 6/19/24 at 6:00 PM. The DON stated that the facility was currently in transition to new management and working through the logistics of the facility's Focused Feeding Program, which was not currently available, but that residents sitting together for meals should eat or receive staff assistance to allow them to eat together.</p> <p>The Administrator was interviewed on 6/20/24 at 2:46 PM and he stated that staff should all be available during meals and that nurses needed to know that meal trays are on the halls so that all hands are on deck to assist residents with their meals and allow residents to eat together.</p> <p>2. Resident #88 was admitted to the facility on [DATE].</p> <p>A 4/16/24 quarterly Minimum Data Set assessment indicated Resident #88 spoke clearly, was understood by others, able to understand others, her vision was severely impaired, her hearing was adequate, her cognition was intact, and she required substantial to maximal staff assistance with eating.</p> <p>A care plan revised 4/30/24 indicated Resident #88 had self-care deficits related to poor muscle control and muscle stiffness. Interventions included for staff to set up her meal tray and to assist her with the completion of her meals.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A continuous observation of dining on the South Unit for the lunch meal occurred on 6/17/24 from 12:08 PM until 12:48 PM. Seven residents, which included Resident #88, were observed seated in their wheelchairs in the commons area of the south unit. Five of the seven residents received their lunch meal from 12:08 PM until 12:15 PM and fed themselves while Resident #88 waited for staff to assist her with her lunch meal. While she waited, Resident #88 responded yes when asked by the Surveyor if she was hungry, ready to eat and preferred to eat with the other residents who were eating around her. NA #3 brought Resident #88 her lunch meal at 12:20 PM, set up her meal tray and fed Resident #88 lunch.</p> <p>NA #3 stated in an interview on 6/17/24 at 1:19 PM that Resident #88 required staff assistance with meals. NA #3 stated that all the meal trays were passed first to residents who fed themselves and then staff provided meal trays to the six residents on the south unit who required staff assistance with meals which caused the residents who required staff assistance with eating to wait about 15 minutes to be fed. NA #3 stated that she was trained to feed more than one resident at a time and that she typically did that for breakfast, but that she did not typically do that for the lunch meal. NA #3 further stated that the facility used to take residents to the dining room who required staff assistance with meals, but she had not seen that occur for about a week.</p> <p>The Director of Nursing (DON) was interviewed on 6/19/24 at 6:00 PM. The DON stated that the facility was currently in transition to new management and working through the logistics of the facility's Focused Feeding Program, which was not currently available, but that residents sitting together for meals should eat or receive staff assistance to allow them to eat together.</p> <p>The Administrator was interviewed on 6/20/24 at 2:46 PM and he stated that nursing staff were trained they could assist more than one resident at a time with meals. He stated that all nursing staff should be available to assist residents during meals. He stated that nurses needed to know that meal trays are on the halls so that all hands are on deck to assist residents with their meals and allow residents to eat together.</p> <p>3. Resident #16 was admitted to the facility 9/16/18.</p> <p>The electronic medical record (EMR) for Resident #16 recorded a family member as her responsible party (RP).</p> <p>A care plan, revised May 2024, indicated Resident #16 had self-care deficits related to severe cognitive impairment with interventions that included staff to set up her meal tray and to assist her with the completion of her meals.</p> <p>A 5/27/24 quarterly Minimum Data Set assessment indicated Resident #16 spoke clearly, usually understood by others, sometimes able to understand others, vision was impaired, had moderate difficulty hearing, her cognition was severely impaired, and she was dependent on staff for assistance with eating.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A continuous observation of dining on the south unit for the lunch meal occurred on 6/17/24 from 12:08 PM until 12:48 PM, seven residents, which included Resident #16, were observed seated in their wheelchairs in the commons area of the south unit. Six of the seven residents received their lunch meal from 12:08 PM until 12:20 PM while Resident #16 waited for staff to assist her with her lunch meal. While she waited, Nurse Aide (NA) #5 brought Resident #16 her lunch at 12:33 PM, placed it covered on the overbed table that was in front of the Resident, and left the Resident to answer another resident's call light. While Resident #16 waited for lunch, she repeated to herself, I am so sick. When asked by the Surveyor while she waited if she was hungry, Resident #16 replied, I am so sick and I am so hungry. NA #5 fed Resident #16 her lunch meal at 12:36 PM.</p> <p>NA #5 was interviewed on 6/17/24 at 1:18 PM, she stated that Resident #16 required staff assistance with her meals. NA #5 stated she was aware that residents should eat together, but further stated that the facility used to offer a focused feeding program in the dining room where residents who required staff assistance with meals ate together. NA #5 stated she did not see the focused feeding program offered for the last few weeks, and there were six residents on the south unit who required staff assistance with eating. NA #5 stated she thought it was against state rules to feed more than one resident at time and so she only fed one resident at a time so that she could give her attention to the resident she was assisting.</p> <p>On 6/20/24 at 11:47 PM, a phone interview with the RP for Resident #16, she stated Resident #16 had dementia now and would not know about her surroundings but when she was aware of her surroundings, she would not like to wait to be fed while others around her ate. The RP stated that at times when she visited Resident #16 between 1:00 PM to 2:00 PM at the facility, Resident #16 had not yet received assistance with her lunch meal, but other residents were eating or had already eaten.</p> <p>The Director of Nursing (DON) was interviewed on 6/19/24 at 6:00 PM. The DON stated that the facility was currently in transition to new management and working through the logistics of the facility's Focused Feeding Program, which was not currently available, but that residents sitting together for meals should eat or receive staff assistance to allow them to eat together.</p> <p>The Administrator was interviewed on 6/20/24 at 2:46 PM and he stated that nursing staff were trained they could assist more than one resident at a time with meals. He stated that all nursing staff should be available to assist residents during meals. He stated that nurses needed to know that meal trays are on the halls so that all hands are on deck to assist residents with their meals and to allow residents to eat together.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934</p> <p>Based on observations, interviews and record review, the facility failed to assess Resident #153 for the ability to self-administer medications. This failure occurred for 1 of 1 sampled resident reviewed for self-administration of medications.</p> <p>The findings included:</p> <p>Resident #153 was readmitted to the facility on [DATE] from the hospital. Diagnoses included urea cycle metabolism disorder (a condition that causes elevated ammonia levels in the blood), osteoarthritis, congestive heart failure and chronic pain.</p> <p>Review of the June 2024 physician (MD) orders in the electronic medical record (EMR) for Resident #153 revealed a 6/3/24 MD order for Aspirin Enteric Coated 81 milligrams (MG), with instructions for the nurse to give by mouth once daily, scheduled in the morning and a 6/3/24 MD order for Lactulose 10 grams (GM)/15 milliliter (ML) solution, for the diagnosis of urea cycle metabolism, with instructions for the nurse to give 45 ML by mouth, twice daily, scheduled in the morning and evening. There was no MD order for Resident #153 to self-administer these medications at the time of this review.</p> <p>Review of a care plan revised 6/5/24 indicated Resident #153 was at risk for skin tears, bruising, bleeding and other medical complications related to the use of Aspirin as an anticoagulant (a medication that thins the blood). The care plan also indicated Resident #153 may experience pain related to her diagnosis of osteoarthritis and pain in her shoulders. Interventions included providing medication therapy as ordered by the MD. There was no care plan for Resident #153 to self-administer medication at the time of this review.</p> <p>A 6/10/24 quarterly Minimum Data Set assessment recorded Resident #153 had adequate hearing, adequate vision, clear speech, understood others, able to understand, intact cognition and no impairment in functional limitation in range of motion.</p> <p>Further review of the EMR on 6/17/24 and 6/18/24 for Resident #153 revealed there was no assessment to self-administer Aspirin or Lactulose.</p> <p>On 6/17/24 at 10:54 AM during an observation and interview with Resident #153 two bottles of medications were observed on her overbed table. The label of one bottle was recorded as a prescription for Sodium Chloride tablets, the contents of the bottle were visible, and the bottle included a pale, yellow-colored liquid. The label of the second bottle recorded a store brand for Aspirin Enteric Coated (pain reliever), 81 MG, 300 tablets; the bottle was approximately three fourths full. During the observation, Resident #153 stated that at times, when her nurse brought the Lactulose, she was not ready to take it, so the nurse left the Lactulose in a medicine cup on her overbed table for her to take later when she was ready. Resident #153 said that she poured the Lactulose from the medicine cup left by the nurse into the bottle (labeled Sodium Chloride) and took it later. Resident #153 stated she could not recall the name of the nurse(s) who left the Lactulose on her overbed table. Resident #153 also stated that she brought the bottle of Aspirin with her when she returned to the facility from a recent hospital stay and that she took it for her pain.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/17/24 at 10:43 AM during an interview with Nurse #8 and observation of Resident #153, the Nurse observed two bottles of medications on the overbed table in Resident #153's room. Nurse #8 asked Resident #153 what were the medications and the Resident responded that one bottle was Aspirin that she brought with her when she came back from the hospital on 6/3/24 and the other bottle was Lactulose that she poured into a prescription bottle that she took later when she did not want to take the Lactulose at the time the nurses brought her medications. Nurse #8 stated that this was her first time as the Nurse for Resident #153, she was not aware that the Resident administered medications to herself, and she did not see any medications on her overbed table when she administered medications to the Resident that morning around 9:00 AM.</p> <p>On 6/19/24 at 12:43 PM, Resident #153 was observed in her room. The same bottle that recorded a prescription for Sodium Chloride tablets was observed on her overbed table and included a pale, yellow-colored liquid. Resident #153 said it was her bottle of Lactulose.