STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on record review, staff, resident and Resident Representative (RR) interviews, the facility failed to ensure advanced directive information was correct throughout the medical record for 1 of 5 residents (Resident #65) reviewed for advanced directives. Findings included: Resident #65 was admitted to the facility on [DATE]. A review of Resident #65's medical chart located at the nurse's station revealed a signed Medical Orders for Scope of Treatment (MOST) form dated 10/18/23 signed by the RR and the Nurse Practitioner that read Attempt Resuscitation (cardiopulmonary resuscitation). A review of the care plan meeting note written by the Social Service Director dated 8/14/24 revealed Resident #65 and her RR attended the meeting and Resident #65 desired for her code status to be changed to Do Not Resuscitate (DNR). A review of the electronic medical record (EMR) indicated Resident #65 had an active physician order dated 8/20/24 that read Full Code. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #65 was moderately cognitively impaired. A review of the care plan dated 11/12/24 indicated Resident #65's code status was DNR. An interview with Unit Manager #1 on 11/20/24 at 3:07 PM revealed the Social Service Director was responsible for reviewing code status with the residents and/or the RR and updating the MOST form if there was a change. She indicated the Social Service Director then notified the nurse manager so they could obtain the physician's order and update the EMR. Unit Manager #1 stated she was not aware that Resident #65 had a change in her code status. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the Social Service Director on 11/20/24 at 3:20 PM indicated she reviewed code status with the resident and/or RR quarterly with the care plan. She stated if the resident and/or RR desired a change she updated the MOST form and care plan and then notified the nurse manager to obtain the physician order and update the EMR. She indicated she did not recall Resident #65 changing her code status to DNR during the care plan meeting on 8/14/24. The Social Service Director revealed she was unsure why Resident #65's care plan reflected the change to DNR, but the MOST form, physician order and EMR had not been updated. An interview with Nurse #2 on 11/21/24 at 9:02 AM revealed to determine a resident's code status she looked at the EMR or the resident's MOST form located in a chart at the nurse's station. Nurse #2 indicated Resident #65's code status was Full Code. An interview conducted with Resident #65 and her RR on 11/21/24 at 3:45 PM indicated Resident #65 desired to have a DNR and did not want to be resuscitated. The RR stated they have discussed Resident #65's code status with the Social Service Director and the facility was aware of her wishes. An interview was conducted with the Director of Nursing (DON) on 11/22/24 at 10:25 AM. She stated the Social Service Director reviewed code status with the resident and/or RR quarterly and if there was a change she updated the MOST form and the care plan. She indicated the Social Service Director also notified the nurse manager of the change so they could obtain the physician's order and update the resident's code status in the EMR. The DON revealed when a resident changed their code status the medical record should be updated and the code status should be correct throughout the resident's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on record review and interviews with staff, Resident, Nurse Practitioner (NP) #2, NP #3 and Medical Director (MD), the facility failed to immediately consult with NP #3, the on-call medical provider, when Resident #49 who had a pre-existing traumatic brain injury lost consciousness and was slumped in his chair after being hit on the back of his head by Resident #79, his roommate. On 09/14/24 at 9:05 AM Nurse #3 heard a loud hit or thud coming from across the unit. She noted Resident #49 was in his wheelchair rolling out from his room and witnessed Resident #79 swing his arm with a fist and hit Resident #49 on the back of the head. NP #3 was notified after the incident occurred about an altercation between Resident #49 and Resident #79 but was not consulted about the blow to Resident #49's head, the slumping in the chair and the loss of consciousness for a few seconds. Resident #49 had a change of condition after the altercation occurred. He slid out of his wheelchair. His level of assistance needed for transfer and bed mobility changed and he was confused. Later in the day and as his condition continued to decline, staff assessed Resident #49 with altered mental status (AMS) and he was sent to the hospital for evaluation due to a concern for a concussion after a fall. The deficient practice affected 1 of 3 residents reviewed for physician notification (Residents #49). Immediate jeopardy began on Saturday, 09/14/24, when the facility failed to immediately consult with NP #3 about Resident #49 who had a pre-existing traumatic brain injury and had a significant change in condition following a blow to the head with a brief loss of consciousness. The immediate jeopardy was removed on 11/23/24 when the facility implemented an acceptable credible allegation. The facility remains out of compliance at a lower scope and severity of a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. The findings included: Resident #49 was admitted to the facility on [DATE] with a diagnosis of traumatic brain injury (TBI). A review of Resident #49's quarterly Minimum Data Set assessment dated [DATE] revealed he was cognitively intact. Resident #49 was coded as independent for eating and putting on/ taking off footwear. He required set up or clean up assistance for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and personal hygiene. Resident #49 required supervision assistance for chair to bed transfers, toileting transfers, tub/shower transfers and lying to sitting on the side of the bed. The resident was noted to be independent for rolling left and right while in bed. Resident #49 was continent of bowel and bladder during the assessment period and was documented to have no behaviors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A nursing note written by Nurse #3 dated 09/14/24 at 10:11 AM revealed she heard hitting noises and turned around to observe Resident #79 hit Resident #49 get hit in the head. The note revealed the residents were separated and assessed for injuries. Resident #49's vital signs were the following: blood pressure 138/66; pulse 72; temperature 97.9; respirations 20; and oxygen saturation level 96% on room air. The Resident was noted with no signs of acute distress at the time of the incident and no complaints of pain. Redness was noted to the back of the Resident's neck. The Resident's Responsible Party, Director of Nursing and on call Nurse Practitioner (NP #3) were notified about the abuse and the Resident's status. On 11/19/24 at 11:38 AM an interview was conducted with Nurse #3. Nurse #3 stated on 09/14/24 around 9:00 AM she heard a loud hit or thud coming from across the unit. She then saw Resident #49 rolling out from his room in his wheelchair and witnessed, Resident #79 swinging his arm with a fist and hit Resident #49 in the back of the head making a second thud sound as his fist hit the back of Resident #49's head. Resident #49 immediately slumped over in his wheelchair as a result of the incident. Nurse #3 stated Resident #49 regained consciousness within a couple of seconds after she got to him to assess his condition. She stated she saw redness at the back of Resident #49's head and neck area. When Resident #49 came to he asked to go outside to smoke so NA #2 took him to the smoking area. Nurse #3 indicated she had obtained initial vital signs on Resident #49 which were within normal range, assessed him. Nurse #3 stated she did not recall reporting the loss of consciousness and slumping in the chair to Unit Manager #1. Nurse #3 explained Resident #49 was moved from his hall around 10:00 AM. Nurse #3 no longer was his nurse and did not see him again that day. The interview revealed Nurse #3 had initiated an action rounding log which documented where Resident #49 was in the facility every 15 minutes. Nurse #3 stated Nurse #4 took over Resident #49's care when he moved to his new room around 10:00 AM. On 11/21/24 at 12:32 PM an interview was conducted with Scheduler #1. She stated she was working as the Manager on Duty on 09/14/24. Scheduler #1 stated her office door was open and she overheard a nurse screaming for help. When she went out into the hall, she saw Nurse #3 in the hall and went to her. She noticed Resident #49 sitting in his wheelchair slumped over around 9:00 AM. Nurse #3 explained to her that he had just been hit in the back of the head by his roommate. After separating the residents, she stated she notified Unit Manager #1 via the facility paging system and Nurse #3 called the Director of Nursing. Scheduler #1 stated Resident #49 was taken to the smoking area because he stated he wanted to go smoke however she stated she did not see him smoking. She stated Resident #49 immediately seemed spaced out and not to be thinking clearly when he went to the smoking area around 9:30 AM. When he initially woke up after being hit and came to, his abilities were not the same, he was using his hands but nothing else like he had before. The interview revealed Resident #49 started trying to go in the wrong direction and had to be redirected by staff, they took him to his new room, and it took Scheduler #1, NA #2 and Nurse #3 to all assist him into the bed. Scheduler #1 stated she left the building at 3:00 PM. She stated they were so concerned with Resident #49's condition they had placed a fall mat under his bed because they felt like he may have a fall from the bed due to his state of immobility. Scheduler #1 stated she did not voice her concerns to anyone because she thought Nurse #3 and Nurse #4 were communicating the Resident's changes to the Medical Provider. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/19/24 at 12:52 PM an interview was conducted with Nurse Aide (NA) #2. NA #2 stated she was responsible for Resident #49 on 09/14/24 during first shift (7:00 AM to 3:00 PM). She stated she did not witness the incident but was notified of what had happened by Nurse #3. NA #2 recalled she was told by Nurse #3 to take the resident outside to smoke and to move Resident #49's belongings out of his room into a new room on another unit. NA #2 indicated she moved Resident #49's belongings and assisted him from the smoking area to his new room around 10:00 AM and assisted him into the bed which was different from that morning. Earlier in morning, he was able to transfer himself. The interview revealed when she went to the smoking area to get Resident #49, he did not have a cigarette and was just sitting outside. NA #2 stated she immediately noticed a difference in the way Resident #49 was responding and moving around 9:30 AM when she took him to the smoking area. He was unable to self-propel his wheelchair. NA #2 stated Resident #49 could not assist her at all for bed mobility and had to remain in bed for the rest of her shift. NA #2 stated she did not recall Resident #49 eating lunch on 09/14/24. Resident #49 had gone from being able to transfer himself that morning to being unable to roll from left to right in the bed following the incident occurring around 10:00 AM and providing incontinent care while the resident was in the bed. NA #2 also noted Resident #49 seemed slow to respond when spoken to immediately following the altercation. NA #2 stated she had discussed Resident #49's change of condition with both Nurse #3 and Nurse #4 as soon as she assisted Resident #49 into his bed that morning. NA #2 stated she was not given instructions to obtain vital signs on Resident #49 during first shift and gave report to NA #1 at 3:00 PM. On 11/19/24 at 2:00 PM an interview was conducted with NA #1. During the interview she stated she came on shift at 3:00 PM and received a report from NA #2. She and Unit Manager #1 assisted Resident #49 to his wheelchair because his legs were dangling off of the bed. NA #1 noted Resident #49 to be disoriented, leaning back in his wheelchair, sliding out of his wheelchair and overall, not looking like he typically did sitting up, self-propelling himself in a regular wheelchair in the hallway. Resident #49 was incontinent of urine and staff were changing his brief while he was in bed. NA #1 remembered having assisted him back up in his wheelchair during that evening and he eventually had a fall around 6:30 to 7:00 PM after sliding completely out of his wheelchair into the floor in the hallway. The interview revealed Resident #49 was sent to the hospital for an evaluation. NA #1 stated she did not recall obtaining vital signs for Resident #49 nor was she asked about his condition. The interview revealed she had notified Nurse #4 during her shift around 4:00 PM that Resident #49 seemed different from his baseline state. A late entry incident report dated 09/14/24 at 11:02 PM written by Nurse #4 revealed Resident #49 had experienced a fall and was found in the hallway sitting on his bottom around 6:30 PM. Resident #49 stated he had slid off his wheelchair. No injuries were observed however the resident was sent to the hospital due to recent change in cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/19/24 at 2:49 PM an interview was conducted with Nurse #4. She stated she was in the building on 09/14/24 during the first shift (7:00 AM to 3:00 PM) and second shift (3:00 PM to 11:00 PM). The interview revealed Resident #49 was moved to her hall following an altercation with his roommate where he was hit in the back of the head. She stated she assumed Resident #49's care for second shift at 3:00 PM. She stated she did not recall the exact time the resident was moved to her unit. The interview revealed Resident #49 was noted to be in bed, which was not typical for him. Nurse #4 stated she was not very familiar with the resident however she did know he was typically up during the day. She stated the nurse aides were telling her he was experiencing a significant change of condition from his normal baseline. She stated she did not contact the on-call provider. The interview revealed Resident #49 was gotten up to his wheelchair for the supper meal and he kept sliding out of the wheelchair. Nurse #4 had to obtain other staff members to assist her to pull him up in his chair. She stated around 6:30 PM Resident #49 was noted to fall out of his wheelchair into the floor in the hallway. The interview revealed he was immediately sent to the hospital for an evaluation based on the nurse aides telling her of the resident's drastic change of condition. Nurse #4 stated she had known Resident #49 was independent in his wheelchair, however when he left to go to the hospital, he was dependent upon staff for all transfers. On 11/21/24 at 9:06 AM an interview was conducted with Unit Manager (UM) #1. During the interview UM #1 stated on 09/14/24 around 9:00 AM she was paged on the overhead call system to come to Resident #49's room around 9:00 AM. Upon arrival Nurse #3 told her Resident #49 had been hit on the back of his head by his roommate. UM #1 stated she looked at the Resident and he was able to respond to her. UM #1 had NA #2 remove Resident #49 from the room and contacted the Director of Nursing (DON) who stated she (UM #1) needed to notify the resident's family and the provider on call. (UM #1) stated the provider on call (NP#3) asked her how the resident was doing, and UM #1 stated it was her first time laying eyes on him, and he seemed okay so she told the provider he seemed fine with no injuries. NP #3 instructed the facility to notify her of any change of condition. UM #1 stated NA #2 immediately moved Resident #49 to another room around 10:00 AM. Unit Manager #1 stated as she was rounding later in the day around 2:30 PM and saw Resident #49's call light on, she stated he was trying to transfer himself from the wheelchair to the toilet which the NA said he was normally able to do. UM #1 stated she had to get two other staff members to assist due to his observed weakness. She stated Resident #49 was so weak she asked the Resident to hold off on all transfers for the rest of the day because he was a full assist. She contacted NP #2 who told her she would be in the building to round shortly. UM #1 stated the DON told her to activate Emergency Medical Services (EMS) because she did not feel comfortable with his condition. EMS arrived at the same time as NP #2 came onsite around 3:00 PM. NP #2 completed an assessment of Resident #49 and stated to her (UM #1) to turn EMS away because the resident had no reason to go out for an evaluation. She stated shortly after she had them turn EMS away, Resident #49 slid out of his wheelchair onto his bottom. Unit Manager #1 called NP#2 and stated Resident #49 was going to be sent to the hospital for an evaluation. UM #1 stated the staff had moved Resident #49 to his wheelchair because his legs kept dangling off of the bed and she was afraid he was going to fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/22/24 at 9:38 AM an interview was conducted with Nurse Practitioner #3. During the interview she stated she was the on-call Nurse Practitioner assigned to the facility on [DATE]. NP #3 stated she did recall being notified of an altercation with Resident #49 around 9:00 AM but did not recall specific details of the incident or who notified her. NP #3 stated if she was notified a resident was struck in the head she would recommend sending the resident to the hospital for an evaluation. She stated she was not contacted by the facility for Resident #49 anymore that day because they had an in-house NP (NP #2) who was rounding on the residents. The interview revealed she did not have any notes from the day as to what orders she gave the facility. An SBAR (Situation, Background, Assessment and Recommendation) Summary dated 09/14/24 at 3:35 PM written by Unit Manager #1 revealed Resident #49 had experienced a