</p> <p>A phone interview with Nurse #9 on 6/21/24 at 8:40 AM revealed she was the Nurse for Resident #153 during the week, and weekends and worked all shifts at the facility. Nurse #9 described that Resident #153 did not work well with staff she did not know and refused medications at times from staff if she did not know them. The Nurse stated that she had not observed medications on the overbed table for the Resident. The Nurse stated that at times Resident #153 refused to take Lactulose and would respond I don't want that now, leave it, I will take it later. Nurse #9 stated that she did not leave medications with residents who did not have a MD order for self-administration and returned later with any medications refused by a resident. Nurse #9 stated, I watch the residents take their pills.</p> <p>An interview with Unit Manager (UM) #1 on 6/19/24 at 5:53 PM revealed she was notified on 6/17/24 by Nurse #8 that Resident #153 had Aspirin at the bedside. UM #1 stated she went to the Resident's room, removed the Aspirin, and notified the Director of Nursing (DON) of the Aspirin and that Resident #153 was not assessed for self-administration of medication. UM #1 stated she did not see the prescription bottle with a label for Sodium Chloride and she was not informed that this bottle was at the bedside and contained a liquid medication that was poured into the bottle by the Resident. UM #1 stated Resident #153 did not have an assessment to self-administer medications when these medications were noted at her bedside on 6/17/24. During the interview, UM #1 observed the overbed table in the room of Resident #153 and stated the Resident had a 100 ML bottle of a liquid that the Resident called Lactulose that should not be there without an assessment.</p> <p>On 6/19/24 at 5:55 PM, the DON was interviewed and stated that she was made aware on Monday, 6/17/24 that Resident #153 had a bottle of Aspirin that the Resident brought with her when she returned from the hospital on 6/3/24. The DON stated Resident #153 had not been assessed to self-administer medications. The DON stated that staff did not see the prescription bottle that contained Lactulose. The DON stated that Residents who self-administer medications, should be assessed to do so and once the assessment is complete, if the resident demonstrates the ability to self-administer medications, the MD is notified, and a MD order is obtained for the specific medication that the resident will self-administer. The DON further stated that the resident is given a locked box to store the medication and that medications should not be stored on the overbed table.</p> <p>The Administrator stated in an interview on 6/20/24 at 2:53 PM that residents who want to self-administer medications, should be assessed to do so, the MD should be notified, an order obtained, and a locked box should be placed in the resident's room for storage of medications.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160</p> <p>Based on record review, resident and staff interviews the facility failed to implement their abuse policy and procedure in the areas of reporting immediately to administration and investigating when Resident #21 reported that a Nurse Aide (NA) intentionally hit her on the hand with a bed remote. This deficient practice occurred for 1 of 5 residents reviewed for abuse.</p> <p>The findings included:</p> <p>A review of the facility's North Carolina Resident Abuse Policy revised 10/3/2022 defined physical abuse as hitting, slapping, pinching, and kicking. The policy stated all allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the Department of Health (DOH) immediately, but not later than 2 hours after the allegation is made. The policy further stated Once the Administrator and DOH are notified, an investigation of the allegation or suspicion will be conducted. The investigation must be conducted within five (5) working days from the alleged occurrence.</p> <p>Resident #21 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (stroke).</p> <p>A review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #21's cognition was intact, and she exhibited verbal and physical behaviors and rejections of care.</p> <p>A review of the care plan dated 5/6/24 revealed Resident #21 had a history of making false accusations against other residents and staff. The interventions included encouraging Resident #21 to vent and express her feelings and explaining the seriousness involved of making false accusations.</p> <p>An interview with NA #4 on 6/19/24 at 10:50 AM revealed she was unsure of the date, but Resident #21 had reported to her a 3rd shift NA was rough with her during care and had intentionally hit her across the hand with the bed remote. She stated Resident #21 was unable to recall the name of the 3rd shift NA. NA #4 revealed Resident #21 was very upset about the incident and would not allow her to provide morning care. NA #4 indicated she informed Medication Aide #1 and then found the Social Work Assistant and requested she meet with Resident #21 as soon as possible.</p> <p>An interview was conducted with Medication Aide (MA) #1 on 6/19/24 at 11:03 AM. MA #1 stated she was unable to recall the date, but during her morning medication pass she observed the Social Work Assistant interviewing Resident #21 in her room and overheard Resident #21 tell the Social Work Assistant that a Nurse Aide hit her with the bed remote. MA #1 had no other details regarding the incident.</p> <p>A review of the facility reported incidents revealed the facility had not reported or investigated the allegation by Resident #21 that a 3rd shift Nurse Aide intentionally hit her across the hand with a bed remote</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Initial Allegation Report submitted by the facility on 6/20/24 at 12:46 PM revealed Resident #21 reported a Nurse Aide had roughly taken a remote out of her hand hitting her hand with the remote. The report further revealed the facility became aware of the incident on 5/28/24 and no employee was named or accused.</p> <p>An interview was conducted with the Administrator on 6/20/24 at 2:18 PM. The Administrator stated he was not employed at the facility on 5/28/24. He stated Resident #21 reporting that a Nurse Aide hit her with a bed remote was an allegation of abuse and the facility's Resident Abuse policy and procedure should have been implemented.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45358</p> <p>Based on record review and staff interviews, the facility failed to accurately code the minimum data set assessment (MDS) assessment for 1 of 3 (Resident #353) sampled residents reviewed for behaviors and failed to accurately code a significant change MDS assessment for 1 of 1 sampled residents reviewed for hospice care (Resident #35).</p> <p>The findings included:</p> <p>1. Resident #353 was readmitted to the facility on [DATE] with diagnoses that included bipolar disorder, blindness, and conduct disorder.</p> <p>A review of Unit Manager #3's progress note dated 9/10/23 indicated Resident #353 became irate, refused care/ assistance from staff when he shouted at staff, by stating they did not need to tell him how to take care of himself.</p> <p>A review of a Nurse Practitioner (NP) progress note dated 9/8/23 revealed Resident #353 refused to be seen by the facility provider on 9/8/23 and has refused previous psyche consults, refused Zyprexa which previously managed bipolar symptoms, refused diagnoses despite 2021 medical records.</p> <p>A quarterly MDS dated [DATE] indicated Resident #353 was cognitively intact, had no behaviors and had not rejected care.</p> <p>An interview on 6/20/24 at 10:42 am with the MDS Coordinator revealed she took over as coordinator in April 2023, was still learning, and that the quarterly MDS should have been coded to reflect Resident #353's on-going behaviors related to refusing care. The MDS Coordinator further revealed behaviors would have been discussed during morning meetings or identified through nurse notes, physician orders or nurse NP notes.</p> <p>During an interview on 6/20/24 at 2:50 pm the interim Administrator revealed the MDS should have coded Resident #353's behaviors related to refusing care and was not coded for refusing care. The Administrator further revealed education on coding the MDS accurately and updating the care plan was necessary.</p> <p>20934</p> <p>2. Resident #35 admitted to the facility on [DATE] with diagnoses that included senile degeneration of the brain and vascular dementia with behavioral disturbance.</p> <p>Review of Resident #35's electronic medical record (EMR) revealed a 2/27/24 physician (MD) order completed by the Director of Nursing (DON) that recorded admit to hospice care for the diagnosis of senile degeneration of the brain.</p> <p>A 3/11/24 significant change MDS assessment for Resident #35, was reviewed. Section O, Special Treatments and Programs did not indicate Resident #35 received hospice care.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Saturn Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 West Sugar Creek Road Charlotte, NC 28262	
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 6/18/24 phone interview at 3:35 PM with the Hospice Nurse revealed Resident #35 admitted to hospice care on 2/27/24 and that the Resident currently received hospice care.</p> <p>The MDS Coordinator stated in an interview on 6/18/24 at 4:34 PM that she completed the significant change MDS assessment for Resident #35 on 3/11/24, and that she was not certain why the hospice care was not indicated on the MDS assessment. The MDS Coordinator stated she would review the 3/11/24 significant change MDS for Resident #35 and follow up.</p> <p>During a follow up interview on 6/19/24 at 11:10 AM, the MDS Coordinator stated that it was an oversight that she did not indicate Resident #35 received hospice care on the 3/11/24 significant change MDS. She stated, she was aware of the MD order for hospice care for Resident #35 from a manager's meeting and stated, I should have marked the MDS for hospice care.</p> <p>The DON stated in an interview on 6/18/24 at 4:59 PM, that she updated the EMR for Resident #35 regarding the MD order for hospice care and that the significant change MDS assessment should have been coded to indicate Resident #35 received hospice care.</p> <p>An interview was conducted with the Administrator on 6/20/24 at 2:46 PM. He stated that the 3/11/24 significant change MDS assessment completed by the MDS Coordinator did not reflect hospice care for Resident #35, but that it should have.</p>		

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<p>F 0679</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380</p> <p>Based on record review, facility activity calendar, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 4 of 4 residents reviewed for activities (Resident #1, #50, #54, and #85). The residents expressed not being able to leave the facility for over a year made them feel more dependent, less social, sad, and they missed getting out with the group to shop and socialize.</p> <p>The findings included:</p> <p>A review of the June 2024 activity calendar revealed activities for inside of the facility during the week and on the weekends. There were no activities scheduled for outside of the facility.</p> <p>Observation on 6/17/24 at 9:30 AM revealed the facility was located within a business and residential area that was within driving distance to numerous local and commercial shops, grocery stores, local and commercial coffee shops, fast food, and sit-down restaurants.</p> <p>a. Resident #1 was admitted to the facility on [DATE].</p> <p>An Annual Minimum Data Set (MDS) dated [DATE] indicated Resident #1 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #1 was cognitively intact.</p> <p>An interview was conducted with Resident #1 on 6/19/24 at 10:30 AM during resident council meeting revealed there had not been a scheduled group activity outside of the facility in over two years and the resident council had requested one during their monthly activity meetings, and met with the previous administrator about it and each time was told there was nothing they could do because the van was broken, and they had no other way to transport residents. She stated in her opinion group activities outside of the facility were important to the residents that were able to go and participate because it allowed them some lasting independence, socialization with the group and outside world, and helped with their mental and physical health, it made them feel normal and that they weren't just stuck in a facility. Resident #1 stated not being able to leave the facility in several years and participate in group activities outside the facility had sometimes made her feel as though she had lost some of her own independence and was having to rely on someone else to do her personal shopping instead of on her own. She revealed personally being able to do her own shopping and socializing with other people outside of the facility was very important to her and would make her feel more human and like she still had some independence left.</p> <p>b. Resident #50 was admitted to the facility on [DATE].</p> <p>An Annual Minimum Data Set (MDS) dated [DATE] indicated Resident #50 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #50 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with Resident #50 on 6/19/24 at 10:32 AM during resident council meeting revealed she had been at the facility for the past several years and there had not been a scheduled group activity outside of the facility in over two years. She stated they discussed it with the Activities Director and the previous Administrator and was always told they were not able to schedule activities outside of the facility due to the van being broken, not being able to transport residents, and corporate not approving for any alternate transportation. Resident #50 revealed that going out to eat at a restaurant and socializing or going into a store and being able to touch items and shop for your own personal belongings made you feel independent and normal, and she felt that not being able to do those things over the past several years made her sad, become more reliant on staff and not as social as she used to be and she would just like the opportunity to have those things again.</p> <p>c. Resident #54 was admitted to the facility on [DATE].</p> <p>An Admission Minimum Data Set (MDS) dated [DATE] indicated Resident #54 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #54 was cognitively intact.</p> <p>An interview was conducted with Resident #54 on 6/19/24 at 10:34 AM during resident council meeting revealed since he had been to the facility there had been no scheduled activities outside of the facility. He stated during the monthly activities meeting, residents had discussed with the Activities Director and the previous Administrator about scheduling activities outside of the facility and were told that was not possible because the facility was not able to provide transportation due to the van being broken. He revealed not having scheduled activities outside of the facility made him feel sad, depressed, and like he was missing out on the world. Resident #54 stated that he felt like he was more reliant on staff to purchase his personal items for him, and he would like the opportunity to go shopping for himself or to eat at a restaurant and socialize with other people.</p> <p>d. Resident #85 was admitted to the facility on [DATE].</p> <p>An Annual Minimum Data Set (MDS) dated [DATE] indicated Resident #85 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #85 was cognitively intact.</p> <p>An interview was conducted with Resident #85 on 6/19/24 at 10:36 AM during resident council meeting revealed since he had been to the facility there had been no scheduled activities outside of the facility. He stated he participated in a monthly activity meeting, and they had discussed with the Activities Director and the previous Administrator on a regular basis about scheduling activities outside of the facility. He revealed they were always told that was not possible because the facility was not able to provide transportation due to the van being broken. Resident #85 stated not having the opportunity to participate in activities outside of the facility made him feel sad, lonely, and like he was losing his independence. He revealed that he felt it was important for residents to have scheduled activities outside of the facility because it allowed them to be able to shop and purchase their own items, maintain their independence, and to be able to socialize with the real world.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A telephone interview was conducted with the previous Administrator on 6/19/24 at 2:25 PM revealed he was employed with the facility for the past 2 1/2 years and his last day was on 5/31/24. He stated during the time he worked as the facility Administrator; residents had not been able to participate in scheduled outside of facility activities due to transportation issues. He revealed the facility had two vans but only one of the vans was working, which was used for medical appointments only and corporate would not approve for the other van to be fixed. The previous Administrator stated the Activities Director would speak with him monthly about residents requesting to schedule an activity outside of the facility and he would speak with corporate about fixing the other van or paying for alternate transportation and corporate would not approve for the van to be fixed stating the van was not worth the cost of the repairs and alternate transportation was too expensive. He revealed he did feel that activities outside of the facility were important for residents and allowed them to keep some of their independence and normalcy and he tried to accommodate their requests but without approval from corporate to either fix the other van or pay for alternate transportation, his hands were tied.</p> <p>An interview was conducted with the Activity Director (AD) on 6/20/24 at 9:05 AM revealed she had been working as the AD at the facility for the past 2 years and part of her responsibilities was scheduling and implementing resident activities inside and outside of the facility for each month. She stated since she began working at the facility as the AD, she had not been able to schedule any resident group activities outside of the facility due to transportation issues. She revealed one of the facility vans had been broken since she began working at the facility and she was told by the previous administrator the other facility van could only be used for medical appointments and residents would just have to participate in activities inside of the facility or on facility grounds. The AD stated she had brought the issue to Administration monthly of the residents requesting to schedule activities outside of the facility and each time was told no due to the transportation and alternate transportation for the residents was not available. She revealed she had been doing personal shopping for residents so they could continue to receive their preferences but understood that was not the same as the residents being able to leave the facility and shop for themselves or eat a meal together at a restaurant or watch a movie outside of the facility. She stated she felt like activities outside of the facility for those residents who could participate were important for their overall mental and physical well-being and allowed them some independence.</p> <p>During an interview conducted with the interim Administrator on 6/20/24 at 10:45 AM revealed he began working at the facility on 6/01/24 and was unaware of residents not having been able to participate in activities outside of the facility over the couple of years. He stated he would investigate the issue and see what current and alternative transportation methods were available that could be used to assist the residents being able to participate in activities outside of the facility.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019</p> <p>Based on observations, record review, resident and staff interviews, the facility failed to provide Thrombo-Embotic Deterrent (TED) stockings as ordered by the physician on 11/07/23 and 01/09/24 for a resident with bilateral lower extremity edema (swelling and puffiness of bilateral lower legs, ankles, and feet) (Resident #65) for one of one resident reviewed for quality of care.</p> <p>The findings included:</p> <p>Resident #65 was admitted to the facility on [DATE] with diagnoses which included hypertension, lower extremity edema, and paraplegia (the inability to voluntarily move the lower parts of the body).</p> <p>Review of a physician's progress note written on 11/07/23 revealed Resident #65 was being seen for a regulatory visit with three or more chronic health problems and interval concerns were being addressed as in the assessment below. Under assessment and plan the note read in part:</p> <p>9. Lower extremity edema: Chronic and ongoing.</p> <p>Patient appears to have some baseline lymphedema with no previous diagnosis.</p> <p>Mild 1-2 pitting edema noted. Patient sits in chair majority of the day.</p> <p>Patient states swelling does improve slightly overnight when legs are elevated in bed.</p> <p>Continue to monitor.</p> <p>We are going to place order for TED hose - to place in AM and take off at night and elevated as much as possible since this provides improvement.</p> <p>Review of Resident #65's physician orders revealed an order written on 11/07/23 for TED stockings to bilateral lower legs - apply stockings in the morning when resident gets up and take them off the resident at bedtime before going to bed.</p> <p>Review of Resident #65's physician orders revealed an order written on 01/09/24 for TED stockings to bilateral lower legs - apply stockings in AM and take them off at night prior to going to bed.</p> <p>Review of Resident #65's Medication Administration Record (MAR) for 01/09/24 through 06/19/24 revealed the TED stockings on almost all days and evenings were checked off by the nurses as being applied in the morning and being taken off at bedtime.</p> <p>Review of Resident #65's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact and required substantial to maximal assistance with upper body dressing, personal hygiene, and bed mobility. The assessment also revealed Resident #65 was dependent on staff for toileting hygiene, showers/bed baths, lower body dressing, putting on and taking off footwear and transfers. According to the assessment the resident had no behaviors including no rejection of care.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 06/19/24 at 10:11 AM revealed Resident #65 up in his wheelchair in his room dressed for the day. The resident stated he was supposed to get TED stockings months ago for his bilateral legs due to edema in his lower extremities. He said the edema was from his high blood pressure and sitting up in his chair for several hours a day. Resident #65 further stated he could not recall if they had ever been in to measure him for TED stockings and said he had not received his stockings. His lower legs, ankles and feet were observed to be swollen as he was sitting up in his wheelchair and there were no stockings on his legs just black non-skid socks.</p> <p>An interview on 06/20/24 at 11:10 AM with the Director of Nursing and the Central Supply (CS) clerk revealed they were aware Resident #65 had TED stockings ordered for bilateral lower extremity edema. The CS clerk stated she had ordered the stockings in November of 2023 and February of 2024 but had not received them. She stated she had not followed up with the company to inquire about the stockings. The DON stated their previous owners would not allow them to use other sources for getting supplies and told them they would have to wait for the contracted company to send them the stockings.