change of condition after a physical altercation with another resident. The chief complaint was listed as Resident #49 had become increasingly weak on the left side after a physical altercation at the hands of another resident. The on- call provider was notified of the resident's condition and instructions were placed to activate Emergency Medical Services (EMS) for an evaluation at the Emergency Department. A SBAR (Situation, Background, Assessment and Recommendation) Summary dated 09/14/24 at 3:35 PM written by Unit Manager #1 revealed Resident #49 had experienced a change of condition after a physical altercation with another resident. The chief complaint was listed as Resident #49 had become increasingly weak on the left side after a physical altercation at the hands of another resident. The on- call provider was notified of the residents' condition and instructions were placed to activate Emergency Medical Services (EMS) for an evaluation at the Emergency Department. On 11/22/24 at 9:14 AM an interview was conducted with Nurse Practitioner #2. She stated she was an in-house provider that rounds in the facility on the weekends. She stated she remembered evaluating Resident #49 while he was sitting in a chair and did not know what had happened that morning with an altercation. NP#2 stated she only recalled sending the resident out to the hospital following a fall and did not recall telling anyone to stop EMS from coming at 3:00 PM. She stated when the resident became unstable and fell , she sent him out. EMS records dated 09/14/24 revealed they were dispatched to the facility with a chief complaint of increased weakness and a fall after an assault earlier in the morning. The resident had a history of TBI and wanted to be evaluated. Resident #49 stated he was hit in the head by his roommate earlier in the morning around 9:00 AM. He stated the roommate used his fist to hit him in the head and denied loss of consciousness. Staff, however, said the resident lost consciousness. The resident was cleared initially by his facility physician (NP #2) to stay at the facility and not be transported to the hospital. Around 6:30 PM Resident #49 was sitting in his wheelchair, when he tried to reposition himself. He had increased weakness that caused him to slide down the chair onto the floor. Resident #49 was noted to be on the floor until a medic arrived. Hospital records dated 09/14/24 revealed Resident #49 was evaluated on this date after sliding out of his wheelchair around 6:30 PM. Per the Medic the resident was also punched in the head by his roommate earlier in the morning around 9:30 AM but cleared by the facility. A computed tomography (CT) scan was completed which resulted in no acute findings. Resident #49 was discharged back to the nursing facility with strict precautions to return with any new or worsening symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Hospital records dated 09/17/24 revealed Resident #49 presented to the hospital for evaluation of acute chronic left-sided weakness. The resident was reported to be punched in the head by a roommate three days prior. He was originally evaluated in the Emergency Department on 09/14/24 and cleared for discharge. He presented back to the hospital complaining of lightheadedness and felt that his left side was weaker than his baseline from prior brain injury. He was also complaining of blurred vision and headaches. Resident #49 was admitted for neuroimaging. The exam showed a decreased edema signal within the brainstem (indicating potential damage or abnormality within the brainstem region) since the prior exam. Neurology was consulted with orders to follow up outpatient. The note revealed the Neurologist felt the findings could represent post concussive changes in the setting of extensive chronic progressive leukoencephalopathy (a rare, progressive brain infection that destroys cells that produce myelin, an insulating material for nerve cells). Resident #49 was discharged back to the facility on [DATE] with orders to follow up with neurology outpatient. On 11/19/24 at 3:12 PM an interview was conducted with Resident #49. During the interview he stated he had gotten hit in the back of the head by his former roommate a couple of months prior. The interview revealed he was sitting in the doorway when his roommate came at him from behind. Resident #49 revealed he did not recall any details about what had occurred after he was hit and did not remember going to the hospital after the incident. He stated since the incident he felt his condition had changed and he could no longer transfer himself from his bed to the wheelchair or self-propel in his wheelchair. The interview revealed he no longer was able to use his regular wheelchair which was still located outside of his room door because he was no longer able to sit up in it. Resident #49 stated he was now confined to a specialized chair and was dependent upon staff for all activities of daily living (ADL). He stated he was unable to assist himself to the toilet to use the restroom so he was now having to wear a brief and reliant of staff to change him. He stated two nurse aides used the mechanical lift to change him. On 11/20/24 at 11:02 AM an interview was conducted with the Medical Director (MD). The MD stated the nurse was responsible for contacting the on-call provider and notifying them of the change of condition. On 11/20/24 at 2:51 PM an interview was conducted with the Director of Nursing. She stated she was notified by Unit Manager #1 early in the morning around 9:00 on 09/14/24 that Resident #49 was hit in the head by his roommate and had no injuries. The interview revealed she was unaware Resident #49 had experienced any change of condition on 09/14/24. The interview revealed if a resident had a change of condition the on-call provider should be notified immediately. On 11/20/24 at 3:17 PM an interview was conducted with the Administrator. During the interview he stated he was notified about the altercation on a weekend day. The interview revealed the Administrator was unaware of any change of condition on the date of 09/14/24. The Administrator was notified of the immediate jeopardy on 11/20/24 at 4:17 PM. The facility provided the following credible allegation of immediate jeopardy removal. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- On 09/14/24 at 9:05 AM Nurse #3 heard a loud hit or thud coming from across the unit. She then noted Resident #49's wheelchair rolling out from his room with him in the wheelchair and witnessed his roommate swing his arm with a fist and hit Resident #49 on the back of the head. Based on staff interview Resident #49 had a significant change of condition recognized by sliding out of his wheelchair, decrease in level of assistance with transfers, a decrease in bed mobility and confusion. - On 9/14/2024 Unit Manger #1 notified the on-call Nurse Practitioner (NP #3) at approximately 10:00 AM to report the altercation with the roommate and change in level of care needs, as more assistance was needed with transfers as it took several people to get him into the bed. The Nurse Practitioner (NP #2) arrived at the facility at approximately 3:20 PM and examined the resident related to mental status changes after an altercation with his roommate. The Nurse Practitioner arrived at the same time as EMS who had been called by the nurses and upon examination by the NP, the NP determined that the resident did not need to go out to the hospital, so EMS was turned away. - The on-call Nurse Practitioner (NP #2) was notified at approximately 6:15 PM after Resident #49 was noted to be lying on the floor after sliding out of his wheelchair with Altered Mental Status (AMS). Resident was sent to the hospital for further evaluation due to a concern for a concussion from the hit to the back of Resident's head on 09/14/24. Hospital records indicate no acute trauma or concussion diagnosed related to the event. Resident #49 returned to the emergency roiagnom on [DATE] and was admitted for further neurological workup to include a Magnetic Resonance Imaging (MRI). MRI showed redemonstration of severe infratentorial and infratentorial white matter signal abnormality mildly worsened since prior MRI of 2020. It showed decreased edema signal within the brainstem, moderate ventriculomegaly, secondary to white matter volume loss. There was no acute infarction. No significant vascular disease. MRI of the Cervical Spine showed severe C4-5 left foraminal stenosis. - On 11/21/24 and 11/22/24, a nursing assessment was completed by the Licensed Nurses to verify all residents were currently stable and were not experiencing a change in condition requiring notification to the physician for further orders. The nursing assessment results are noted in the residents' electronic health record. The DON reviewed the results of the Licensed Nurse assessments and the 24-hour report to ensure there were no residents experiencing a change in condition requiring notification to the physician for further orders. Additionally, the DON reviewed the 24-hour report to ensure no other incidents requiring notification to the provider for which the Medical Provider had not been notified. No adverse outcomes were identified in this audit. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. - Nurse #3 was re-educated on notification of medical provider per the policy and procedure for a resident with a change in condition on 11/22/24 based on the urgency of the situation to include but not be limited to falls, resident to resident altercations, injuries, unstable vital signs, head trauma and indwelling catheter with recurrent symptomatic urinary tract infections, or recurrent pneumonia, changes in skin color or condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- All licensed nurses, agency/contract staff, and all newly hired licensed nursing employees along with Certified Nurse Aides will be educated on proper notifications to the Medical Provider or to the On Call Provider after hours and on weekends when a resident has a change in condition or incident, immediately after the incident or immediately at the time when a change in condition occurs. The On Call After Hours provider numbers are posted at each nurses' station. Education will be completed by the DON/Nurse Manager on 11/22/2024. Nursing staff not educated by 11/22/2024 will be educated prior to the start of their next scheduled shift. This education will be completed in person or by telephone. Education for newly hired staff will be completed by the Director of Nursing/Nurse Manager during the orientation period. Staff who were not educated on 11/22/2024 either in person or by telephone will be educated prior to the start of their next scheduled shift. The DON is responsible for tracking staff who still require education. The DON/Licensed Nurse Manager will provide education to staff not educated by 11-22-24 prior to the start of the next scheduled shift. DON and Licensed Nurse Manager were notified of this responsibility on 11-22-24. The Administrator will be responsible for the completion of the immediate jeopardy removal plan. The immediate jeopardy removal date is 11/23/2024. On 10/27/22, the credible allegation of immediate jeopardy removal date of 11/23/24 was validated by onsite verification through facility staff interviews. The interviews revealed all nursing staff had received education on proper notifications to the Medical Provider or to the On Call Provider after hours and on weekends when a resident has a change in condition or incident, immediately after the incident or immediately at the time. The facility's in-service log and training material was reviewed. The IJ removal date of 11/23/24 was validated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49366 Based on observations and staff interviews, the facility failed to protect Resident #67's financial privacy. This practice affected 1 of 1 resident reviewed for privacy (Resident #67). The findings included: Resident #67 was admitted to the facility on [DATE]. An observation was completed on 11/20/24 at 10:45 AM of a bulletin board in the [NAME] Hall common area. The bulletin board had a sign-up sheet for the beauty/barber shop and a price list for all services in the beauty/barber shop. The sign-up list had Resident #67's name with a price owed of $15. Multiple staff members, visitors, and residents were observed walking by the bulletin board. An interview with Nurse Aide #1 on 11/21/24 at 12:50 PM revealed the beauty/barber shop sign-up sheet had been on the bulletin board for many weeks with Resident #67's name and debt amount on it. She stated that no one ever utilized the sign-up sheet and was unsure of when the hairdresser was scheduled to come to the facility. An interview with the Activity Director on 11/22/24 at 9:27 AM revealed the hairdresser was at the facility the previous week. She stated each unit has a sign-up sheet and a price list. Staff had been educated to write resident's names on the list if they wanted to visit the beauty/barber shop. The Activity Director further revealed she coordinated with the Business Office Manager to make sure each resident had enough funds to pay for the requested service. She stated she had no knowledge of any debts posted on the sheet, as the staff was educated only list names of residents who were requesting services. The Activity Director further explained she did not write the amount owed on the sign-up sheet and did not know who did. An additional observation was conducted on 11/22/24 at 9:38 AM and revealed the sign-up sheet with Resident #67's name and owed amount of $15 was visible to staff members, residents, and visitors walking by. An interview with the Business Office Manager on 11/27/24 at 10:19 AM revealed the Activity Director coordinated with the hairdresser and he would alert them if there were funds in the resident's accounts. Services would then be rendered. The Business Office Manager was not aware of a sign-up sheet in the common area. An interview with the Administrator was completed on 11/27/24 at 11:26 AM. He stated Resident #67's name and an amount owed for a service rendered should not be visible in a common area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on observations, record review, and resident, facility staff, Nurse Practitioner (NP), Medical Director (MD), and Physician Assistant (PA) interviews, the facility failed to protect a resident's right to be from physical abuse (Resident #49). On 09/14/24 at approximately 9:00 AM Nurse #3 heard a loud hit or thud coming from across the unit and then observed Resident #49 rolling out of his room in his wheelchair and witnessed Resident #79 swinging his arm with a fist and hit Resident #49 on the back of the head. Resident #49 was noted to slump over in his wheelchair and have a loss of consciousness for a few seconds before opening his eyes and requesting to go outside and smoke. Resident #49 had a history of a traumatic brain injury and immediately after being hit in the head by Resident #79 he was noted to have a change of condition as evidenced by a change in level of assistance needed for transfer and bed mobility changed, confusion and inability to self-propel in his wheelchair. Later in the day Resident #49 slid out of wheelchair to the floor and was assessed with worsening generalized weakness and concern for a concussion. Emergency Medical Services (EMS) was dispatched on 9/14/24 at 6:31 PM and Resident #49 was taken to the hospital for evaluation. A Computed Tomography (CT) scan was completed which resulted in no acute findings. Resident #49 was discharged back to the nursing facility on 9/15/24 with strict precautions to return with any new or worsening symptoms. Resident #49 returned to the hospital on 9/17/24 for evaluation of acute chronic left-sided weakness, lightheadedness, blurred vision and headaches. Resident #49 was admitted for neuroimaging (brain scanning). The Neurologist felt the findings could represent post concussive changes and Resident #49 was discharged back to the facility on [DATE] with orders to follow up with neurology outpatient. At the time of the survey, Resident #49 reported he felt his condition had changed since the incident and noted he was now confined to a specialized chair and was dependent upon staff for all activities of daily living and required the use of mechanical lift for transfers. The deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #49). Immediate Jeopardy began on 09/14/24 when Resident #49 who had a history of a traumatic brain injury was hit with a closed fist in the back of the head by Resident #79. The immediate jeopardy was removed on 11/23/24 when the facility implemented an acceptable credible allegation. The facility remains out of compliance at a lower scope and severity of a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. The findings included: Resident #49 was a [AGE] year-old admitted to the facility on [DATE] with a diagnosis of traumatic brain injury (TBI). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident #49's quarterly Minimum Data Set assessment dated [DATE] revealed he was cognitively intact. Resident #49 was coded as independent for eating and putting on/ taking off footwear. He required set up or clean up assistance for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and personal hygiene. Resident #49 required supervision assistance for chair to bed transfers, toileting transfers, tub/shower transfers and lying to sitting on the side of the bed. The resident was noted to be independent for rolling left and right while in bed. Resident #49 was continent of bowel and bladder during the assessment period and was documented to have no behaviors. Resident #79 was a [AGE] year-old admitted to the facility on [DATE] with a diagnosis of TBI. A review of Resident #79's quarterly Minimum Data Set assessment dated [DATE] revealed he was cognitively intact. Resident #79 was coded as independent for all activities of daily living (ADL) including eating, toileting, oral hygiene, shower/bathe self, upper body dressing, lower body dressing and all transfers. He was coded as using a cane to ambulate during the assessment period. Resident #79 was documented to have no behaviors. A review of the facility's investigation report initiated on 09/14/24 at 9:05 AM by the Administrator revealed Resident #49 was hit on the back of his neck/head by his roommate. After the nurse assessed Resident #49, he was noted with no injuries and the residents were immediately separated by moving Resident #49 to another room. Staff were briefed on the incident and monitored the residents every 15 minutes to avoid further incidents. Resident #49's roommate had stated he hit the resident because he was trying to exit the room and Resident #49 was blocking the doorway with his wheelchair. A nursing note written by Nurse #3 dated 09/14/24 at 10:11 AM revealed she heard hitting noises and turned around to observe Resident #49 get hit in the head by his roommate. The note revealed the residents were separated and assessed for injuries. Resident #49's vital signs were the following: blood pressure 138/66, pulse 72, temperature 97.9, respirations 20, oxygen saturation level 96% on room air. The resident was noted with no signs of acute distress at the time of the incident and no complaints of pain. Redness was noted to the back of the resident's neck. The residents Responsible Party, Director of Nursing and on call Nurse Practitioner were notified. New orders were obtained for a psychological evaluation of Resident #79 and every 15-minute monitoring for a duration of 24 hours. On 11/19/24 at 11:38 AM an interview was conducted with Nurse #3. Nurse #3 stated on 09/14/24 around 9:00 AM she heard a loud hit or thud coming from across the unit. She then saw Resident #49 rolling out from his room in his wheelchair and witnessed (Resident #79) who was cognitively intact, swinging his arm with a fist and hit Resident #49 at the back of the head making a second thud sound as his fist hit the back of Resident #49's head. Resident #49 immediately slumped over in his wheelchair and regained consciousness within a couple of seconds after she got to him to assess his condition. She stated she saw redness at the back of Resident #49's head and neck area. When Resident #49 came to he asked to go outside to smoke so Nurse Aide (NA) #2 took him to the smoking area. Nurse #3 indicated she had obtained initial vital signs on the resident which were within normal range, assessed him and the Unit Manager notified the Nurse Practitioner of what had occurred. Nurse #3 explained when Resident #49 was moved from her hall around 10:00 AM, she no longer was his nurse and did not see him again that day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/21/24 at 12:32 PM an interview was conducted with Scheduler #1. She stated she was working as the Manager on Duty on 09/14/24. Scheduler #1 stated her office door was open and she overheard a nurse screaming for help. When she went out into the hall, she saw Nurse #3 and went to her. Scheduler #1 stated Resident #49 sitting in his wheelchair slumped over and was unconscious for approximately a minute. Nurse #3 explained to her that he had just been hit in the back of the head by Resident #79. When he initially woke up after being hit and came to, his abilities were not the same, he was using his hands but nothing else like he had before. She stated he was no longer able to self-propel himself in the hallway as he had done that morning or self-transfer to bed. After separating the residents, she stated she notified the Unit Manager #1 via the facility paging system and Nurse #3 called the Director of Nursing. Scheduler #1 stated Resident #49 was taken to the smoking area by NA#2 because he stated he wanted to go smoke. She stated Resident #49 immediately seemed spaced out by responding slowly when spoken to and not thinking clearly. The interview revealed Resident #49 started trying to go in the wrong direction and had to be redirected by staff. When they took him to his new room, it took Scheduler #1, NA #2 and Nurse #3 to all assist him into the bed. Scheduler #1 told Nurse #3 she would need to complete neurological assessments. She stated they were so concerned with Resident #49's condition they had placed a fall mat under his bed because they felt like he may have a fall from the bed due to his state of immobility. On 11/21/24 at 9:06 AM an interview was conducted with Unit Manager (UM) #1. During the interview she stated on 09/14/24 around 9:00 AM she was paged on the overhead call system to come to Resident #49's room. Upon arrival Nurse #3 told her Resident #49 had been hit on the back of his head by Resident #79. She stated she looked at the resident and he was able to respond to her. She had them remove Resident #49 from the room and contacted the Director of Nursing (DON) who stated she needed to notify the resident's family and the provider on call. She stated the provider on call (NP #3) asked her how the resident was doing, and she stated it was her first time laying eyes on him, and he seemed okay. UM #1 recalled they immediately moved Resident #49 to a room in another hall around 10:00 AM. Unit Manager #1 stated she was rounding later in the day and saw Resident #49's call light on, she stated he was trying to transfer himself from the wheelchair to the toilet which the NA said he was normally able to do. She stated she had to get two other staff members to assist due to his weakness. On 11/19/24 at 12:52 PM an interview was conducted with Nurse Aide (NA) #2. NA #2 stated she was responsible for Resident #49 on 09/14/24 during first shift (7:00 AM to 3:00 PM). She stated she did not witness the incident but was notified of what had happened by Nurse #3. NA #2 recalled she was told by Nurse #3 to move Resident #49's belongings out of his room into a new room on another unit. NA #2 indicated she moved Resident #49's belongings and assisted him from the smoking area to his new room around 10:00 AM and assisted him into the bed which was different from that morning. Earlier in morning, he was able to transfer himself. NA #2 stated she had discussed Resident #49's change of condition with both Nurse #3 and Nurse #4 as soon as she assisted Resident #39 into his bed in the new room that morning. NA #2 stated she immediately noticed a difference in the way Resident #49 was responding and moving. NA #2 stated Resident #49 could not assist her at all for bed mobility and had to remain in bed for the rest of her shift. NA #2 explained she decided to continue to provide care to the resident despite him being on another unit due to staffing concerns. NA #2 indicated Resident #49 had gone from being able to transfer himself that morning to being unable to roll from left to right in the bed following the incident. For the remainder of the shift Resident #49 was provided with incontinent care in bed, which was a change of condition. NA #2 also noted Resident #49 seemed slow to respond when she spoke to him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/19/24 at 2:00 PM an interview was conducted with NA #1. During the interview she stated she came on shift at 3:00 PM and received report from NA #2. She and the Unit Manager #1 assisted Resident #49 to his wheelchair because his legs were dangling off of the bed around 4:00 PM. NA #1 noted Resident #49 to be disoriented, leaning back in his wheelchair, sliding out of his wheelchair and overall, not looking like he typically did, sitting up, self-propelling himself in a regular wheelchair in the hallway. NA #1 indicated she was changing Resident #49's brief while he was in bed, which was a change as he could usually transfer himself to the bathroom. NA #1 remembered having to assist him back up in his wheelchair during that evening and he eventually slid completely out of his wheelchair into the floor in the hallway around 6:30 to 7:00 PM. On 11/19/24 at 2:49 PM an interview was conducted with Nurse #4. She stated she was in the building on 09/14/24 during the first shift (7:00 AM to 3:00 PM) and second shift (3:00 PM to 11:00 PM). The interview revealed Resident #49 was moved to her hall following an altercation with Resident #79 during which Resident #79 hit Resident #49 on the back of his head. She stated she assumed Resident #49's care for second shift at 3:00 PM. The interview revealed Resident #49 was noted to be in bed, which was not usual because he was typically up and out in the facility in the hallway during the day. Nurse #4 stated the NA #1 and NA #2 were telling her he was experiencing a significant change of condition from his normal baseline by being in bed, a decrease in mobility, decreased alertness and incontinence throughout the day. Nurse #4 explained Resident #49 was gotten up to his wheelchair for the supper meal and he kept sliding out of the wheelchair and Nurse #4 had to obtain other staff members to assist her to pull him up in his chair. Nurse #4 indicated around 6:30 PM Resident #49 was noted to fall out of his wheelchair onto the floor in the hallway. A late entry incident report dated 09/14/24 at 11:02 PM written by Nurse #4 revealed Resident #49 had experienced a fall and was found in the hallway sitting on his bottom around 6:30 PM. Resident #49 stated he had slid off his wheelchair. No injuries were observed however the resident was sent to the hospital due to recent change in cognition. On 11/19/24 at 3:12 PM an interview was conducted with Resident #49. During the interview Resident #49 stated he had gotten hit in the back of the head by Resident #79 a couple of months prior. The interview revealed he was sitting in the doorway when Resident #79 came at him from behind. Resident #49 revealed he did not recall any details about what had occurred after he was hit and did not remember going to the hospital after the incident. He felt his condition had changed since the incident and noted he could no longer transfer himself from his bed to the wheelchair or self-propel in his wheelchair. Resident #49 revealed he was no longer able to use his regular wheelchair, which was still located outside of his room, because he was no longer able to sit up in it. Resident #49 stated he was now confined to a specialized chair and was dependent upon staff for all activities of daily living and required the use of mechanical life for transfers. He stated he was unable to transfer himself to the toilet to use the restroom and was having to wear a brief, urinate on himself, and reliant on staff to change him. A Nurse Practitioner note written by NP #2 on 09/15/24 as late entry for 09/14/24 revealed she was asked to see Resident #49 for altered mental status after an altercation in which the resident ended up on the floor knocked out cold, he did not hit his head and regained consciousness right away but now seen with altered mental status. At the time of the assessment, although he was able to follow simple commands, he was noted to have worsening generalized weakness drop in extremity sitting in the chair. She was noted to be concerned for a concussion and escalated the resident to the emergency room for an evaluation and management. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/22/24 at 9:14 AM an interview was conducted with Nurse Practitioner #2. She stated she was an in-house provider that rounded in the facility on the weekends. She stated she remembered evaluating Resident #49 while he was sitting in a chair, but NP #3 was originally notified that morning about an altercation. NP #2 stated staff did tell her the resident had been hit in the head by his roommate and had experienced altered mental status. However, she did not witness the incident and therefore it was only hearsay. She stated when the resident became unstable and fell , she sent him out. Review of the Emergency Medical Services (EMS) dispatch log for the facility on 09/14/24 revealed they were notified to respond for Resident #49 at 6:31 PM due to a fall in which the resident slipped from his chair to the floor. EMS arrived at the facility and transported Resident #49 to the hospital. EMS records dated 09/14/24 revealed they were dispatched to the facility with a chief complaint of increased weakness and a fall after an assault earlier in the morning. The resident had a history of TBI and wanted to be evaluated. Resident #49 stated he was hit in the head by Resident #79 earlier in the morning around 9:00 AM. He stated Resident #79 used his fist to hit him in the head and denied loss of consciousness. Staff, however, did say the resident lost consciousness. The resident was cleared initially by his facility physician to stay at the facility and not be transported to the hospital. Around 6:30 PM Resident #49 was sitting in his wheelchair, when he tried to reposition himself, he had increased weakness that caused him to slide down the chair onto the floor. The resident was noted to be on the floor when the medic arrived. Resident #49 was mechanically lifted into the medic's stretcher. EMS documented the resident's vital signs at 6:52 PM to include the following: blood pressure 120/76, pulse 70 beats per minute (bpm), respirations 16, oxygen saturation level 94% (normal >92%). Resident #46 was noted to be oriented to person, place and time. The resident stated to EMS he felt safe at the facility, however, would like a new roommate. The note read, Patient is requesting we transport him to the hospital for further evaluation. Hospital records dated 09/14/24 revealed Resident #49 was evaluated on this date after sliding out of his wheelchair around 6:30 PM. Per the Medic the resident was also punched in the head by his roommate earlier in the morning around 9:30 AM but cleared by the facility. The residents' diagnoses included fall, closed head injury and generalized weakness. A Computed Tomography (CT) scan was completed which resulted in no acute findings. Resident #49 was discharged back to the nursing facility on 9/15/24 with strict precautions to return with any new or worsening symptoms. A nursing progress note dated 09/15/24 at 6:55 AM revealed Resident #49 had returned to the facility from the hospital by EMS transport. Resident #49 was noted to be in no acute distress or discomfort. A Nurse Practitioner note dated 09/16/24 written by NP #1 revealed she was asked to evaluate Resident #49 on this date by the Director of Nursing (DON) due to the resident being sent to the Emergency Department (ED) after he was forcefully hit in the head by his roommate and had experienced a couple of falls since the incident. Resident #49 was noted to have been evaluated for a close head injury while in the hospital. At the time of her assessment the resident was noted to be in a stable condition with no complaints of pain or weakness. During the evaluation he was noted to be in bed resting with no acute distress. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/19/24 at 3:36 PM an interview was conducted with Nurse Practitioner #1. During the interview she stated Resident #49 was sent to the hospital on 09/14/24 following a fall in the facility. She stated she was not in the facility or on call the weekend the incident occurred but learned of the altercation the following Monday after returning to the facility. NP #1 stated Resident #49 had experienced two falls after returning back to the facility from the hospital and she was asked to evaluate him on 09/16/24 following the second fall. Resident #49 was in no distress during her evaluation. The interview revealed Resident #49 started experiencing headache, weakness and lightheadedness on 09/17/24 while she was in the building and was sent back to the hospital. He was discharged back to the facility on [DATE]. NP #1 stated she had written a progress note on 10/21/24 discussing the hospital course and they had conducted a neurological work up while the resident was in the hospital. She stated the hospital notes did discuss the resident could have had post concussive findings meaning it was possible he had experienced a concussion from the incident, but they were unable to determine if it was that or a past misdiagnosis. NP #1 stated Resident #49 is now in a specialized wheelchair that leaned back unlike the chair he was in prior to the incident which was a regular wheelchair. She stated once he came back from the hospital, he was slow to respond with occasional headaches and was not as active as he was prior to the incident. She stated it was possible the effects he has experienced could be from the altercation, but the resident had other conditions that could have contributed to the changes he had experienced. Hospital records dated 09/17/24 revealed Resident #49 presented to the hospital for evaluation of acute chronic left-sided weakness. The resident was reported to have been punched in the head by a roommate 3 days prior. He was originally evaluated in the Emergency Department on 09/14/24 and cleared for discharge. He presented back to the hospital complaining of lightheadedness and felt that his left side was weaker than his baseline from prior brain injury. He was also complaining of blurred vision and headaches. Resident #49 was admitted for neuroimaging. The exam showed a decreased edema signal within the brainstem (indicating potential damage or abnormality within the brainstem region) since the prior exam. Neurology was consulted with orders to follow up outpatient. The note revealed the Neurologist felt the findings could represent post concussive changes in the setting of extensive chronic progressive leukoencephalopathy (a rare, progress brain infection that destroys cells that produce myelin, an insulating material for nerve cells). The resident's hospital course included a full stroke workup resulting in no findings of a stroke, Physical Therapy and Occupational Therapy evaluation, lab workup and inpatient neurology evaluation. Resident #49 was discharged back to the facility on [DATE] with orders to follow up with neurology outpatient. On 11/20/24 at 11:02 PM an interview was conducted with the Medical Director (MD). The MD stated she had only been in the facility since September 2024 and was not familiar with Resident #49's prior state. She stated she knew of the incident occurring, but the on-call Nurse Practitioner was notified since the incident occurred on a weekend. The MD indicated the resident was sent to the hospital following a fall in the hallway and his CT at the hospital was negative, so he was sent back to the facility. The interview revealed Resident #49 continued to have symptoms of a concussion, so he was sent to the hospital for a reevaluation on 09/17/24. The MD explained it could take a couple of days for symptoms of a concussion to appear. She stated at the hospital there were changes from his previous MRI with a decreased signal to the brainstem which she felt couldn't have happened from a hit to the resident's head. Neurology was consulted while Resident #49 was hospitalized and mentioned post concussive findings in their note, however they were also ruling out a possible misdiagnosis in the past. The interview further revealed concussion symptoms would have included lightheadedness, light sensitivity and blurred vision, all which Resident #49 was noted to have during his 09/17/24 hospitalization . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/27/24 at 2:05 PM an interview was conducted with the Neurologist Physician Assistant. She stated she had evaluated Resident #49 during his follow up appointment on 10/18/24. She stated the resident was being seen due to an abnormal brain MRI, white matter disease, left side numbness, incoordination and weakness. The PA stated she had only seen the resident during a one-time snapshot, and it is very hard to say the findings came directly from the altercation. She stated she had ordered follow up blood work, a lumbar puncture and was going to be reevaluating Resident #49 at the first of the year to see if there was a possible relationship between the altercation and the changes the resident has experienced. On 11/20/24 at 2:51 PM an interview was conducted with the Director of Nursing (DON). The DON stated she was notified early in the morning around 9:00 on 09/14/24 that Resident #49 was hit in the head by Resident #79. She stated Resident #49 was sitting in his wheelchair in the doorway of the room and Resident #79 wanted to get out of the room. On 11/20/24 at 3:17 PM an interview was conducted with the Administrator. During the interview he stated he was notified about the altercation on a weekend day. Staff had told him Resident #79 had popped Resident #49 on the back of the neck. The Administrator stated based on his understanding of what had happened that day staff did not make it seem like Resident #49 was hit hard by Resident #79. He was unaware Resident #79 used a fist to swing and hit Resident #49 in the back of the head. The Administrator was notified of the Immediate Jeopardy on 11/20/24 at 4:17 PM. The facility provided the following Credible Allegation of immediate jeopardy removal. Plan for Removal of Immediate Jeopardy for F600 Identify those recipients who have suffered, or are likely to suffer a serious adverse outcome as a result of the noncompliance: The facility failed to protect Resident #49's rights to be from physical abuse. On 09/14/2024 at 9:05 AM Nurse #1 heard a loud hit or thud coming from across the unit. She then noted Resident #49's wheelchair rolling out from his room with the resident in the wheelchair and witnessed his roommate who was cognitively intact swing his arm with a fist and hit Resident #49 in the back of the head. Resident #49 was noted to slump over in his wheelchair for a few seconds before opening his eyes and requesting to go outside and smoke. Resident #49 had a history of traumatic brain injury. On 9/14/2024 at approximately 3:20pm, Resident #49 was seen by the Nurse Practitioner at the facility at the same time that Emergency Medical Services arrived. After assessing the resident, the Nurse Practitioner did not feel the resident needed to go to the hospital for further treatment despite the knowledge that Resident #49 had an altercation with the roommate and was struck in head with a significant decline from baseline as reported by several staff during the observation period. On 09/14/2024, at approximately 9:05 AM Resident #49 was separated from his roommate by the nurse and was assessed by the nurse. Resident #49 was then moved to another room away from the roommate to ensure their safety. The 15-minute safety checks are done by nursing staff to ensure residents are visualized and placed and not in harm's way. The 15-minute safety checks were initiated for both Resident #49 and his roommate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 09/14/2024, Resident #49 and the roommate had a skin check performed by a licensed nurse status post the event to check for apparent injuries without findings. On 9/14/2024 at 7:00 PM the nurse called the Nurse Practitioner gave the order to send Resident #49 out to the hospital related to the resident sliding out of his chair and in conjunction with significant changes in condition related to Resident #49's altered mental status, and increased need for assistance with transfer mobility and bed mobility. On 11/22/2024 the Nurse Manager and the Social Services Director completed interviews with residents with a Brief Interview for Mental Status (BIMS) of 13 and above were interviewed to ensure no abuse or neglect. On 11/21/2024, current residents with a Brief Interview for Mental Status (BIMS) of 12 and below had skin checks performed by a licensed nurse and documented on a skin inspection sheet, to ensure no suspicious injuries or indication of abuse or neglect. On 11/22/2024, the Administrator and the Director of Clinical Services reviewed the incident log for the past 30 days for any other potential abuse allegations needing to be self-reported to the state of North Carolina without any further instances noted. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On 11/22/2024, current residents with targeted physical behaviors of becoming aggressive to others were identified by the Interdisciplinary Team to include the Administrator, Director of Nursing, Medical Director, Nurse Practitioner, Social Services Director, Activities Director, Therapy Director. On 11/22/2024, current residents with targeted physical behaviors care plans and behavior monitoring tools were reviewed and updated as needed by the Interdisciplinary Team to ensure interventions are in place for safety. On 11/21/2024, the Regional Director of Clinical Services reviewed the policy with and completed re-education of the facility's policy and procedures for abuse and neglect with the Administrator and the Director of Nursing to ensure understanding with a verbal return demonstration as to the types of abuse and neglect to include but not be limited to delay of care and treatment or sending a resident to a higher level of care when they have a significant change in condition. Additionally, education included what to do if you witness abuse and neglect, when to report abuse and neglect, to whom to report abuse and neglect and the designated facility abuse coordinator, who is the facility administrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/22/2024, the Director of Nursing and Nurse Managers completed re-education with all current staff, including Dietary, Housekeeping, Laundry, administration, Maintenance, Social Services, Therapy, Activities, Department Managers, Nursing, including Licensed Nurses, Medication Aides and Certified Nursing Assistants, including agency staff on the facility's policy and procedure for abuse and neglect to ensure understanding with a verbal return demonstration as to the types of abuse and neglect to include but not be limited to delay of care and treatment or sending a resident to a higher level of care when they have a significant change in condition. Additionally, education included what to do if you witness abuse and neglect, when to report abuse and neglect, to whom to report abuse and neglect and the designated facility abuse coordinator, who is the facility administrator. This education for the nursing staff will be the responsibility of the DON/Licensed Nurse Manager for current staff. Staff who were not educated on 11/22/2024 either in person or by telephone will be educated prior to the start of their next scheduled shift. The DON is responsible for tracking staff who still require education. The DON/Licensed Nurse Manager will provide education to staff not educated by 11-22-24 prior to the start of the next scheduled shift. DON and Licensed Nurse Manager were notified of this responsibility on 11-22-24. Education will be done by the DON/RN Nurse Manager during the orientation period for any newly hired staff ongoing, including agency staff for abuse and neglect. An Ad-Hoc Quality Assurance Performance Improvement Committee was held on 11/21/2024, which included the Regional Clinical Director, Medical Director, the Director of Nursing, Administrator, Maintenance Director, Unit Managers, Social Service Director, Activities Director, Rehab Program Manager and a Certified Nursing Assistant to formulate and approve a plan of correction for the deficient practice. The Administrator will be responsible for the completion of the corrective action plan. Alleged date of IJ removal: 11/23/2024 On 10/27/22, the credible allegation of Immediate Jeopardy removal date of 11/23/24 was validated by onsite verification through facility staff interviews. The interviewed staff across all disciplines including Dietary, Housekeeping, Laundry, administration, Maintenance, Social Services, Therapy, Activities, Department Managers, Nursing, including Licensed Nurses, Medication Aides and Certified Nursing Assistants, and agency staff on the facility's policy and procedure for abuse and neglect revealed they had received in-service training regarding spotting, identifying, and reporting abuse. Records were reviewed of residents identified with targeted physical behaviors. A sample of residents were interviewed to ensure they had been asked about abuse and neglect by the facility. Skin assessments were reviewed for residents with a BIMS score of less than 12. < [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on record review and staff interviews, the facility failed to complete a thorough investigation of an allegation of resident-to-resident abuse for 2 of 3 residents reviewed for abuse (Resident #49 and Resident #79). Findings included: The facility's Abuse Investigation and Reporting policy revised in July 2017 read in part as follows: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/ or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The role of the investigator included: - Review the completed documentation forms. - Resident the residents medical record to determine events leading up to the incident. - Interview the person reporting the incident. - Interview any witnesses to the incident. - Interview the resident. - Interview the residents Attending Physician as needed to determine the resident's current level of cognitive function. - Interview the resident's roommate, family members and visitors. - Interview other residents to whom the accused employee provided care or services. - Review all events leading up to the alleged incident. The following guidelines will be used when conducting interviews: - Each interview will be conducted separately in a private location. - Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. Resident #49 was a [AGE] year-old admitted to the facility on [DATE] with a diagnosis of traumatic brain injury (TBI). A review of Resident #49's quarterly Minimum Data Set assessment dated [DATE] revealed he was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #79 was a [AGE] year-old admitted to the facility on [DATE] with a diagnosis of TBI. A review of Resident #79's quarterly Minimum Data Set assessment dated [DATE] revealed he was cognitively intact. Review of a 5-day Investigation Report dated 09/20/24 revealed the allegation/incident type being investigated was Resident Abuse that occurred on 09/14/24. The report read in part; Resident #79 hit Resident #49 in the back. The two residents are roommates and got into an argument. After the nurse assessed, there was no injury, and the residents were immediately separated by moving Resident #49 to another room. Staff were briefed and will continue to monitor the residents every 15 minutes to avoid further incidents. Labs were submitted on Resident #79 to rule out a urinary tract infection. Review of the facility investigation file revealed a typed summary of the incident that occurred on 09/14/24 and read in part, Resident #79 hit his roommate Resident #49 on 09/14/24 at approximately 8:46 AM on the back of his neck/head. The nurse noted no injury to either resident upon skin sweeps performed on 09/14/24 for Resident #49 and Resident #79. Resident #79 stated that he hit Resident #49 because he was trying to exit the room and Resident #49 was blocking the doorway with his wheelchair. Both residents were immediately separated by staff and a room changed was completed for Resident #49. Resident #49 and Resident #79 were both placed on safety checks. The Physician was notified of the incident involving the residents. Law enforcement was notified of the incident. Current staff across departments were re-educated on abuse and neglect. The interdisciplinary team reviewed/updated the plan of care for both residents after the incident. The conclusion: the incident was unsubstantiated as abuse; it was an impulsive act and was without intent. On 11/20/24 at 2:51 PM an interview was conducted with the Director of Nursing (DON). The DON stated she was notified early in the morning around 9:00 on 09/14/24 that Resident #49 was hit in the head by Resident #79. She stated Resident #49 was sitting in his wheelchair in the doorway of the room and Resident #79 wanted to get out of the room. The DON contacted the Administrator because she was out of town and he handled the investigation along with Unit Manager #1. A review of the facility investigation file and interview with the Administrator were conducted on 11/20/24 at 3:17 PM. The Administrator stated he was notified of the incident on a weekend day (09/14/24) by the Director of Nursing (DON) via telephone. He stated he told the DON he would handle the situation due to her being out of town. The interview revealed he asked Unit Manager #1 to complete the on-site witness interviews and obtain statements regarding the incident on 09/14/24 but they were not completed. The Administrator stated Unit Manager #1 had told him Resident #79 had popped Resident #49 on the back of the neck and he did not realize Resident #49 had been hit in the head. The Administrator confirmed he did not have any resident or witness statements from the date of 09/14/24 nor, were the Nurse Aides and staff involved in caring for the resident following the incident interviewed. The interview revealed the Administrator was unaware Resident #49 had experienced a change of condition following the altercation with Resident #79 and thought the resident had no injures from the altercation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47695 Based on record review, observation, and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for pain (Resident #9 and Resident #69), activities of daily living (ADL) (Resident #69), and pressure ulcers (Resident #199) for 3 of 6 residents whose MDS were reviewed for accuracy. The findings included: 1. Resident #9 was admitted to the facility on [DATE] with diagnoses that included chronic pain syndrome and osteoarthritis. A review of the most recent quarterly (MDS) assessment dated [DATE] revealed Resident #9 had severe cognitive impairment. The pain assessment interview indicated the resident interview should be conducted; however, it was not completed, nor was the staff assessment for pain conducted. A telephone interview was completed on 11/21/2024 at 10:55 AM with MDS Coordinator #2. During the interview MDS Coordinator #2 revealed he worked remotely and did not come into the building. MDS Coordinator #2 said the pain assessments were supposed to be completed by the nurse in the facility and they had to be completed by the assessment reference date (ARD), which was the last day of the MDS review period, to be counted. He reported the pain assessment was in the computer system to be completed and if they were not completed timely, he could not use them. MDS Coordinator #2 explained that there were spaces on the resident's medication administration record (MAR) where pain was recorded, however he could not use that information for the actual pain interview. MDS Coordinator #2 said he could only do the staff interview if the resident was unable to answer and it had to be completed by the ARD. On 11/21/2024 at 11:40 AM a telephone interview was completed with the Regional MDS Coordinator. During the interview the Regional MDS Coordinator reported the pain assessments should have been completed by the nurses in the facility, however MDS Coordinator #2 could have read through the nurse's notes to get the information that was needed for the pain interview. 