</p> <p>An interview on 06/19/24 at 3:20 PM with Nurse #1 who was frequently assigned to care for Resident #65 during the 7:00 AM to 7:00 PM shift revealed she had documented his TED stockings as being put on him the morning of 06/19/24 and other dates that she had worked. Nurse #1 was asked to show the resident's TED stockings on him and when she pulled his blanket back to expose his legs, she stated they were not on him. She stated she depended on the NAs to put his stockings on him in the morning and had just assumed his NA had put them on, so she had checked it off on the MAR.</p> <p>A telephone interview on 06/19/24 at 5:11 PM with Nurse #5 who was frequently assigned to care for Resident #65 during the 7:00 PM to 3:00 PM shift revealed she had documented the TED stockings as being put on during the morning on dates she was assigned to Resident #65. Nurse #5 stated the NAs that work with him usually put his TED stockings on him and the nurses document it on the MAR. She said she just assumed it had been done so she signed off on it. Nurse #5 further stated she had never gone into his room and checked to see if he had the stockings on and said she was not aware the resident did not have TED stockings.</p> <p>A telephone interview on 06/19/24 at 5:17 PM with Nurse #6 who was frequently assigned to care for Resident #65 during the 7:00 PM to 7:00 AM shift revealed she had documented on the MAR his TED stockings had been removed prior to him going to bed at night. She stated she depended on the NAs working with the resident to take them off before he goes to bed. Nurse #6 further stated she marked it off on the MAR and the NA took care of taking them off. Nurse #6 indicated no one had told her he didn't have TED stockings and she said she had never gone into the room and checked to see if they were on or off Resident #65 because she assumed the NAs took care of it.</p> <p>An interview on 06/19/24 at 5:27 PM with Nurse Aide (NA) #2 revealed she was frequently assigned to care for Resident #65 during the 3:00 PM to 11:00 PM shift. She stated she had never seen Resident #65 with TED stockings on and said she had never taken them off him prior to putting him to bed at night. NA #2 further stated she had never seen TED stockings in Resident #65's room.</p> <p>An interview on 06/20/24 with Nurse Aide (NA) #1 revealed she was frequently assigned to care for Resident #65 during the 7:00 AM to 3:00 PM shift. She stated she had never put TED stockings on Resident #65 and said she had never seen TED stockings in his room. NA #1 further stated she had only placed non-skid socks on the resident after washing him up and getting him dressed for the day.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>20934</p> <p>Based on observations, record review, and interviews with the wound physician and staff, the facility failed to maintain a dressing intact to a stage 3 sacral pressure ulcer for 1 of 2 sampled residents reviewed for pressure ulcers (Resident #35).</p> <p>The findings included:</p> <p>Resident #35 was admitted to the facility 2/13/17. Some of Resident #35's diagnoses included vascular dementia, Alzheimer's disease, mild protein calorie malnutrition (PCM), failure to thrive and stage 3 sacral pressure ulcer.</p> <p>A care plan revised 3/11/24 recorded Resident #35 had self-care deficits, required staff assistance with activities of daily living (ADL) and at increased risk for developing pressure ulcers due to a history of pressure ulcers, a current pressure ulcer, incontinence, and PCM. Interventions included staff assist Resident #35 with turning and positioning, provide incontinence care and wound care per physician (MD) order.</p> <p>Review of Resident #35's MD orders in the electronic medical record (EMR) recorded a 3/11/24 MD order to cleanse sacral pressure ulcer with wound cleanser, pat dry, apply silver calcium alginate (a debridement), cover with a dry dressing daily and as needed (PRN) until healed.</p> <p>A 5/6/24 MD progress note recorded Resident #35 was evaluated for chronic disease management, received hospice services, required total staff assistance with ADL, received treatment for a stage 3 pressure ulcer of the sacrum, and followed by wound care MD. The plan was to continue with current wound treatments.</p> <p>A 6/10/24 quarterly Minimum Data Set (MDS) assessment recorded Resident #5 had adequate hearing, impaired vision, clear speech, usually understood by others, sometimes understood others, always incontinent of bowel and bladder function and rejected care one to three days of the assessment period. The MDS assessment indicated Resident #35 was at risk for developing pressure ulcers and had an unhealed stage 3 pressure ulcer.</p> <p>The June 2024 Treatment Administration Record documented Resident #35 received wound care per MD order on Sunday, 6/16/24 at 2:30 PM.</p> <p>A 6/17/24 MD Wound Evaluation and Management Summary recorded Resident #35 had a current stage 3 sacral pressure ulcer, that measured 2 centimeters (CM) by, 1 cm, by 0.1 cm with moderate serous exudate (bloody discharge). The wound progress was described as not on goal with her behavior as a possible factor. The treatment plan recorded alginate calcium with sliver, apply once daily for 30 days, apply a gauze island border dressing once daily for 30 days.</p> <p>A 6/17/24 Wound Assessment Note, recorded by Unit Manager (UM) #4 recorded Resident #35 had a stage 3 pressure ulcer to the sacrum with full thickness that measured 2 cm by 1 cm by 0.1 cm, and moderate serous exudate noted as assessed by the wound MD during wound rounds on 6/17/2024.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/17/24 at 10:39 AM, Resident #35 was observed in her room in bed without a brief on or a dressing in place to her stage 3 sacral pressure ulcer. Nurse Aide (NA) #8 provided peri-care and applied a brief.</p> <p>On 6/17/24 at 11:00 AM a wound care observation for Resident #35 with the wound MD and UM #4 revealed the stage 3 sacral pressure ulcer was not covered with a dressing prior to the wound care provided by the wound MD.</p> <p>NA #8 was interviewed on 6/17/24 at 10:39 AM and stated that she had just completed peri care for Resident #35 for bladder incontinence. NA #8 described that she rounded when she came on shift around 7:00 AM on 6/17/24 and checked Resident #35's brief for incontinence, but her brief was dry. She stated that the previous NA did not report to NA #8 that Resident #35 did not have a dressing in place to her sacral pressure ulcer during rounds. NA #8 stated that she did not remove Resident #35's dry brief during rounds and that she could not say if a dressing was in place to the sacral pressure ulcer at the time (7:00 AM) but stated there was no dressing in place or in the brief at 10:30 AM that morning on 6/17/24 when she provided peri care to Resident #35 for the first time that shift. NA #8 described Resident #35 was always incontinent of bowel/bladder and that she provided peri care to Resident #35 before and found her a few times without a dressing in place to her wound; when that occurred, she told the nurse. The brief was observed wet without a dressing in the brief.</p> <p>Multiple attempts to interview the NA assigned to care for Resident #35 on the 11:00 PM to 7:00 AM shift were unsuccessful.</p> <p>On 6/17/24 at 10:41 AM, Nurse #8, the assigned nurse for Resident #35 on the 7:00 AM to 3:00 PM shift stated in interview that this was her first time as the assigned nurse for Resident #35, she was not aware that a dressing was not in place for Resident #35's sacral pressure ulcer and she had not provided wound care to this Resident before.</p> <p>During a phone interview on 6/19/24 at 5:01 PM with Nurse #10, she confirmed she was the 7:00 AM to 3:00 PM Nurse on the south unit where Resident #35 resided on Sunday 6/16/24 but stated that she could not continue the interview due to a family emergency. Nurse #10 ended the call. A follow up attempt to interview Nurse #10 was unsuccessful.</p> <p>A phone interview on 4/21/24 at 4:29 PM, Nurse #11 stated she worked Sunday, 6/16/24 on the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts through an agency. Nurse #11 stated she was the assigned nurse for Resident #35 on 6/16/24 but did not recall providing wound care to this Resident on her shift. Nurse #11 stated that when she worked, she provided wound care per MD order for residents assigned but that she did not recall being notified that Resident #35's dressing was not in place or asked to reapply a dressing to Resident #35's sacral pressure ulcer.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Saturn Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 West Sugar Creek Road Charlotte, NC 28262	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 6/21/24 phone interview at 8:40 AM with Nurse #9 revealed she worked at the facility and she was the assigned nurse for Resident #35 two days per week on the 7:00 AM to 3:00 PM and every other weekend. Nurse #9 described Resident #35 as declining due to poor nutritional status, received hospice services, incontinence care and wound care for a stage 3 sacral pressure ulcer. Nurse #9 stated that at times during incontinence care, the dressing to Resident #35's sacral pressure ulcer came off and sometimes the NA did not tell the nurse which meant Resident #35 was without a dressing to her pressure ulcer for a while. Nurse #9 stated that if she went to provide Resident #35 with treatment for her sacral pressure ulcer and a dressing was not in place, she asked the NA what happened, and often the response was that the dressing came off during incontinence care. Nurse #9 stated that when this occurred, she reminded the NA to tell the nurse so that the dressing could be reapplied. Nurse #9 stated that if a dressing came off during incontinence care, the NA was supposed to tell the nurse so that the nurse could put another dressing on, but that all the NA did not notify the nurse.</p> <p>UM #4 was interviewed on 6/18/24 at 4:44 PM and stated that Resident #35 received treatment for a stage 3 sacral pressure ulcer. UM #4 described that the pressure ulcer was taking a while to heal which could be contributed to Resident #35's poor nutritional status. UM #4 stated that she rounded with the wound MD on 6/17/24 and when wound care was provided to Resident #35, there was no dressing in place to the pressure ulcer, but a dressing should have been in place. UM #4 stated The MD order was for daily wound treatments changes and PRN, so that in the event the dressing came off the nurse should be notified so that a new dressing could be applied. UM #4 stated that due to the location of Resident #35's pressure ulcer, it was at risk for infection and for getting urine/feces in the pressure ulcer which along with her poor nutritional status, could also inhibit the healing of the pressure ulcer.</p> <p>A phone interview on 6/18/24 at 3:35 PM with Hospice Nurse revealed Resident #35 admitted to hospice services with a stage 3 pressure ulcer. The Hospice Nurse stated that it would be of concern if Resident #35's stage 3 pressure ulcer was not covered for an extended period which she described as not changed on the same shift of care. The Hospice Nurse described that the concern would be due to the location of the pressure ulcer, the high risk, if left uncovered, of the pressure ulcer encountering fecal/urine material that could inhibit the healing progress and increase the risk of infection.</p> <p>The Wound Physician (MD) was interviewed on 6/17/24 at 11:00 AM during his evaluation of Resident #35's pressure ulcer. He stated that there was no dressing in place for Resident #35's stage 3 sacral pressure ulcer prior to his evaluation on 6/17/24 during his wound rounds. The Wound MD stated that he would expect Resident #35's stage 3 sacral pressure ulcer to be covered and receive treatment per MD order, which included a MD order for treatment PRN. He further stated that if the dressing came off for any reason, he expected staff to reapply a dressing, per the MD order for PRN treatment and that the pressure ulcer should not be left open like this. A follow up phone interview on 6/19/24 at 4:32 PM, the Wound MD described that Resident #35's stage 3 pressure ulcer had been stagnant for a while which he attributed to her end-of-life status. He stated that Resident #35's behaviors of fighting, punching and scratching staff when staff tried to reposition the Resident used to contribute to the slow healing progress, but stated that since her decline she no longer displayed this behavior, and the current concern was her poor nutritional status. The Wound MD stated that when he assessed the pressure ulcer for Resident #35 on 6/17/24 during wound rounds, she did not have a dressing in place to the pressure ulcer. He further stated that he would be concerned if the pressure ulcer was left uncovered for more than an hour or two as stool/urine could get in the pressure ulcer which increased the risk for contamination and could also be a factor to slow down the healing process along with her nutritional status.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing stated in an interview on 6/18/24 at 4:59 PM that residents with treatment orders for wound care should have a dressing in place per MD order to prevent infection or the wound being contaminated with urine/feces.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>48006</p> <p>Based on record reviews and staff interviews, the facility failed to maintain daily nurse staffing sheets for 244 of 305 days during the period reviewed from August 2023 to May 2024. The facility also failed to ensure the daily nurse staffing sheets were maintained for a minimum of 18 months.</p> <p>The finding included:</p> <p>Review of the daily nurse staffing sheets for October 2023 revealed no information was available for the days of 10/01/2023 through 10/31/2023.</p> <p>Review of the daily nurse staffing sheets for November 2023 revealed no information was available for the days of 11/01/2023 through 11/30/2023.</p> <p>Review of the daily nurse staffing sheets for December 2023 revealed no information was available for the days of 12/01/2023 through 12/31/2023.</p> <p>Review of the daily nurse staffing sheets for January 2024 revealed no information was available for the days of 01/01/2024 through 01/31/2024.</p> <p>Review of the daily nurse staffing sheets for February 2024 revealed no information was available for the days of 02/01/2024 through 02/29/2023.</p> <p>Review of the daily nurse staffing sheets for March 2024 revealed no information was available for the days of 03/01/2024 through 03/31/2024.</p> <p>Review of the daily nurse staffing sheets for April 2024 revealed no information was available for the days of 04/01/2024 through 04/30/2024.</p> <p>Review of the daily nurse staffing sheets for May 2024 revealed no information was available for the days of 05/01/2024 through 05/31/2024.</p> <p>An interview was conducted with the Director of Nursing on 06/19/2024 at 2:43 PM. The Director of Nursing stated that the staffing coordinator was responsible for maintaining the daily nurse staffing sheets.</p> <p>During an interview on 06/20/2024 at 8:25 AM, the staffing coordinator revealed that she was responsible for the daily nurse staffing sheets, and she did not have any daily staff posting sheets from October 2023 through May 2024. She further revealed that the previous Administrator started collecting the daily nurse staffing sheets in October of 2023 and maintained the sheets in his office. She also stated that she does not know what he did with those sheets.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>During an interview with the Administrator on 06/20/2024 at 9:17AM, the Administrator revealed that he was new to the facility as of June 1, 2024. The Administrator also stated that the staffing coordinator was responsible for the daily nurse staffing sheets, and the staffing coordinator had informed him that the previous Administrator collected the daily nurse staffing sheets and maintained them in his office. The Administrator further revealed that he had searched through his entire office and had not found any daily staff posting sheets. The Administrator also confirmed that he was aware of the regulatory requirement to maintain 18 months of daily nurse staffing sheets. The Administrator explained a change in ownership had occurred on June 1st, 2024, and the facility had not been successful in locating the October 2023 to May 2024 daily staff posting sheets.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515</p> <p>Based on record review and staff, physician, and resident responsible party (RP) interviews, the facility failed to discontinue a benzodiazepine medication (Ativan) used for anxiety as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Resident #5).</p> <p>The findings included:</p> <p>Resident #5 was admitted on [DATE] to the facility with diagnoses that included anxiety, unspecified dementia with other behaviors.</p> <p>Review of Resident #5's physician orders from October 2023 revealed the following orders:</p> <ul style="list-style-type: none"> - Ativan 0.5 milligram (mg) tablet - give 1/2 tablet by mouth twice a day for agitation/anxiety with a start date of 07/05/23 and an end date of 10/10/23. - Clonazepam (benzodiazepine medication) 0.25 mg tablet - give 1 tablet by mouth 3 times daily for anxiety with start date of 10/04/23 and an end date of 10/10/23. <p>Additional review of Resident #5's physician orders revealed the following order written on 10/04/23:</p> <ul style="list-style-type: none"> - discontinue Ativan and start clonazepam 0.25mg by mouth three times per day for anxiety with an effective date of 10/04/23. <p>The order was received and transcribed by Former Unit Manager #1.</p> <p>Review of Resident #5's medication administration record revealed Resident #5 received both Ativan 0.5mg and clonazepam 0.25mg from 10/04/23 through 10/10/23.</p> <p>Review of Resident #5's most recent quarterly Minimum Data Set assessment dated [DATE] revealed he was severely impaired with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #5 was coded as taking antianxiety and antidepressant medications.</p> <p>An interview with Resident #5's responsible party on 06/18/24 at 2:15 PM via telephone, revealed on 10/10/23, Resident #5 was sent to the hospital. The following day, she was contacted by a physician from the hospital who informed her that Resident #5 had been receiving Ativan and clonazepam. She continued, stating this was concerning since at a care plan meeting conducted on 10/04/23 it was discussed that the facility would discontinue the use of Ativan and start Resident #5 on clonazepam. She stated she contacted the Director of Nursing (DON) on 10/13/23 and discussed the situation with her and was informed that the continuation of Ativan with the dosing of clonazepam was a medication error and that the facility would investigate and re-educate the staff. Resident #5's responsible party reported he was able to return to the facility following a short hospitalization .</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was completed with Former Unit Manager #1 by telephone on 06/20/24 at 10:07 AM. She reported she remembered Resident #5 and verified she was the staff member that took the physician order to discontinue his Ativan and start clonazepam on 10/04/23. She stated at that the time, she was serving as the unit manager while also working as a hall nurse. Former Unit Manager #1 also verified that Resident #5 received both Ativan and clonazepam from 10/04/23 though 10/10/23 when the facility was contacted by his responsible party, alerting them to the error. She stated she did not know how or why she was able to add and start the clonazepam and did not enter in the discontinue Ativan order into the electronic health record. She reported with her serving as a hall nurse and the unit manager at the time the orders were written, she may have been overwhelmed or had become distracted while entering the orders and had forgotten to enter the discontinue Ativan physician order. She stated Resident #5 was sent out to the hospital on 10/10/23 for heart related issues and the hospital had identified that Resident #5 was prescribed the two medications and reached out to his responsible party who then, in turn, contacted the facility. Former Unit Manager #1 reported during the 7 days that Resident #5 received both the Ativan and clonazepam, she did not note any change in his behaviors or notice him being more lethargic or drowsy.</p> <p>During an interview with the Director of Nursing (DON) on 06/20/24 at 11:59 AM, she reported she remembered the incident and stated it was her understanding that Former Unit Manager #1 had received the telephone order and instead of writing two separate orders, one to discontinue Ativan and another to start clonazepam, she wrote both orders on one physician order form. She stated she could only assume that when Former Unit Manager #1 went to enter the order, she somehow overlooked the entry of discontinue Ativan which resulted in Resident #5 receiving both medications until Resident #5 discharged to the hospital on 06/10/23. The DON reported she completed an investigation into the error, re-educated Former Unit Manager #1 and other hall nurses and medication aides. The DON also stated she contacted the hospital and spoke to Resident #5's attending physician and spoke with him about possible side effects and was told there did not appear to be any adverse effects from Resident #5 receiving both medications. The DON reported during the days that Resident #5 received both Ativan and clonazepam, she did not receive one concern regarding excessive drowsiness, or other potential side effects from Resident #5 receiving both medications. The DON reported Resident #5 returned to the facility after a brief hospitalization .</p> <p>During an interview with the Medical Director on 06/20/24 at 11:14 AM, she reported the risks of taking both Ativan and clonazepam would be excessive drowsiness and respiratory depression. She reported she was not at the facility at the time of the investigation and stated it would be almost impossible for her to determine if Resident #5 had an adverse reaction due to receiving both Ativan and clonazepam. The Medical Director stated it was a medication error, but she was unable to state with certainty if it was a significant medication error.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>40476</p> <p>Based on observations and staff interviews, the facility failed to remove expired over the counter medications available for use from a medication storage room in 2 of 2 medication rooms reviewed for medication storage (south side and west side).</p> <p>The findings included:</p> <p>1a. On 06/19/24 at 10:00 AM during an observation of the south side medication room with Unit Manager (UM) #1 the observation yielded 1 unopened bottle of Vitamin D 10 micrograms (mcg) with an expiration date of 01/24 (January/2024) and 6 unopened bottles of Vitamin D 10 (mcg) with an expiration date of 05/24 (May/2024).</p> <p>On 06/19/24 at 10:10 AM an interview was conducted with Unit Manger #1. During the interview she stated the medication storage room was checked monthly by the facility staff. She stated she was responsible for checking the medication storage room and had just missed the expiration date by mistake. The interview revealed the medication was available for nurses to obtain from the room and should have been discarded if it was past the date listed on the bottle.</p> <p>1b. On 06/19/24 at 10:45 AM during an observation of the west side medication room with Unit Manager (UM) #2 the observation yielded 4 unopened bottles of Vitamin D 10 (mcg) with an expiration date of 05/24.</p> <p>On 06/19/24 at 11:00 AM an interview was conducted with Unit Manger #2. During the interview she stated the medication storage room was checked monthly by staff. She stated she was responsible for checking the west side medication storage room and had not seen the medication had expired. The interview revealed the medication was available for nurses to obtain from the room and should have been discarded if it was past the date listed on the bottle.