2. Resident #69 was admitted to the facility on [DATE] with diagnoses of depression, neuropathy (peripheral nerve damage often causing weakness, numbness or pain usually in the hands or feet), and a diabetic ulcer to the left heel. Review of Physician orders dated 7/15/2024 showed an order for Gabapentin (treats nerve pain) capsule 300 milligram (mg) three times a day related to a diagnosis of neuropathy. Review of the most recent quarterly MDS assessment dated [DATE] showed Resident #69 had no cognitive impairment and had no range of motion limitations. Resident #69 was marked as being dependent upon staff for eating and oral hygiene, but independent with toilet hygiene. Further review revealed Resident #69 was marked as dependent with walking 50 feet but was independent walking 150 feet. The pain assessment interview indicated the resident interview should be conducted; however, it was not completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation with Resident #69 were conducted on 11/18/2024 at 11:22 AM. During the interview Resident #69 reported she was able to walk to the bathroom while using a walker. There was a walker at the resident's bedside. Resident #69 reported she felt like she had an improvement in her ADL since admission. A telephone interview was completed on 11/21/2024 at 10:55 AM with MDS Coordinator #2. During the interview MDS Coordinator #2 revealed he worked remotely and did not come into the building. MDS Coordinator #2 said the pain assessments were supposed to be completed by the nurse in the facility and they had to be completed by the assessment reference date (ARD), which was the last day of the MDS review period, to be counted. He reported the pain assessment was in the computer system to be completed and if they were not completed timely, he could not use them. MDS Coordinator #2 explained that there were spaces on the resident's medication administration record (MAR) where pain was recorded, however he could not use that information for the actual pain interview. MDS Coordinator #2 said he could only do the staff interview if the resident was unable to answer and it had to be completed by the ARD. MDS Coordinator #2 explained the coding of ADLs was completed using nursing and nurse's aide documentation and if any discrepancies were noted he could call the facility and question the staff. MDS Coordinator #2 reported he did not call about any discrepancies prior to completing the assessment and the coding for walking and eating for Resident #69 was not accurate. An interview was completed with the Director of Nursing (DON) on 11/22/2024 at 10:03 AM. During the interview the DON stated she expected to see the MDS assessments completed accurately for all residents. 3. Resident #199 was readmitted to the facility on [DATE] with the following diagnosis: quadriplegia and two stage 3 pressure ulcers. A review of Resident #199's medical diagnosis list indicated Resident #199 previously had a diagnosis of Stage 2 pressure ulcer dated 1/25/2021, and a non-pressure ulcer of the back dated 6/16/2021 that had previously been resolved. Review of a wound note dated 11/4/2024 noted Resident #199 had one stage 3 pressure ulcer to the left proximal thigh, and one stage 3 pressure ulcer to the left buttock. Review of a quarterly MDS assessment dated [DATE] showed Resident #199 was coded No for at risk of developing a pressure ulcer, but coded Yes for having one or more unhealed pressure ulcers. Three stage 3 pressure ulcers present upon admission were coded along with diagnoses of a stage 2 pressure ulcer to the right heel and a non-pressure ulcer to the back were also marked on the MDS assessment. An observation and interview were completed with the facility Wound Nurse on 11/20/2024. During the observation there were 3 pressure areas noted to Resident #199's left thigh and left buttock. The Wound Nurse indicated those areas were the only areas Resident #199 had and was receiving treatment for. She also reported Resident #199 had 2 of the wounds for a while, but a new area had recently developed on the left thigh making the total amount of wounds 3. The wound nurse stated Resident #199 did not have a pressure area to his back or his right heel. A telephone interview was completed on 11/21/2024 at 10:43 PM with MDS Coordinator #1. During the interview MDS Coordinator #1 reported obsolete diagnoses should not be coded on the MDS assessment. If the resident was not receiving treatment for the diagnosis, then it should not be coded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Director of Nursing (DON) on 11/22/2024 at 10:03 AM. During the interview the DON stated she expected to see the MDS assessments completed accurately and timely for all residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47695 Based on observations, record review and staff interview, the facility failed to develop a comprehensive person-centered care plan that addressed suprapubic urinary catheter and pressure ulcers (Resident #199), assistance with activities of daily living (ADL) (Resident#1), Diabetes Mellitus Type 2 therapy (Resident #1), medical conditions and high-risk medications that require monitoring (Resident #1 and Resident #9) for 3 of 13 residents whose care plans were reviewed. 1. Resident #9 was admitted to the facility on [DATE]. Her diagnoses included diabetes mellitus type 2 (DM), unspecified dementia, hypertension (HTN), atrial fibrillation (A-fib), depression, anxiety, pseudobulbar affect (a condition with inappropriate crying and laughing) and post-traumatic stress disorder (PTSD). Review of Resident #9's care plan dated 8/13/2024 and revised on 11/14/2024 revealed no care plans related to a diagnosis of DM or the use of antidepressant, antianxiety, anticoagulant, diuretic, or insulin medications. Review of Physician orders showed the following orders in place: 7/22/2024 - Insulin detemir insulin pen subcutaneous solution 100 units/milliliters (ml), inject 30 units subcutaneously in the morning 8/15/2024 - Sertraline 50 milligrams (mg) (antidepressant medication), give 1.5 tablet by mouth one time a day for anxiety 10/2/2024 - Lorazepam 0.5 mg (antianxiety medication), give 1 tablet three times a day for agitation 10/14/2024 - Torsemide 10 mg (diuretic medication to help remove excess fluid), give one time a day for HTN and hold if systolic blood pressure is less than 110. 11/15/2024 - Apixaban tablet 5 mg (medication used to keep blood thin), give 0.5 tablet two times a day for A-fib. Review of November 2024 medication administration records indicated Resident #9 had received all ordered medication. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9 had severe cognitive impairment, was dependent upon staff for her activities of daily living (ADLs), and had a diagnosis of DM. The MDS assessment showed Resident #9 received insulin, antianxiety, antidepressant, anticoagulant, and diuretic medications during the assessment lookback period. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview completed on 11/21/2024 at 10:55 AM with MDS Coordinator #2 revealed care plans should have been in place for Resident #9's medications, including risk for side effects and the risk for complications related to a diagnosis of DM. MDS Coordinator #2 reported he was not sure why he did not put care plans in place other than he forgot due to half of the care plans being in the computer system and half of them still being on paper. On 11/21/2024 at 11:40 AM an interview was conducted with the Regional MDS Coordinator. During the interview the Regional MDS Coordinator explained when the company changed ownership, they had to print out all existing care plans that were now kept in the MDS office. She also said the paper copy care plans were accessible to all staff so they could see the information. The Regional MDS Coordinator further explained that the care plans were supposed to be entered into the computer system, but there was no full-time MDS Coordinator in the facility and there were difficulties getting that done. She reported the care plans should have been updated to reflect the residents' current status. A review of the paper copies of care plans for Resident #9 that were stored in the locked MDS office failed to show any care plans for risk for complications related to a diagnosis of DM, use of insulin, psychotropic, anticoagulant, or diuretic medications. An interview was completed on 11/22/2024 at 10:03 AM with the Director of Nursing (DON). During the interview the DON revealed her expectations were that all medications such as antianxiety, antidepressant, anticoagulants, hypnotic, and diuretic medication be care planned. The DON explained the diagnosis of DM needed to be care planned as well due to the risk for complications. 2. Resident #199 was readmitted to the facility on [DATE]. His diagnoses included urinary retention. Review of Physician orders showed the following orders in place: 11/4/2024 - Use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate side of securement daily and as needed. 11/4/2024 - Monitor for potential complications of indwelling urinary catheter use such as redness, irritation, signs/symptoms of infection, obstruction, urethral erosion, bladder spasms, hematuria, or leakage around the catheter. 11/4/2024 - Provide catheter cleansing and perineal hygiene daily and as needed if soiled. 11/11/2024 - Flush suprapubic catheter with 60 milliliters (ml) of normal saline every shift 11/13/2024 - Treatment: Clean wound on left proximal thigh with dermal wound cleaner then apply calcium alginate to wound bed and cover with gauze island dressing. Review of the most recent wound note dated 11/18/24 revealed the following information: Stage 3 Pressure Ulcer to left proximal thigh older than 88 days, showing improvement. Stage 3 Pressure ulcer to left buttock older than 39 days, showing improvement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Non-pressure ulcer wound to the left distal thigh less than one day old. A review of Resident #199's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #69 had no cognitive issues, was dependent upon staff for toilet hygiene, had an indwelling (suprapubic) catheter, and had 3 stage 3 pressure ulcers present with pressure ulcer care marked. Review of Resident #199's care plan last reviewed on 11/15/2024 revealed no care plans related to a suprapubic catheter or current pressure ulcers. An observation and interview were completed with Resident #199 at 11/18/2024 at 1:31 PM. During the interview Resident #199 reported he had a catheter in place, and it had been there for about 6 months due to not being able to feel the need to urinate. During the interview an indwelling catheter was observed draining light yellow liquid. A telephone interview was completed on 11/21/2024 at 11:40 AM with the Regional MDS Coordinator. During the interview she reported there should have been a care plan in place for Resident #199's indwelling catheter and pressure ulcers. The [NAME] MDS Coordinator further explained there was not a full-time MDS Coordinator in the facility and there had been issues making sure all the care plans had been updated. She also reported that when the facility changed ownership in June of 2024 all of the care plans were printed off and stored in the MDS office that was accessible to all staff, but they should be updated in the computer system. A review of the paper care plan for Resident #199 dated 6/17/2024 that was stored in the locked MDS office failed to show care plans in place for an indwelling catheter or pressure ulcers. An interview was completed on 11/22/2024 at 10:03 AM with the Director of Nursing (DON). During the interview the DON stated she expected to see any special equipment such as indwelling catheters and skin issues to be on the care plan. During an interview completed with the former Administrator due to the new Administrator being in the facility for less than a week, on 11/22/2024 at 11:03 AM he stated the care plans should reflect the current status of the resident including medications. 49366 3. Resident #1 was admitted to the facility on [DATE] with diagnoses of major depressive disorder and diabetes mellitus. A review of Resident #1's medical record revealed a physician order dated 7/15/24 for aripiprazole (an antipsychotic medication) 15 milligrams (mg) once daily for bipolar disorder, a physician order dated 7/15/24 for zolpidem tartrate (a sedative) 5mg once at bedtime for insomnia, a physician order dated 7/15/24 for dulaglutide injection (a medication to lower blood sugar) inject 0.5 milliliters (ml) subcutaneously one time a day every Tuesday for diabetes mellitus, and a physician's order dated 8/1/24 for glipizide (a medication to lower blood sugar) 1.5 tablets one time a day for diabetes mellitus. A review of Resident #1's October and November 2024 Medication Administration Record (MAR) revealed she had been receiving the psychotropic medication, and diabetes mellitus medications as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] showed Resident #1 received antipsychotic and hypnotic medications. The MDS further revealed she required substantial assistance with dressing, bathing, and bed mobility and was dependent on staff for toileting and transferring. Resident #1's care plan last reviewed on 9/20/2024 revealed there was no care plan in place for psychotropic medication use, assistance with ADL, and diabetes mellitus therapy. An interview was completed with the MDS Consultant on 11/21/24 at 11:54 AM. It revealed the care plan should be updated after the MDS assessment is completed. She stated the updated care plans were in a physical binder in the MDS office, not in the Electronic Medical Record (EMR), as the facility switched EMR systems recently. The MDS Consultant revealed assistance with ADL, diabetes mellitus therapy, and psychotropic should be itemized in the care plan for Resident #1. An interview with the DON on 11/22/24 at 10:07 AM revealed assistance with ADL, diabetes mellitus therapy, and psychotropic medication should be listed in the care plan for Resident #1 to reflect her needs. An interview with the Administrator on 11/27/24 at 11:20 AM revealed he expected a care plan that detailed assistance with ADL's, diabetes mellitus therapy, and psychotropic medication use would be in place for Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on observations, record review, and resident, facility staff, Nurse Practitioner (NP), Medical Director (MD), and Physician Assistant (PA) interviews, the facility staff failed to recognize the seriousness of a significant change in condition, complete comprehensive and ongoing assessments, and identify the need for urgent medical attention. On 09/14/24 at 9:05 AM Nurse #3 heard a loud hit or thud coming from across the unit and then observed Resident #49 rolling out of his room in his wheelchair and witnessed Resident #79 swinging his arm with a fist and hit Resident #49 on the back of the head. Resident #49 was noted to slump over in his wheelchair and have a loss of consciousness for a few seconds before opening his eyes and requesting to go outside and smoke. Resident #49 had a history of a traumatic brain injury and immediately after being hit in the head by Resident #79 he was noted to have a change of condition as evidenced by a change in level of assistance needed for transfer and bed mobility changed, confusion and inability to self-propel in his wheelchair. There was a lack of effective communication between staff after Resident #49 was transferred to a different hall around 10:00 AM and no care or assessments were provided by a nurse until 3:00 PM. There were no documented comprehensive assessments or neurological checks located in the medical record after the initial nursing note after the incident. Later in the day Resident #49 slid out of wheelchair to the floor and was assessed with worsening generalized weakness and concern for a concussion. Emergency Medical Services (EMS) was dispatched on 9/14/24 at 6:31 PM and Resident #49 was taken to the hospital for evaluation. A Computed Tomography (CT) scan was completed which resulted in no acute findings. Resident #49 was discharged back to the nursing facility on 9/15/24 with strict precautions to return with any new or worsening symptoms. Resident #49 returned to the hospital on 9/17/24 for evaluation of acute chronic left-sided weakness, lightheadedness, blurred vision and headaches. Resident #49 was admitted for neuroimaging (brain scanning). The Neurologist felt the findings could represent post concussive changes and Resident #49 was discharged back to the facility on [DATE] with orders to follow up with neurology outpatient. At the time of the survey, Resident #49 reported he felt his condition had changed since the incident and noted he was now confined to a specialized chair and was dependent upon staff for all activities of daily living and required the use of mechanical lift for transfers. In addtion, the facility failed to assess a resident for injury before moving them when Driver #1 was transporting Resident #55 in the facility van and he fell backwards in his wheelchair and hit his head on the van floor resulting in severe head pain. Driver #1 lifted Resident #55 back into an upright position and drove him back to the facility without being assessed by a medical professional. Driver #1 had not been trained on how to respond or what to do in emergency situation or accident. Resident #55 was assessed by Nurse #1 and noted to have a swollen area with abrasions to the back of his head. Resident #55 was transferred to the hospital for further evaluation and was diagnosed with a closed head injury, scalp abrasion and strained neck muscles. This deficient practice occurred for 2 of 3 sampled residents reviewed for quality of care (Resident #49 and Resident #55). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Immediate Jeopardy began on 09/14/24 when Resident #49 who had a history of a traumatic brain injury was hit in the head and facility staff failed to identify the seriousness of the change in condition and complete comprehensive assessments to determine if a higher level of care was needed. Immediate jeopardy began for Resident #55 on 11/15/24 when he was lifted back into an upright position by Driver #1 before he was assessed for injury by a medical professional. The immediate jeopardy was removed for Resident #55 on 11/22/24 and for Resident #49 on 11/23/24 when the facility implemented an acceptable credible allegation. The facility remains out of compliance at a lower scope and severity of a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. The findings included: 1. Resident #49 was a [AGE] year-old admitted to the facility on [DATE] with a diagnosis of traumatic brain injury (TBI). A review of Resident #49's quarterly Minimum Data Set assessment dated [DATE] revealed he was cognitively intact. Resident #49 was coded as independent for eating and putting on/ taking off footwear. He required set up or clean up assistance for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and personal hygiene. Resident #49 required supervision assistance for chair to bed transfers, toileting transfers, tub/shower transfers and lying to sitting on the side of the bed. The resident was noted to be independent for rolling left and right while in bed. Resident #49 was continent of bowel and bladder during the assessment period and was documented to have no behaviors. Resident #79 was a [AGE] year-old admitted to the facility on [DATE] with a diagnosis of TBI. A review of Resident #79's quarterly Minimum Data Set assessment dated [DATE] revealed he was cognitively intact. Resident #79 was coded as independent for all activities of daily living (ADL) including eating, toileting, oral hygiene, shower/bathe self, upper body dressing, lower body dressing and all transfers. He was coded as using a cane to ambulate during the assessment period. Resident #79 was documented to have no behaviors. A review of the facility's investigation report initiated on 09/14/24 at 9:05 AM by the Administrator revealed Resident #49 was hit on the back of his neck/head by his roommate. After the nurse assessed Resident #49, he was noted with no injuries and the residents were immediately separated by moving Resident #49 to another room. Staff were briefed on the incident and monitored the residents every 15 minutes to avoid further incidents. Resident #49's roommate had stated he hit the resident because he was trying to exit the room and Resident #49 was blocking the doorway with his wheelchair. An Occupation Therapy (OT) discharge summary dated 09/06/24 revealed Resident #49 received therapy services initiated on 07/18/24 through 09/06/24. Skilled interventions provided included instructing and training Resident #49 in proper body mechanics, positioning/ pressure relieving techniques, safe transfer techniques and use of adaptive equipment in order to improve independence and engagement of ADL and self-care task. At the time of therapy discharge Resident #49 was set up assistance for eating, partial/moderate assistance for toileting hygiene, supervision for toileting transfers and set up assistance for bathing. The resident's self-care function score on a scale of 0-12 (12 being the highest function of independence) was a 10. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A nursing note written by Nurse #3 dated 09/14/24 at 10:11 AM revealed she heard hitting noises and turned around to observe Resident #49 get hit in the head by his roommate. The note revealed the residents were separated and assessed for injuries. Resident #49's vital signs were the following: blood pressure 138/66, pulse 72, temperature 97.9, respirations 20, oxygen saturation level 96% on room air. The resident was noted with no signs of acute distress at the time of the incident and no complaints of pain. Redness was noted to the back of the resident's neck. The residents Responsible Party, Director of Nursing and on call Nurse Practitioner were notified. New orders were obtained for a psychological evaluation of Resident #79 and every 15-minute monitoring for a duration of 24 hours. A review of Resident #49's medical record revealed the only documented vital signs were included on Nurse #3's progress note on 9/14/24 at 10:11 AM. Further review of the medical record revealed no neurological or resident assessments were documented. On 11/19/24 at 11:38 AM an interview was conducted with Nurse #3. Nurse #3 stated on 09/14/24 around 9:00 AM she heard a loud hit or thud coming from across the unit. She then saw Resident #49 rolling out from his room in his wheelchair and witnessed (Resident #79) who was cognitively intact, swinging his arm with a fist and hit Resident #49 at the back of the head making a second thud sound as his fist hit the back of Resident #49's head. Resident #49 immediately slumped over in his wheelchair and regained consciousness within a couple of seconds after she got to him to assess his condition. She stated she saw redness at the back of Resident #49's head and neck area. When Resident #49 came to he asked to go outside to smoke so Nurse Aide (NA) #2 took him to the smoking area. Nurse #3 indicated she had obtained initial vital signs on the resident which were within normal range, assessed him and the Unit Manager notified the Nurse Practitioner of what had occurred. Nurse #3 explained when Resident #49 was moved from her hall around 10:00 AM, she no longer was his nurse and did not see him again that day. The interview revealed she had initiated an action rounding log which documented where the resident was in the facility every 15 minutes. Upon review of the action rounding sheet Nurse #3 confirmed her initials were on the sheet documenting on the resident from 9:00 AM to 3:00 PM, however she did not recall putting her initials on the paper nor had she checked on the resident every 15 minutes during the shift. Nurse #3 stated Nurse #4 took over Resident #49's care when he moved to his new room around 10:00 AM. Nurse #3 gave Nurse #4 a short description of what had occurred between the two residents and went back to her unit. The interview revealed the facility would typically complete neurological assessments after a head injury, however since Nurse #4 assumed responsibility for the resident it would have been up to her to complete the assessments and monitoring. Nurse #3 stated she did not initiate neuro checks for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/21/24 at 12:32 PM an interview was conducted with Scheduler #1. She stated she was working as the Manager on Duty on 09/14/24. Scheduler #1 stated her office door was open and she overheard a nurse screaming for help. When she went out into the hall, she saw Nurse #3 and went to her. Scheduler #1 stated Resident #49 sitting in his wheelchair slumped over and was unconscious for approximately a minute. Nurse #3 explained to her that he had just been hit in the back of the head by Resident #79. When he initially woke up after being hit and came to, his abilities were not the same, he was using his hands but nothing else like he had before. She stated he was no longer able to self-propel himself in the hallway as he had done that morning or self-transfer to bed. After separating the residents, she stated she notified the Unit Manager #1 via the facility paging system and Nurse #3 called the Director of Nursing. Scheduler #1 stated Resident #49 was taken to the smoking area by NA#2 because he stated he wanted to go smoke. She stated Resident #49 immediately seemed spaced out by responding slowly when spoken to and not thinking clearly. The interview revealed Resident #49 started trying to go in the wrong direction and had to be redirected by staff. When they took him to his new room, it took Scheduler #1, NA #2 and Nurse #3 to all assist him into the bed. Scheduler #1 told Nurse #3 she would need to complete neurological assessments. She stated they were so concerned with Resident #49's condition they had placed a fall mat under his bed because they felt like he may have a fall from the bed due to his state of immobility. Scheduler #1 stated she did not voice her concerns to anyone because she thought Nurse #3 and Nurse #4 were communicating the residents' changes to the Medical Provider. The interview revealed Resident #49 had experienced a couple of falls following the incident and was sent back to the hospital on 09/17/24 for a reevaluation due to complaints of a headache. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/21/24 at 9:06 AM an interview was conducted with Unit Manager (UM) #1. During the interview she stated on 09/14/24 around 9:00 AM she was paged on the overhead call system to come to Resident #49s room. Upon arrival Nurse #3 told her Resident #49 had been hit on the back of his head by Resident #79. She stated she looked at the resident and he was able to respond to her. She had them remove Resident #49 from the room and contacted the Director of Nursing (DON) who stated she needed to notify the resident's family and the provider on call. She stated the provider on call (NP #3) asked her how the resident was doing, and she stated it was her first time laying eyes on him, and he seemed okay. NP #3 instructed the facility to notify them of any change of condition. UM #1 recalled they immediately moved Resident #49 to a room in another hall around 10:00 AM. She stated it was her understanding after talking with Nurse #3 that Nurse #4 was going to assume care of the resident when he moved to the new room. Unit Manager #1 stated she was rounding later in the day and saw Resident #49's call light on, she stated he was trying to transfer himself from the wheelchair to the toilet which the NA said he was normally able to do. She stated she had to get two other staff members to assist due to his weakness. She stated Resident #49 was so weak she asked the Resident to hold off on all transfers for the rest of the day because he was now a full assist for transfers. She contacted Nurse Practitioner (NP) #2 who told her she would be in the building to round shortly. UM #1 explained she spoke with the DON after she called NP #2 to let her know NP #2 was going to evaluate the resident. UM #1 revealed the DON told her to activate Emergency Medical Services (EMS) because she did not feel comfortable with his condition. EMS arrived at the same time as NP #2 came onsite around 3:00 PM. NP #2 completed an assessment of Resident #49 and stated to her (UM #1) to turn EMS away, that the resident had no reason to go out for an evaluation. UM #1 indicated she disagreed with the decision, however, went along with it and sent a message to the DON letting her know EMS was turned away. UM #1 indicated shortly after she had them turn EMS away the resident was in his wheelchair he slid out of his wheelchair onto his bottom. She stated the staff had moved Resident #49 to his wheelchair because his legs kept dangling off of the bed and she was afraid he was going to fall. Unit Manager #1 indicated after Resident #49 slid out of his wheelchair she called NP #2 and notified her Resident #49 was going to be sent to the hospital for an evaluation. On 11/22/24 at 9:38 AM an interview was conducted with NP #3. During the interview she stated she was the on-call provider assigned for the facility on 09/14/24 (Saturday). NP #3 stated she did recall being notified of an altercation with Resident #49 around 10:00 AM but did not recall the details of the phone conversation of what she was told by the nurse. She stated typically if she was notified a resident was struck in the head she would recommend sending the resident to the hospital for an evaluation. She stated she was not contacted by the facility for Resident #49 anymore that day because they had an in-house NP (NP #2) that was rounding on the residents. The interview revealed she did not have any notes from the day as to what orders she gave the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/19/24 at 12:52 PM an interview was conducted with Nurse Aide (NA) #2. NA #2 stated she was responsible for Resident #49 on 09/14/24 during first shift (7:00 AM to 3:00 PM). She stated she did not witness the incident but was notified of what had happened by Nurse #3. NA #2 recalled she was told by Nurse #3 to take Resident #49 outside to smoke and to move Resident #49's belongings out of his room into a new room on another unit. NA #2 indicated she moved Resident #49's belongings and assisted him from the smoking area to his new room around 10:00 AM and assisted him into the bed which was different from that morning. Earlier in morning, he was able to transfer himself. The interview revealed when she went to the smoking area to get Resident #49, he did not have a cigarette and was just sitting outside. NA #2 stated she had discussed Resident #49's change of condition with both Nurse #3 and Nurse #4 as soon as she assisted Resident #39 into his bed in the new room that morning. NA #2 stated she immediately noticed a difference in the way Resident #49 was responding and moving. NA #2 stated Resident #49 could not assist her at all for bed mobility and had to remain in bed for the rest of her shift. NA #2 explained she decided to continue to provide care to the resident despite him being on another unit due to staffing concerns. NA #2 indicated Resident #49 had gone from being able to transfer himself that morning to being unable to roll from left to right in the bed following the incident. For the remainder of the shift Resident #49 was provided with incontinent care in bed, which was a change of condition. NA #2 also noted Resident #49 seemed slow to respond when she spoke to him. NA #2 stated she was not given instructions to obtain vital signs on Resident #49 during first shift and gave report to NA #1 at 3:00 PM. On 11/19/24 at 2:00 PM an interview was conducted with NA #1. During the interview she stated she came on shift at 3:00 PM and received report from NA #2. NA #1 recalled she and the Unit Manager #1 assisted Resident #49 to his wheelchair because his legs were dangling off of the bed around 4:00 PM. NA #1 noted Resident #49 to be disoriented, leaning back in his wheelchair, sliding out of his wheelchair and overall, not looking like he typically did, sitting up, self-propelling himself in a regular wheelchair in the hallway. NA #1 indicated Resident #49 usually transferred himself to the bathroom but that shift he was incontinent, and she was changing Resident #49's brief while he was in bed which was a change. NA #1 remembered having to assist him back up in his wheelchair during that evening and he eventually slid completely out of his wheelchair into the floor in the hallway around 6:30 to 7:00 PM. The interview revealed Resident #49 was sent to the hospital for an evaluation. NA #1 stated she did not recall obtaining vital signs for Resident #49 nor was she asked about his condition. The interview revealed she had notified Nurse #4 during her shift around 4:00 PM that Resident #49 seemed different from his baseline state. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/19/24 at 2:49 PM an interview was conducted with Nurse #4. She stated she was in the building on 09/14/24 during the first shift (7:00 AM to 3:00 PM) and second shift (3:00 PM to 11:00 PM). The interview revealed Resident #49 was moved to her hall following an altercation with Resident #79 during which Resident #79 hit Resident #49 on the back of his head. She stated she assumed Resident #49's care for second shift at 3:00 PM. The interview revealed Resident #49 was noted to be in bed, which was not usual because he was typically up and out in the facility in the hallway during the day. Nurse #4 indicated she did not report the change of condition to the Medical Provider. Nurse #4 stated the NA #1 and NA #2 were telling her he was experiencing a significant change of condition from his normal baseline by being in bed, a decrease in mobility, decreased alertness and incontinence throughout the day. Nurse #4 explained Resident #49 was gotten up to his wheelchair for the supper meal and he kept sliding out of the wheelchair and Nurse #4 had to obtain other staff members to assist her to pull him up in his chair. Nurse #4 indicated around 6:30 PM Resident #49 was noted to fall out of his wheelchair onto the floor in the hallway. Resident #49 was immediately sent to the hospital for an evaluation based on the nurse aides telling her of the resident's drastic change of condition and the fall. Nurse #4 stated prior to the incident Resident #49 was independent in his wheelchair, however when he left to go to the hospital, he was dependent upon staff for transfers using a mechanical lift. Nurse #4 recalled she had completed an action rounding sheet starting at 3:00 PM on Resident #49 which meant every 15 minutes the staff were documenting where the resident was in the facility. She stated they did not have to complete vital signs on a schedule or neurological assessments on the resident because she thought Nurse #3 had completed them. Nurse #4 thought the first shift nurse had taken care of the neurological assessments and the resident until 3:00 PM. She explained that Nurse #3 had initialed the action rounding sheet during the first shift. Nurse #4 stated she did not receive report from Nurse #3, it was just known around the facility what had happened to Resident #49 and why he had to change rooms. The interview revealed Nurse #4 did not know she was supposed to assume the residents care when he initially moved to the new room around 10:00 AM because typically if a resident moved the nurse initially responsible would continue to care for them throughout the shift until the next shift arrived. Nurse #4 further stated after the resident came back from the hospital, she had taken care of him during second shift on 09/15/24 when he experienced a fall out of bed. The resident stated he was trying to fix himself in the bed and had just slipped down onto the fall mat located to the side of his bed. She stated he did not report hitting his head and was placed back in bed. The on-call physician was notified on 09/15/24 at 11:40 PM of the fall and stated to monitor the resident. Nurse #4 confirmed she did not assess or provide any care to Resident #49 until 3:00 PM. A SBAR (Situation, Background, Assessment and Recommendation) Summary dated 09/14/24 at 3:35 PM written by Unit Manager #1 revealed Resident #49 had experienced a change of condition after a physical altercation with another resident. The chief complaint was listed as Resident #49 had become increasingly weak on the left side after a physical altercation at the hands of another resident. The on- call provider was notified of the residents' condition and instructions were placed to activate Emergency Medical Services (EMS) for an evaluation at the Emergency Department. Review of the Emergency Medical Services dispatch log for the facility on 09/14/24 revealed they were initially notified to respond for Resident #49 at 3:33 PM due to a physical decline after a physical altercation. EMS was en route to the facility at 3:47 PM and cancelled at 4:04 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A Nurse Practitioner note written by NP #2 on 09/15/24 as late entry for 09/14/24 revealed she was asked to see Resident #49 for altered mental