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/19/24 at 11:31 AM. The DON was informed of the findings in the medication storage rooms and the DON stated the facility staff had looked in both rooms a couple of days prior and had not found the expired medication. She stated the facility went by the expiration date listed on the bottle of the medication and the expired medications should have been discarded.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934</p> <p>Based on a lunch meal test tray observation, record review and resident interviews (Resident #4, #70, #153 and #65), the facility failed to provide food per resident preference for taste and temperature for 4 of 4 sampled residents on the south unit reviewed for food palatability. This failure had the potential to affect a census of 93 residents who received food in the facility.</p> <p>The findings included:</p> <p>1a. Resident #4's admitted to the facility was 10/31/20 and included diagnoses of type 2 diabetes mellitus, hypertension, and hyperlipidemia (high blood cholesterol).</p> <p>Resident #4's 5/17/24 annual Minimum Data Set (MDS) assessment recorded adequate hearing, adequate vision with corrective lenses, spoke clearly, understood, understands, severely impaired cognition, received a therapeutic diet and fed herself after staff assisted to set up her meal tray.</p> <p>Resident #4's care plan, revised May 2024 recorded she was at risk for altered nutrition due to her receipt of a regular therapeutic diet, with no added salt. Interventions included providing foods per her preferences.</p> <p>An observation of the lunch meal on 6/17/24 at 12:08 PM, revealed Resident #4's lunch meal tray card recorded a regular diet with no added salt. Resident #4 received ham and macaroni casserole, and spinach for lunch. Resident #4 fed herself lunch after staff assisted in setting up her tray. While eating her lunch, when asked if she liked her food, she stated, This macaroni is not good and it's not hot. Resident #4 did not eat the macaroni and ham casserole she received for lunch.</p> <p>1b. Resident #70's re-admitted to the facility was 9/6/23 with diagnoses that included type 2 diabetes mellitus and hyperlipidemia.</p> <p>Resident #70's 4/26/24 quarterly MDS assessment recorded adequate hearing, impaired vision, spoke clearly, understood, understands, severely impaired cognition, received a mechanically altered, therapeutic diet and fed herself after staff assisted to set up her meal tray.</p> <p>Resident #70's care plan, revised 5/1/24 recorded she was at risk for inadequate nutritional intake due to her receipt of a mechanically altered, therapeutic diet. Interventions included providing foods per her preferences.</p> <p>An observation of the lunch meal on 6/17/24 at 12:19 PM, revealed Resident #70's lunch meal tray card recorded a mechanical soft textured no concentrated sweets diet. Resident #70 received ham and macaroni casserole, and spinach for lunch. Resident #70 fed herself lunch after staff assisted in setting up her tray. While eating her lunch, when asked if she liked her food, she stated, I don't like these greens, they are not hot. Resident #70 did not eat the spinach she received for lunch.</p> <p>1c. Resident #153 was readmitted to the facility on [DATE] and included diagnoses of chronic renal failure and hypertension.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #153's 6/10/24 quarterly MDS assessment recorded adequate hearing, adequate vision, clear speech, understood, understands, intact cognition, received a therapeutic diet and fed herself after staff assisted to set up her meal tray.</p> <p>Resident #153's care plan, revised 6/14/24 recorded she was at risk for altered nutrition due to her receipt of a regular therapeutic diet, with no added salt. Interventions included providing foods per her preferences.</p> <p>An interview with Resident #153 and observation occurred on 6/19/24 at 12:43 PM. Resident #153's lunch meal remained covered and uneaten at the time of the observation. Resident #153 stated that she did not receive salt on her meal tray with her food, and she did not like the food. Resident #153 stated, They could do better with the food and add more seasonings, it's like they just open a can and pour it in the pot.</p> <p>1d. The admitted for Resident #65 to the facility was 12/8/22 and included a diagnosis of hypertension.</p> <p>Resident #65's 5/13/24 quarterly MDS assessment recorded adequate hearing, adequate vision with corrective lenses, spoke clearly, understood, understands, intact cognition, received a therapeutic diet and fed himself after staff assisted to set up his meal tray.</p> <p>Resident #65's care plan, revised 5/24/24 recorded he was at risk for cardiac complications and altered nutrition regarding his diagnosis of hypertension and receipt of a therapeutic diet. Interventions included providing foods per diet order and preferences.</p> <p>Resident #65 stated in an interview on 6/17/24 at 4:49 PM that since the fall of 2023, he reported to dietary staff that he did not like the taste of the food and the facility served cold food. He stated that dietary staff advised that the facility served foods per the corporate menus/recipes which was out of the facility's control, so he asked his family to provide him food or he ordered out. Resident #65 provided pictures from his mobile phone for review of foods received at the facility dated October 2023 to May 2024. A follow up phone interview on 6/21/24 at 9:20 AM, Resident #65 stated he received fish cakes for dinner on Wednesday, 6/20/24, and described that the fish cakes were grey on the inside. He stated, When I bit into it, the fish should have been white, but it was grey, so I could not eat it. He further stated that the food at the facility was not the quality of food he should receive, and the food quality was just not good.</p> <p>1e. A request for a lunch meal test tray from the tray line occurred on 6/17/24 at 11:58 AM. On 6/17/24 at 12:05 PM, 16 trays left the kitchen for delivery to the south unit and the cup of tea placed on the test tray in the kitchen contained ice cubes. The meal cart arrived on the south unit on 6/17/24 at 12:07 PM and two staff delivered meal trays to residents on the south unit until 12:48 PM. A sample of the lunch meal test tray occurred on 6/17/24 at 12:49 PM. The Certified Dietary Manager (CDM) removed the lid from the test tray and stated she did not see any steam coming from the food. The CDM added margarine to the food, which remained congealed and required continuous stirring to melt. The CDM tasted the food on the test tray and stated the macaroni and ham casserole would have been really good if it was hot, that it was slightly warm, but not hot. The CDM stated the spinach was not hot like it was when she tasted it in the past right off the line. An observation of the cup of tea on the test tray revealed the tea was without ice and had a watered appearance.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Saturn Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 West Sugar Creek Road Charlotte, NC 28262	
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the CDM on 6/18/24 at 12:25 PM for follow up she stated that she was aware of resident complaints of cold food on the weekends in September 2023 and since then she and the corporate dietary staff responded by completing test trays on the weekends. The CDM stated that when she conducted a test tray, she sampled food right from the tray line, monitored food temperatures in the kitchen and based on her weekend test tray audits of food right from the tray line, she had no current concerns with cold food. The CDM stated that if there were current concerns with cold food, nursing staff would need to increase the availability of staff to distribute meal trays to residents. She stated that there was one resident, she identified as Resident #65 who she stated complained for a while about the food, and that she told Resident #65 that dietary staff followed corporate menus/recipes, complaints were forwarded to the corporate office and that menu changes were out of her control. The CDM stated that the corporate office did not approve all the requested menu changes, but the dietary department changed what they could. The CDM stated she told residents about the alternate menu, but residents preferred to order food for delivery or have family provide them food.</p> <p>An interview on 6/20/24 at 1:40 PM with the District Training Dietary Manager revealed the facility was a new account for her, the facility was in transition to new management, she was unaware of resident complaints of food quality but that she would discuss that further with the CDM.</p> <p>The Director of Nursing (DON) interview on 6/19/24 at 6:00 PM revealed that the facility was currently in transition to new management and working through some of the logistics with dining services to provide residents with meals that were not cold, but palatable.</p> <p>The Administrator interview on 6/20/24 at 2:46 PM revealed that staff should all be available during meals, nurses needed to know that meal trays were on the halls so that all hands are on deck to assist residents with their meals and allow residents to receive hot food.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380</p> <p>Based on observations, resident and staff interviews the facility failed to provide evening snacks to residents when requested for 4 of 4 residents (Resident #1, #50, #54, and #85) reviewed for frequency of snacks. This practice had the potential to affect other residents who requested evening snacks.</p> <p>The findings included:</p> <p>a. Resident #1 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes.</p> <p>The annual Minimum Data Set (MDS) dated [DATE] indicated Resident #1 was cognitively intact.</p> <p>An interview with Resident #1 during resident council meeting on 6/19/24 at 10:30 AM revealed since she had been at the facility she might have received an evening snack maybe once or twice but not on a consistent basis. She stated she did not have the money to be able to purchase her own snacks all of the time and felt the facility should be able to provide her with an evening snack when requested. Resident #1 revealed when she would ask staff about receiving an evening snack, they would tell her there were no snacks available in the nourishment room for them to give to her and they did not have access to get snacks from the kitchen.</p> <p>b. Resident #50 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes.</p> <p>An annual MDS dated [DATE] indicated Resident #50 was cognitively intact.</p> <p>An interview with Resident #50 during resident council meeting on 6/19/24 at 10:31 AM revealed during her stay at the facility she might have received an evening snack maybe once or twice but not on a consistent basis. She stated she would have her family bring her snacks or buy them herself. Resident #50 revealed when she would ask staff about receiving an evening snack, they would tell her there were no snacks available for them to give to her.</p> <p>c. Resident #54 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes.</p> <p>An admission MDS dated [DATE] indicated Resident #54 was cognitively intact.</p> <p>An interview with Resident #54 during resident council meeting on 6/19/24 at 10:32 AM revealed during her stay at the facility she had never received an evening snack on a consistent basis. He stated he was never made aware that he could request an evening snack and staff have never offered him an evening snack. He revealed he did not have the money to buy snacks and drinks all the time, so having an evening snack and drink offered and available would be nice.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. Resident #85 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes.</p> <p>An annual MDS dated [DATE] indicated Resident #85 was cognitively intact.</p> <p>An interview with Resident #85 during resident council meeting on 6/19/24 at 10:33 AM revealed since he had been at the facility he had never received an evening snack or been offered an evening snack consistently. He stated sometimes nursing staff will ask if you want a snack and other times you must request it and when you do the staff will usually come back and say they couldn't find any snacks in the nourishment room and they were not able to access the kitchen for more snacks.</p> <p>An observation of nourishment rooms on 6/17/24 and 6/19/24 revealed no snacks, sandwiches, or drinks available for residents.</p> <p>An interview with Nursing Assistant (NA) #6 on 6/19/24 at 3:05 PM revealed she worked both 1st and 2nd shift and had never seen evening snacks being offered to residents, she had never offered evening snacks to residents, and had never been told to offer evening snacks to residents. She stated if a resident asked for a snack, then staff would get them one, but she wasn't sure if most residents were aware they could request a snack or that snacks were supposed to be offered. She revealed the nourishment rooms did not keep snacks, juices, or sandwiches in them for residents so staff would have to request those from the kitchen, and to her knowledge the kitchen did not order or keep diabetic or sugar free snacks for residents and they did not have pudding or Jello, only applesauce for the medication carts and the only soda available was ginger ale for dialysis residents only. NA #6 stated she felt it was important for residents to be offered snacks but for the facility to have a variety of snacks including diabetic snacks for the residents.</p> <p>An interview with NA #7 on 6/19/24 at 3:11 PM revealed she worked both 1st and 2nd shift at the facility. She stated to her knowledge staff do not offer residents evening snacks but if a resident requested a snack, they would provide them with one. She stated she was not sure why staff did not offer evening snacks; and had never been told to offer evening snacks to residents and never seen other staff offering evening snacks. She revealed it would make sense to offer residents an evening snack because not all residents are able to request an evening snack, and some require certain types of snacks or liquids based on their diets. NA #7 stated she did not recall residents complaining about not receiving an evening snack, but she was also not sure if most residents were aware staff should be offering an evening snack or could request an evening snack. She revealed the nourishment rooms did not keep available snacks or drinks in them for residents so any request for those items staff would get from the kitchen and to her knowledge the facility did not order or have available any sugar-free snacks, puddings, or Jello for residents with diet restrictions.</p> <p>An interview with the Dietary Manager on 6/20/24 at 9:48 AM revealed every morning and afternoon dietary staff were supposed to provide nursing staff on each hall with a bag of snacks for residents that included some crackers, chips, and snack cakes. She stated nursing staff should be offering snacks to each resident, but she believed they only provided snacks to residents who asked. She revealed dietary did not order or have available sugar-free snacks, puddings, or sodas and they do not stock the nourishment rooms with snacks, sandwiches, juices or milk. The dietary manager stated if a resident or staff let her know about a resident preference for a sandwich or chips, she will make sure to include those items on the resident's lunch or dinner tray but was not sure about snacks for residents who are not able to make requests or needed an alternative snack due to dietary restrictions.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the interim Administrator on 6/20/24 at 10:45 AM revealed he was not aware of snacks and drinks not being available in the nourishment rooms and residents not being offered or receiving their evening snacks. He stated he expected there to always be a variety of snacks available for residents, dietary staff should be ordering a variety of snacks and drinks at least monthly, nourishment rooms should always be stocked, and nursing staff should be offering and assisting with resident snack and drink requests.</p> <p>An interview with the Director of Nursing (DON) on 6/20/24 at 11:55 AM revealed she was not aware there was an issue with residents not receiving or being offered evening snacks. She stated nursing staff should be offering all residents an evening snack and if there was an issue with not having snacks available she would expect administration to be notified immediately so they could correct the issue.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>20934</p> <p>Based on observations, interviews, manufacturer's recommendations and record review, the facility failed to have a thermometer that registered an accurate temperature in 1 of 1 kitchen reach-in refrigerators and 1 of 4 nourishment room refrigerators on the south unit. The facility failed to use a quaternary ammonia (QUAT) sanitizer (a chemical disinfectant) per manufacturer recommendations of 150 - 400 parts per million for manual dishwashing in the three-compartment sink, use a condiment cart free of food debris, and wear a beard restraint (a facial hair guard) during kitchen tasks. This failure had the potential to affect food served to residents.</p> <p>The findings included:</p> <p>1a. An observation with the Certified Dietary Manager (CDM) on 6/17/24 at 11:55 AM of the thermometer inside the kitchen reach-in refrigerator revealed a temperature of 28 degrees Fahrenheit (F). The CDM obtained a temperature of 38.5 degrees F for an eight-ounce carton of milk that was stored in the kitchen reach-in refrigerator. The CDM stated she would place a new thermometer in the kitchen reach-in refrigerator to check for accuracy of the temperature.</p> <p>On 6/20/24 at 12:49 PM during a follow up observation of the kitchen reach-in refrigerator, the new thermometer revealed a temperature of 38 degrees F.</p> <p>1b. An observation on 6/17/24 at 12:30 PM of the south unit nourishment room occurred with the CDM. The thermometer stored inside the nourishment room refrigerator revealed a temperature of 28 degrees. The refrigerator contained multiple unopened containers of high calorie nutritional supplements. The CDM stated she would place a new thermometer in the nourishment room refrigerator to check for accuracy of the temperature.</p> <p>On 6/19/24 at 4:00 PM, during a follow up observation of the south unit nourishment room refrigerator the new thermometer revealed a temperature of 38 degrees F.</p> <p>On 6/20/24 at 12:49 PM, the CDM stated she placed a new thermometer in the kitchen reach-in refrigerator and in the south unit nourishment room refrigerator on 6/17/24 and discarded the thermometers that were in use because the thermometers were not working. The CDM further stated that dietary staff periodically monitored the refrigerator thermometers for accuracy, but that she did not notice that the two thermometers were not working. She could not recall the last time the thermometers were checked for accuracy.</p> <p>An interview with the Administrator on 6/20/24 at 2:50 PM revealed he expected thermometers to provide accurate refrigerator temperatures and that dietary staff would require re-education on monitoring the refrigerator thermometers for accuracy.</p> <p>2. Review of the QUAT sanitizer manufacture recommendations revealed the acceptable range for concentration of the QUAT sanitizer was 150 - 400 parts per million (PPM).</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Instructions posted above the three-compartment sink recorded to fill the third sink with water to the fill line, add a chemical sanitizing solution, use a test kit to check the concentration of the sanitizing solution and immerse clean dishes in the solution for 30 seconds.</p> <p>An observation on 6/20/24 at 1:40 PM of the three-compartment sink while in use by [NAME] #1 revealed the water level in the sink was approximately six inches below the water fill line label on the sink. [NAME] #1 was observed washing dishes manually at the three-compartment sink. [NAME] #1 stated that the water in the three-compartment sink was set up by the Training District Dietary Manager (DM) and that [NAME] #1 did not check the concentration of the QUAT sanitizer in the three-compartment sink before she began to wash dishes manually.</p> <p>On 6/20/24 at 1:41 PM the Training District DM used a QUAT sanitizer test strip to check the concentration of the QUAT sanitizer in the three-compartment sink and obtained a reading that registered greater than 400 parts PPM, as evidenced by a darker color than the manufacturer recommendation of 400 PPM for maximum concentration. The Training District DM stated that she turned on the water to fill the three-compartment sink and left the water running but [NAME] #1 turned the water off before the water reached the water fill line. The Training District DM stated that the concentration of the QUAT sanitizer should be checked to ensure the correct concentration.</p> <p>The Administrator stated in an interview on 6/20/24 at 2:50 PM, that the dietary staff should check the concentration of the QUAT sanitizer to disinfect dishes per manufacture recommendations. He stated that dietary staff would require re-education on the use of the three-compartment sink.</p> <p>3. A lunch meal tray line observation occurred on 6/17/24 from 11:40 AM until 12:07 PM. The condiment cart was observed in use by Dietary Aide (DA) #1. The condiment cart was observed soiled with brown stains and the compartments on the condiment cart were observed with a heavy buildup of white and black granular food debris.</p> <p>DA #1 stated on 6/17/24 at 11:59 AM that she did not notice the condiment cart was soiled and that the compartments had a heavy buildup of food debris.</p> <p>On 6/17/24 at 12:00 PM, the Certified Dietary Manager observed the posted cleaning schedule and stated the condiment cart was scheduled for weekly cleaning. She said per the cleaning schedule, the condiment cart was last cleaned on 6/11/24, but that the cleaning schedule would need to be revised to allow for more frequent cleaning of the condiment cart.</p> <p>The Administrator stated on 6/20/24 at 2:50 PM in an interview that the condiment cart should be maintained clean by dietary staff and that re-education would be provided on maintaining the condiment cart clean.</p> <p>4. A lunch meal tray line observation occurred on 6/17/24 from 11:40 AM until 12:07 PM. Dietary Aide (DA) #2 was observed assisting on the lunch meal tray line when he took food carts out of the kitchen for delivery of the lunch meal to residents. DA #2 had a full beard but did not wear a beard restraint for his facial hair.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/17/24 at 12:07 PM, DA #2 stated he arrived at work that day at 7:00 AM and that he worked in the kitchen for the past nine months as a cook and a dietary aide. He stated that he was aware that he should have a beard restraint in place to cover his facial hair, but that he just forgot to put on a beard restraint to cover his facial hair when he arrived to work that day.</p> <p>On 6/20/24 at 12:49 PM, the Certified Dietary Manager (CDM) stated that all dietary staff should have hair restraints in place and staff with facial hair should have a beard restraint in place while completing tasks in the kitchen. The CDM stated that she did not notice that DA #2 did not have a beard restraint in place while completing kitchen tasks on 6/17/24.</p> <p>The Administrator stated on 6/20/24 at 2:50 PM in an interview that all dietary staff were trained to have hair and beard restraints in place while completing tasks in the kitchen. He stated that re-education would be provided to the dietary department on the use of hair restraints.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>20934</p> <p>Based on observations, and interviews, the facility failed to maintain the lid closed for one of two commercial trash dumpsters and the grounds surrounding the trash dumpster free of broken equipment and bags of odorous trash. This failure attracted pest activity around the exposed trash.</p> <p>The findings included:</p> <p>An observation on 6/20/24 at 9:03 AM revealed the trash dumpster lid was not closed and exposed multiple bags of odorous trash and broken cardboard boxes stored inside the trash dumpster. The grounds around the trash dumpster were observed with multiple items of broken equipment stored on the grounds. The broken items included two broken motorized wheelchairs, one broken bed, one plastic table and two broken wooden pallets. Two large utility trucks were also observed on the grounds near the trash dumpster without lids that exposed multiple bags of odorous trash. Multiple flies were observed around the opened commercial trash dumpster and the utility trucks with bags of exposed trash. A second trash dumpster was observed available for use, and it was observed to be full of trash.</p> <p>A second observation on 6/20/24 at 12:50 PM of the trash dumpster and surrounding grounds occurred with the Certified Dietary Manager (CDM), the Training District Dietary Manager (DM), the Maintenance Director and the Housekeeping District Manager. The lid of the trash dumpster was not closed and the surrounding grounds near the trash dumpster was observed with multiple items of broken equipment stored on the grounds and two large utility trucks without lids that exposed multiple bags of odorous trash. Multiple flies were observed around the opened commercial trash dumpster and the utility trucks with bags of exposed trash.</p> <p>The CDM stated on 6/20/24 at 12:50 PM that two trash dumpsters were just delivered on 6/18/24 and that the facility was expecting a third trash dumpster as two commercial trash dumpsters were not enough to contain the trash off the grounds.</p> <p>The Training District DM stated in an interview on 6/20/24 at 1:00 PM that the second commercial trash dumpster used by the dietary department was full of trash and could not be used to store more trash.</p> <p>The Maintenance Director stated in an interview on 6/20/24 at 1:11 PM that he was the previous Maintenance Director at the facility a few months ago and returned to the facility in his role on Monday, 6/17/24. He stated that when he returned on Monday, 6/17/24, there were no commercial trash dumpsters at the facility. He stated two commercial trash dumpsters were delivered to the facility on Tuesday, 6/18/24. The Maintenance Director stated that the broken equipment was stored on the grounds when he arrived at the facility on Monday, 6/17/24 and that he arranged on Thursday, 6/20/24 for someone in the community to pick up the broken equipment. He stated that he advised staff not to place the two large open utility trucks with bags of exposed trash outside until the third commercial trash dumpster was delivered. However, he stated that staff placed the bags of exposed trash outside anyway in the two large utility trucks without lids and so the exposed trash and broken equipment remained outside on the grounds awaiting delivery of a third commercial trash dumpster.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019</p> <p>Based on observations, record review, resident and staff interviews, the facility failed to ensure a resident's medical record accurately reflected that Thrombo-Embolitic Deterrent (TED) stockings were not being applied in the morning and removed at night as ordered by the physician for a resident with bilateral lower extremity edema (swelling and puffiness of bilateral lower legs, ankles, and feet). This was for one of one resident (Resident #65) reviewed for accuracy of medical records.</p> <p>The findings included:</p> <p>Resident #65 was admitted to the facility on [DATE].</p> <p>Review of Resident #65's physician orders revealed an order written on 01/09/24 for TED stockings to bilateral lower legs - apply stockings in AM and take them off at night prior to going to bed.</p> <p>Review of Resident #65's Medication Administration Record (MAR) for 01/09/24 through 06/19/24 revealed the TED stockings on almost all days and evenings were checked off by the nurses as being applied in the morning and being taken off at bedtime.</p> <p>Review of Resident #65's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact.</p> <p>Observation and interview on 06/19/24 at 10:11 AM revealed Resident #65 up in his wheelchair in his room dressed for the day. The resident stated he was supposed to get TED stockings months ago for his bilateral legs due to edema in his lower extremities. He said the edema was from his high blood pressure and sitting up in his chair for several hours a day. His lower legs, ankles and feet were observed to be swollen as he was sitting up in his wheelchair and there were no stockings on his legs just black non-skid socks.</p> <p>An interview on 06/20/24 at 11:10 AM with the Director of Nursing revealed she was aware Resident #65 had TED stockings ordered by the physician and said they had not received them from the durable medical equipment company they had ordered them from. She stated she was not aware the Nurses were documenting the TED hose as being put on in the morning and taken off at night. She further stated she would have expected them to have documented on the MAR that the stockings were not available and said the Nurses obviously needed education on accurately documenting in the resident's electronic medical record including the MAR.</p> <p>An interview on 06/19/24 at 3:20 PM with Nurse #1 who was frequently assigned to care for Resident #65 during the 7:00 AM to 7:00 PM shift revealed she had documented his TED stockings as being put on him the morning of 06/19/24 and other dates that she had worked. Nurse #1 was asked to show the resident's TED stockings on him and when she pulled his blanket back to expose his legs, she stated they were not on him. She stated she depended on the NAs to put his stockings on him in the morning and had just assumed his NA had put them on, so she had checked it off on the MAR.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Saturn Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 West Sugar Creek Road Charlotte, NC 28262	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A telephone interview on 06/19/24 at 5:11 PM with Nurse #5 who was frequently assigned to care for Resident #65 during the 7:00 PM to 3:00 PM shift revealed she had documented the TED stockings as being put on during the morning on dates she was assigned to Resident #65. Nurse #5 stated the NAs that work with him usually put his TED stockings on him and the nurses document it on the MAR. She said she just assumed it had been done so she signed off on it. Nurse #5 further stated she had never gone into his room and checked to see if he had the stockings on and said she was not aware the resident did not have TED stockings.</p> <p>A telephone interview on 06/19/24 at 5:17 PM with Nurse #6 who was frequently assigned to care for Resident #65 during the 7:00 PM to 7:00 AM shift revealed she had documented on the MAR his TED stockings had been removed prior to him going to bed at night. She stated she depended on the NAs working with the resident to take them off before he goes to bed. Nurse #6 further stated she marked it off on the MAR and the NA took care of taking them off. Nurse #6 indicated no one had told her he didn't have TED stockings and she said she had never gone into the room and checked to see if they were on or off Resident #65 because she assumed the NAs took care of it.</p> <p>An interview on 06/19/24 at 5:27 PM with Nurse Aide (NA) #2 revealed she was frequently assigned to care for Resident #65 during the 3:00 PM to 11:00 PM shift. She stated she had never seen Resident #65 with TED stockings on and said she had never taken them off him prior to putting him to bed at night. NA #2 further stated she had never seen TED stockings in Resident #65's room.</p> <p>An interview on 06/20/24 with Nurse Aide (NA) #1 revealed she was frequently assigned to care for Resident #65 during the 7:00 AM to 3:00 PM shift. She stated she had never put TED stockings on Resident #65 and said she had never seen TED stockings in his room.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49160</p> <p>Based on observations, record review, and staff interviews the facility failed to follow their Enhanced Barrier Precautions (EBP) policy when a nurse failed to wear a gown while providing tracheostomy care for 1 of 6 residents (Resident #62) reviewed for infection control practices.</p> <p>The findings included:</p> <p>A review of the facility's policy entitled Categories of Transmission Based Precautions last revised October 2018 stated Enhanced Barrier Precautions requires the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). The policy further stated High-contact resident care activities included device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing.</p> <p>An observation conducted on 6/17/24 at 12:02 PM revealed Resident #62 had EBP signage on the door to his room and personal protective equipment (PPE) including gloves and gowns beside his door. The EBP signage stated, All healthcare personnel must: wear gloves and gown for the following high-contact resident care activities which listed Device care or use: central line, urinary catheter, feeding tube and tracheostomy.</p> <p>An observation was conducted on 6/19/24 at 2:33 PM of Nurse #1 providing tracheostomy care for Resident #62. Nurse #1 performed hand hygiene upon entering the room and donned a clean pair of gloves. She did not don a gown. Nurse #1 removed the cap of the tracheostomy and then doffed her gloves and performed hand hygiene. She donned a clean pair of gloves before cleaning the tracheostomy site but did not don a gown.</p> <p>An interview conducted with Nurse #1 on 6/19/24 at 2:55 PM revealed she received training on the facility's EBP policy and procedure. Nurse #1 stated she was aware Resident #62 was on EBP due to having a catheter and she wore a gown when providing his catheter care. Nurse #1 indicated she did not wear a gown when providing Resident #62's tracheostomy care because it was not high contact care. Nurse #1 reviewed the EBP signage on Resident #62's door and stated according to the signage she should have worn a gown when providing tracheostomy care.</p> <p>An interview was conducted with the Director of Nursing (DON) on 6/20/24 at 11:20 AM. She indicated she was also the facility's Infection Preventionist. She stated the facility's EBP policy required staff to wear gowns and gloves when providing high contact care for any resident with a wound, catheter, tracheostomy, feeding tube, or central line. The DON indicated all staff received EBP training when the policy was implemented 4/1/24. She further indicated newly hired staff receive the training during orientation. The DON revealed when they identify a resident requiring EBP, a sign was placed on the resident's door and PPE was made available outside of their room. The DON stated a nurse providing tracheostomy care should wear a gown and gloves</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Administrator on 6/20/24 at 2:18 PM. He stated his employment at the facility began on 6/1/24 and he was not yet familiar with their EBP policy. The Administrator further stated staff should follow the policy for any infection precautions put in place for a resident and appropriate PPE should be worn.</p>		