status after an altercation in which the resident ended up on the floor knocked out cold, he did not hit his head and regained consciousness right away but now seen with altered mental status. At the time of the assessment, although he was able to follow simple commands, he was noted to have worsening generalized weakness drop in extremity sitting in the chair. She was noted to be concerned for a concussion and escalated the resident to the emergency room for an evaluation and management. On 11/22/24 at 9:14 AM an interview was conducted with Nurse Practitioner #2. She stated she was an in-house provider that rounded in the facility on the weekends. She stated she remembered evaluating Resident #49 while he was sitting in a chair, but NP #3 was originally notified that morning about an altercation. NP #2 stated staff did tell her the resident had been hit in the head by his roommate and had experienced altered mental status. However, she did not witness the incident and therefore it was only hearsay. NP #2 stated she only recalled sending the resident out to the hospital following a fall around 6:30 PM and did not recall telling anyone to stop EMS from coming at 3:00 PM. A late entry incident report dated 09/14/24 at 11:02 PM written by Nurse #4 revealed Resident #49 had experienced a fall and was found in the hallway sitting on his bottom around 6:30 PM. Resident #49 stated he had slid off his wheelchair. No injuries were observed however the resident was sent to the hospital due to recent change in cognition. Review of the Emergency Medical Services (EMS) dispatch log for the facility on 09/14/24 revealed they were notified to respond for Resident #49 at 6:31 PM due to a fall in which the resident slipped from his chair to the floor. EMS arrived at the facility and transported Resident #49 to the hospital. EMS records dated 09/14/24 revealed they were dispatched to the facility with a chief complaint of increased weakness and a fall after an assault earlier in the morning. The resident had a history of TBI and wanted to be evaluated. Resident #49 stated he was hit in the head by Resident #79 earlier in the morning around 9:00 AM. He stated Resident #79 used his fist to hit him in the head and denied loss of consciousness. Staff, however, did say the resident lost consciousness. The resident was cleared initially by his facility physician to stay at the facility and not be transported to the hospital. Around 6:30 PM Resident #49 was sitting in his wheelchair, when he tried to reposition himself, he had increased weakness that caused him to slide down the chair onto the floor. The resident was noted to be on the floor when the medic arrived. Resident #49 was mechanically lifted into the medic's stretcher. EMS documented the resident's vital signs at 6:52 PM to include the following: blood pressure 120/76, pulse 70 beats per minute (bpm), respirations 16, oxygen saturation level 94% (normal >92%). Resident #46 was noted to be oriented to person, place and time. The resident stated to EMS he felt safe at the facility, however, would like a new roommate. The note read, Patient is requesting we transport him to the hospital for further evaluation. Hospital records dated 09/14/24 revealed Resident #49 was evaluated on this date after sliding out of his wheelchair around 6:30 PM. Per the Medic the resident was also punched in the head by his roommate earlier in the morning around 9:30 AM but cleared by the facility. The residents' diagnoses included fall, closed head injury and generalized weakness. A Computed Tomography (CT) scan was completed which resulted in no acute findings. Resident #49 was discharged back to the nursing facility on 9/15/24 with strict precautions to return with any new or worsening symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A nursing progress note dated 09/15/24 at 6:55 AM revealed Resident #49 had returned to the facility from the hospital by EMS transport. Resident #49 was noted to be in no acute distress or discomfort. An incident report dated 09/15/24 at 11:38 PM written by Nurse #4 revealed Resident #49 had an unwitnessed fall and was found on the floor of his room. The resident stated to the nurse that he was trying to fix himself in the bed. No injuries were observed at the time of the incident and the resident denied hitting his head. A Nurse Practitioner on call was notified of the fall and stated to monitor the resident for any changes. An incident report dated 09/16/24 at 6:15 AM written by Nurse #5 revealed Resident #49 had experienced an unwitnessed fall and was observed laying on his back on the floor of his room. His legs and feet were noted to be tangled in his sheets while he was on the floor. Resident #49 denied hitting his head, he stated he had slid with the covers landing on his bottom and his back. No open or bruised areas were noted to the residents' body. NP #1 was notified of the fall on 09/16/24 at 7:54AM. An interview was attempted with Nurse #5 on 11/20/24 at 10:35 AM with no return phone call received to the surveyor. A Nurse Practitioner note dated 09/16/24 written by NP #1 revealed she was asked to evaluate Resident #49 on this date by the Director of Nursing (DON) due to the resident being sent to the Emergency Department (ED) after he was forcefully hit in the head by his roommate and had experienced a couple of falls since the incident. Resident #49 was noted to have been evaluated for a close head injury while in the hospital. At the time of her assessment the resident was noted to be in a stable condition with no complaints of pain or weakness. During the evaluation he was noted to be in bed resting with no acute distress. On 11/19/24 at 3:36 PM an interview was conducted with Nurse Practitioner #1. During the interview she stated Resident #49 was sent to the hospital on 09/14/24 following a fall in the facility. She stated she was not in the facility or on call the weekend the incident occurred but learned of the altercation the following Monday after returning to the facility. NP #1 stated Resident #49 had experienced two falls after returning back to the facility from the hospital and she was asked to evaluate him on 09/16/24 following the second fall. Resident #49 was in no distress during her evaluation. The interview revealed Resident #49 started experiencing headache, weakness and lightheadedness on 09/17/24 while she was in the building and was sent back to the hospital. He was discharged back to the facility on [DATE]. NP #1 stated she had written a progress note on 10/21/24 discussing the hospital course and they had conducted a neurological work up while the resident was in the hospital. She stated the hospital notes did discuss the resident could have had post concussive findings meaning it was possible he had experienced a concussion from the incident, but they were unable to determine if it was that or a past misdiagnosis. NP #1 stated Resident #49 is now in a specialized wheelchair that leaned back unlike the chair he was in prior to the incident which was a regular wheelchair. She stated once he came back from the hospital, he was slow to respond with occasional headaches and was not as active as he was prior to the incident. She stated it was possible the effects he has experienced could be from the altercation, but the resident had other conditions that could have contributed to the changes he had experienced. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Hospital records dated 09/17/24 revealed Resident #49 presented to the hospital for evaluation of acute chronic left-sided weakness. The resident was reported to have been punched in the head by a roommate 3 days prior. He was originally evaluated in the Emergency Department on 09/14/24 and cleared for discharge. He presented back to the hospital complaining of lightheadedness and felt that his left side was weaker than his baseline from prior brain injury. He was also complaining of blurred vision and headaches. Resident #49 was admitted for neuroimaging. The exam showed a decreased edema signal within the brainstem (indicating potential damage or abnormality within the brainstem region) since the prior exam. Neurology was consulted with orders to follow up outpatient. The note revealed the Neurologist felt the findings could represent post concussive changes in the setting of extensive chronic progressive leukoencephalopathy (a rare, progress brain infection that destroys cells that produce myelin, an insulating material for nerve cells). The resident's hospital course included a full stroke workup resulting in no findings of a stroke, Physical Therapy and Occupational Therapy evaluation, lab workup and inpatient neurology evaluation. Resident #49 was discharged back to the facility on [DATE] with orders to follow up with neurology outpatient. A Nurse Practitioner note written by NP #1 revealed Resident #49 was evaluated on 09/23/24 after a reevaluation post hospitalization regarding altered mental status. The resident was noted to have been recently sent to the Emergency Department (ED) after being hit in the head by another resident. He was evaluated in the ED and cleared for discharge. However, after his return to the facility he had a decline with altered mental status and was sent back for further evaluation. Resident #49 was admitted for further neurological imaging. The plan included concussion/leukoencephalopathy/closed head injury. Neurology felt the resident had post concussive findings in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on observations, record review, resident, Medical Director and staff interviews, the facility failed to provide safe van transportation when Driver #1 failed to secure Resident #55's wheelchair in the facility van per the manufacturer's instructions. On 11/15/24, during transport from the dialysis center, Driver #1 did not secure Resident #55's wheelchair in the facility van per the manufacturer's instructions, and when he drove out of the parking lot and turned right onto the main road, Resident #55 fell backwards in his wheelchair and hit his head on the van floor. Resident #55 was assessed by Nurse #1 when he returned to the facility, was noted to have an abrasion and swelling to the back of his head and was complaining of severe head pain. He was transported to the Emergency Department (ED) for further evaluation and diagnosed with a closed head injury, scalp abrasion, and strained neck muscles. There was a high likelihood of a serious adverse outcome or injury when Resident #55's wheelchair was not secured in the transportation van per the manufacturer's instructions. Resident #55 was not receiving an anticoagulant (blood thinner). This deficient practice occurred for 1 of 9 residents reviewed for accidents (Resident #55). Immediate jeopardy began on 11/15/24 when Resident #55's wheelchair was not secured in the facility's transport van per the manufacturer's instructions, and he fell backwards in his wheelchair and hit his head on the van floor. Immediate jeopardy was removed on 11/19/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: A review of the manufacturer's instruction manual for the transport van 4-point wheelchair securement system provided by the facility read in part: Attach the tie-down (fabric strap connecting a hook and a floor anchor) anchor into the floor anchorages and lock them into place. Attach the 4 tie-down hooks to a solid part of the wheelchair frame below the seat ensuring the tie downs are fixed at approximately 45 degrees. Ensure all tie-downs are locked and properly tensioned (tightened). A review of Driver #1's training records revealed a competency evaluation dated 11/12/24 completed by the Former Administrator that Driver #1 was reviewed for securing a wheelchair into the facility's transport van per the manufacturer's instructions and all competencies were checked as met. Resident #55 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, right below the knee amputation, abnormalities of gait/mobility and muscle weakness. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #55 was cognitively intact, had lower extremity impairment on one side, utilized a manual wheelchair for mobility, required supervision to moderate assistance with transfers and was receiving dialysis treatment. The MDS further revealed Resident #55 was not coded for receiving an anticoagulant. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Care Plan dated 11/13/24 indicated Resident #55 required minimal to extensive assistance with activities of daily living, was a right lower extremity amputee with a prosthesis, utilized a wheelchair to assist with mobility and received dialysis treatment 3 days a week. A review of the facility incident report dated 11/15/24 written by Nurse #1 indicated Resident #55 was being transported in the facility van from dialysis and when the van started moving forward, he fell backwards in his wheelchair and hit his head. Resident #55 returned to the facility and Nurse #1 completed a full body assessment. Resident #55 had an area to the back of his head with a small amount of bleeding, redness, and swelling. Resident #55 was alert and oriented and his vital signs were stable. Nurse #1 cleaned the area to his head and applied a border gauze dressing (absorbent gauze pad with a sticky border to hold it in place). Resident #55 was complaining of head pain and requested to go to the hospital. The on-call physician was notified, an order was received and Resident #55 was transported to the emergency department (ED) via emergency medical services for further evaluation. A review of the ED records dated 11/15/24 revealed Resident #55 reported he fell backwards in his wheelchair in a transport van hitting his head on the van floor. He was noted to have a wound to the back of his head with the bleeding controlled prior to his arrival at the ED. A computed tomography (CT) scan of the head and spine, and x-rays of the pelvis and chest were obtained. The CT scan results were negative for intracranial hemorrhage (brain bleed) and fractures, the x-rays were also negative for any fractures and the scalp abrasion did not require any treatment. Resident #55 was stable and discharged back to the facility with diagnoses including closed head injury, scalp abrasion, and strain of the neck muscle. A review of Driver #1's statement dated 11/15/24 indicated he picked up Resident #55 from the dialysis center loaded him in the transportation van and secured his wheelchair. Driver #1 was pulling out of the parking lot onto the main road when he heard Resident #55 yelling whoa, whoa, and he looked back to find Resident #55 had fallen backwards in his wheelchair. Driver #1 immediately pulled over into a parking lot and stopped the van, waved down a person to help and they lifted Resident #55 back into an upright position. Driver #1 noted Resident #55 had a small amount of blood on the back of his head which he cleaned with an alcohol wipe. Driver #1 secured Resident #55's wheelchair, started driving back to the facility and called Unit Manager #1 to inform her of the incident. Upon returning to the facility, Driver #1 took Resident #55 to the nurse's station and informed the nurse of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with Driver #1 on 11/19/24 at 2:02 PM he indicated the Former Administrator trained him on how to secure a wheelchair in the facility van on 11/12/24. Driver #1 indicated he watched the Former Administrator secure a wheelchair in the van using the manufacturer instructions. Driver #1 stated the Former Administrator then observed him secure an empty wheelchair in the van, and then the Former Administrator sat in a wheelchair, he secured it in the van and drove the van out of the parking lot and on the main road for a few minutes to ensure the wheelchair was properly secured. Driver #1 indicated the Former Administrator filled out a vehicle safety and operation competency evaluation and he was checked off for meeting the competencies for proper placement and securement of the wheelchair. Driver #1 stated he started transporting residents in the facility van on 11/13/24 and transported 3 residents to appointments on that day without incident. Driver #1 indicated on 11/15/24 around 11:00 AM he picked up Resident #55 from the dialysis center, secured his wheelchair in the transport van, and started to drive out of the parking lot. He stated when he accelerated the van and turned onto the main road, Resident #55 began yelling whoa, whoa, and when he looked back Resident #55 had fallen backwards in his wheelchair. Driver #1 indicated he drove about 200-300 feet, pulled over into a parking lot, and stopped the van. He stated he went to the back of the van and Resident #55 was tipped over in his wheelchair and lying on his right side. Driver #1 stated he observed that the front left anchor on the tiedown strap had come loose from the floor anchorage. He indicated he asked Resident #55 if he was ok and he said he was. Driver #1 stated he waved down a person in the parking lot to help and they lifted Resident #55 back into an upright position. Driver #1 revealed he secured Resident #55's wheelchair making sure all of the tie-down anchors were locked into the floor anchorages and then drove back to the facility. He stated that while he was driving back to the facility he called and reported the incident to Unit Manager #1. Driver #1 indicated when he arrived at the facility, he took Resident #55 to the nurse's station and reported the incident to Nurse #1. An interview with Resident #55 on 11/19/24 at 12:36 PM indicated the facility transports him to dialysis on Mondays, Wednesdays and Fridays. He stated Driver #1 transported him in the facility van for the first time on 11/13/24. Resident #55 revealed when the van was moving his wheelchair was moving around a little and he did not feel properly secured but did not report this to Driver #1. Resident #55 indicated Driver #1 transported him to dialysis on 11/15/24 and on the way back to the facility when he drove out of the parking lot and turned onto the main road, he fell backwards in his wheelchair and hit his head on the van floor. Resident #55 stated Driver #1 stopped the van and asked if he was injured, and he told him his head hurt. He stated that Driver #1 waved down a person to come and help and they lifted him back into an upright position. Resident #55 revealed that Driver #1 secured his wheelchair and drove him back to the facility. He stated a nurse assessed him when he returned to the facility but he did not recall her name. Resident #55 indicated he told the nurse he was having severe head pain and that he wanted to go to the hospital. He revealed the nurse called 911 and he was transferred to the ED for further evaluation. An interview was conducted with Unit Manager #1 on 11/20/24 at 10:06 AM. Unit Manager #1 revealed on 11/15/24 she received a phone call from Driver #1 informing her that Resident #55 fell backwards in his wheelchair while being transported in the facility's van. She stated she asked Driver #1 how it happened, and he told her the tie-downs were not secured properly and came loose. Unit Manager #1 indicated Driver #1 informed her he lifted Resident #55 back into an upright position and there was a little blood on the back of his head he wiped off. She revealed Driver #1 reported no other injuries, so she told him to bring Resident #55 back to the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Nurse #1 on 11/20/24 at 10:21 AM indicated she was assigned to Resident #55 on 11/15/24. She stated Driver #1 returned to the facility with Resident #55 after his dialysis appointment and informed her the resident fell backwards in his wheelchair in the van and hit his head on the floor. Nurse #1 revealed she completed a head-to-toe assessment and noted Resident #55 had a large swollen area to the right back side of his head with abrasions and a small amount of bleeding. She indicated Resident #55 did not have hair, so she was able to clean the area and applied a gauze border dressing. She stated that Resident #55 was complaining of severe head pain and requested to go to the hospital. She revealed she administered Resident #55 pain medication ordered as needed, called the on-call physician and obtained an order to transfer Resident #55 to the ED for further evaluation. An interview conducted with the Former Administrator on 11/19/24 at 3:08 PM indicated on 11/07/24 the facility's transport driver resigned, and the facility's part time receptionist (Driver #1) was hired as the transport driver. He stated on 11/12/24 he trained Driver #1 by showing him how to secure a wheelchair in the transport van using the manufacturer instructions for the 4-point wheelchair securement system and then watched Driver #1 secure an empty wheelchair in the van. The Former Administrator revealed he then sat in a wheelchair while Driver #1 secured it in the van and drove the van out of the parking lot and on the main road. He indicated Driver #1 secured the wheelchair properly and no concerns were identified. The Former Administrator stated he filled out the facility's vehicle safety and operation competency evaluation and Driver #1 met all the competencies on the form including proper placement and securement of the wheelchair per the manufacturer instructions. An interview conducted with the Medical Director on 11/20/24 at 11:01 AM indicated she was aware of the van incident that occurred with Resident #55. She stated she was informed Resident #55's wheelchair was not secured properly in the transport van and when the van started moving, he fell backwards in his wheelchair hitting his head on the van floor. The Medical Director revealed that residents should be secured properly in the transport van and a resident that fell should be evaluated by a medical professional prior to being moved to prevent further injury. An interview with the Administrator on 11/19/24 at 3:30 PM revealed he started working at the facility on 11/12/24. He stated he was aware of the incident that occurred on 11/15/24 involving Resident #55. He indicated Driver #1 had not secured Resident #55's wheelchair and when the van started moving Resident #55 fell backwards in his wheelchair and hit his head on the van floor. The Administrator indicated Driver #1 lifted Resident #55 back into an upright position, secured his wheelchair and drove him back to the facility. The Administrator stated Resident #55's wheelchair should have been properly secured in the transport van. The Administrator was notified of immediate jeopardy on 11/20/24 at 2:04 PM. The facility provided the following credible allegation for immediate jeopardy removal: Identify those residents who have suffered, or are likely to suffer a serious adverse outcome as a result of the non-compliance: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/15/2024 at approximately 11:20 AM Resident #55 had a fall in the facility van during return from dialysis when the wheelchair tipped backwards and Resident #55 struck his head on the van floor resulting in an injury to the back of his head and pain. The facility Transportation Driver failed to provide safe van transportation for Resident #55 by not securing his wheelchair in the transportation van per the manufacturer's instructions. On 11/15/2024 at approximately 11:30 AM Resident #55 returned to the facility. The nurse immediately assessed Resident #55 including Head-to-Toe assessment, Range of Motion all extremities, pupils equal, round and reactive to light and accommodation, and completed a pain assessment. Resident #55 was alert and oriented x 4 per baseline. Resident #55 sustained a hematoma to the back of his head with a small abrasion noted to the area. First aid was provided by the nurse to the area on resident's head, and medications administered per schedule and pain medication administered. The resident reported to the nurse that when the van moved, he fell backwards and hit his head. The nurse called 911 and sent Resident #55 out via emergency medical services at approximately 12:01 PM. The Director of Nursing and the Nurse Practitioner were notified along with Resident #55's Responsible Party. On 11/15/2024 the facility Transportation Driver was suspended pending investigation, and the facility van was removed from service until the Regional Maintenance Director inspection was complete. On 11/15/2024 an Investigation immediately initiated by the Director of Nursing, which included an interview and the visualization of return demonstration by the facility Transportation Driver. The facility Transportation Driver stated that Resident #55 was strapped into the van with all 4 wheelchair restraints and the seat belt. The wheelchair locks were also locked on both wheels. The facility Transportation Driver stated he pulled out of the parking lot, turning right, when he heard Resident #55 say whoa, he looked in the mirror and saw Resident #55 fall backward to the side. The conclusion is that a strap was not fully engaged in the track which allowed the wheelchair to come loose and fall backwards, whereby the resident hit his head. On 11/15/2024, at approximately 5:49 PM, Resident #55 returned from the Emergency Department status post Computed Tomography Scan which was negative. No orders were received from the emergency room . Upon return to the facility, neurological checks were initiated. Head to toe skin assessment and pain assessment completed. Resident #55 complained of headache, and Hydrocodone/Acetaminophen 5/325mg was administered by the nurse as ordered. Resident #55 was alert and oriented per baseline. Upon Resident #55's return to the facility the Nurse Practitioner was notified, and an order was given to apply ice to the back of Resident #55's head and an additional order to cleanse the area and apply a dry dressing to his head daily and as needed. On 11/15/2024 the Director of Nursing scheduled all resident transport with contracted transportation company until further notice. On 11/15/2024 Head-to-toe skin assessments were completed for all residents on the transportation schedule for the facility van from 11/13/2024-11/15/2024 as a precaution since van driver had only started driving the van on 11/13/2024. No concerns were identified. Alert and oriented residents that had been scheduled for transportation on the facility van from 11/13/2024-11/15/2024 were asked if they felt safe and secure on the van during transport. No concerns were identified. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/15/2024, at approximately 12:20 PM immediate education was provided via phone by the Regional Director of Clinical Services to the Administrator and Director of Nursing. This education included Vehicle Driver Safety Program, proper use of wheelchair securement devices per manufacturer's instructions, vehicle lift competency evaluation, placing the van out of service immediately, and not allowing the facility transportation driver to drive until investigation completed. On 11/15/2024, at approximately 3:00 PM, Immediate education provided by the Director of Nursing to the facility Transportation Driver. This written and verbal education included Vehicle Driver Safety Program, proper use of wheelchair securement devices as per manufacturer's instructions, vehicle lift competency evaluation, placing the van out of service immediately, not allowing the facility transportation driver to drive until investigation completed. On 11/15/2024, the Contracted Transportation company provided the facility with their policy and procedures for securing and strapping a wheelchair and competencies for the 2 current drivers. The education and competencies are completed upon hire and annually. On 11/18/2024 the facility Transportation Driver, Maintenance Director and Maintenance Assistant were re-educated by the Regional Maintenance Director on the Facility Vehicle Driver Safety Program, including proper use of wheelchair securement devices ensuring proper tension of devices per manufacturer's instructions, with return demonstration, and competency check off completion, and validated facility Transportation Driver was able to safely operate facility van. This education will be added to the facility orientation program for new Transportation Drivers, Maintenance Director or Maintenance Assistant. This education and competencies will be completed annually for the current Transportation Driver, Maintenance Director and Maintenance Assistant. On 11/18/2024 the Regional Maintenance Director inspected the facility van. The Regional Maintenance Director placed the facility van back in service. The facility Transportation Driver resumed transportation for the facility on 11/19/2024. Alleged Date of Immediate Jeopardy Removal: 11/19/2024 The facility's credible allegation of immediate jeopardy removal was validated on 11/22/24. Observations were conducted of transport drivers securing a wheelchair for transport according to the manufacturer instructions which included securing the tie-down anchors into the floor anchorages and locking them into place. A review of the head-to-toe skin assessments for residents that were transported on the facility van 11/13/24 through 11/15/24 had been completed and no concerns were identified. Interviews conducted with the facility transporters revealed education was provided by the Regional Director of Maintenance which included vehicle driver safety and how to properly secure a resident in the facility van using the 4-point wheelchair securement system per the manufacturer's instructions. The facility transporters also stated they had to verbalize their understanding of the education and complete a return demonstration of how to properly secure a wheelchair in the facility van. An interview conducted with the Regional Director of Maintenance indicated he completed a safety inspection of the wheelchair securement system in the facility van and no concerns were identified. The Regional Director of Maintenance stated he provided education to the facility transporters on how to use the 4-point securement system per the manufacturer's instructions and observations of return demonstrations by the drivers indicated they were able to properly secure a resident in the van. The facility's immediate jeopardy removal date of 11/19/24 was validated on 11/22/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47695 Based on record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 13 of 155 days reviewed for sufficient staffing. This deficient practice had the potential to affect all facility residents. Findings included: Review of the daily assignment schedules from June 22, 2024, to November 22, 2024, revealed the facility failed to provide 8 hours of Registered Nurse (RN) coverage on the following dates: 7/5/2024, 7/6/2024, 7/7/2024, 7/20/2024, 8/17/2024, 8/18/2024, 8/24/2024, 9/1/2024, 9/2/2024, 9/7/2024, 9/8/2024, 9/14/2024, and 9/15/2024. An interview was completed with the facility Scheduler on 11/21/2024 at 1:26 PM. During the interview the Scheduler reported there were no RN hours listed on the staffing sheets due to not having any RNs on the schedule. The Scheduler explained that there had been a large amount of staff turnover, including RNs, since the facility changed ownership in June 2024. She further explained the facility had been using staffing agencies but could not get any RN coverage when it was needed, however the facility was in the process of hiring RN's. During the interview the above schedules were reviewed with the facility Scheduler to verify there had been no RNs scheduled to work on those days. On 11/22/2024 at 10:03 AM an interview was completed with the Director of Nursing (DON) who had been at the facility since August 2024. During the interview the DON reported she was aware there had been issues related to RN staffing, including the lack of RNs in supervisory roles. She explained the facility was in the process of hiring RNs, including an Assistant Director of Nursing (ADON) and Unit Manager roles. During an interview with the prior Administrator on 11/22/2024 at 11:03 AM he revealed he was aware RN coverage had been an issue at the building since June 2024 after it changed ownership. The Administrator reported many nurses, including RNs, had to be let go and the facility was almost all agency staff except for a few Medication Aides. The Administrator explained he was aware the Scheduler had difficulty filling the RN spots that were open, and the facility was in the process of hiring additional RNs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47695 Based on record review, and staff and Psychiatric Services Nurse Practitioner (NP) interviews, the facility failed to conduct an Abnormal Involuntary Movement Scale (AIMS) assessment used to monitor abnormal bodily movements related to the use of psychotropic medications for 1of 5 residents (Resident #69) reviewed for unnecessary medications. The findings included: Resident #69 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, major depressive disorder, and personal history of other mental and behavioral disorders. Review of physician orders for Resident #69 revealed the following orders: Quetiapine 300 milligrams (MG) (an antipsychotic medication), to be given at bedtime dated 4/12/2024. A review of Resident #69's care plan last reviewed on 8/13/2024 revealed a goal that the diagnosis will be managed with medication therapy evidenced by no changes in mood or behavior within the next review. The interventions in place included note signs and symptoms of changes in mood and behavior, note resident concerns of depression, medical regimen as ordered, and notify physician of changes, and treat as ordered. Review of quarterly Minimum Date Set (MDS) assessment date 10/8/2024 revealed Resident #69 was receiving antipsychotic. There were no mood indicators or behaviors marked on the assessment. A review of Resident #69's Medication Administration Record (MAR) for the months of May 2024 and November 2024 revealed the resident was receiving the antipsychotic medication, Quetiapine 300 mg at bedtime for depression. Review of the most recent Pharmacy note for Resident #69 dated 11/6/2024 revealed the last AIMS assessment was completed in May of 2024. A review of Resident #69's physician orders dated 11/13/2024 showed orders in place to monitor behaviors and side effects every shift related to the use of antipsychotic medications. Further review of Resident #69's medical record revealed that there were no AIMS assessments completed after May 2024. An observation and interview were conducted on 11/18/2024 at 10:59 AM of Resident #69. She was observed lying in bed with no signs of distress. Resident #69 reported she had been receiving her medications daily. There were no signs of abnormal bodily movement noted, however Resident #69 said she did require assistance with her activities of daily living (ADL). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 11:40 AM with the Regional MDS Coordinator who had only been with the facility for a couple of months, it was revealed the AIMS assessment was referred to as an UDA (User-Defined Assessment) in the computer system. She further explained, all UDAs like the AIMS assessment were to be completed by nursing quarterly so the MDS nurses could complete their assessments using the information. The Regional MDS Coordinator also said the Director of Nursing (DON) should be notified of any missing UDAs. The Regional MDS Coordinator could not say why the AIMS assessments for Resident #69 had not been completed. An interview was completed on 11/21/2024 at 2:25 PM with Unit Manager (UM) #1. During the interview UM 1 reported the AIMS assessment should be completed at least quarterly, and they were completed in the computer system. There were no paper copies of the AIMS assessment. UM #1 further explained the AIMS assessments were usually scheduled in the computer system by a MDS nurse or the former Assistant Director of Nursing (ADON). UM #1 said she was not sure why the assessments had not been scheduled. An interview was conducted on 11/22/2024 at 10:03 AM with the DON. During the interview the DON reported there had been confusion related to who was responsible for triggering the UDAs, including the AIMS assessment, and they had to be rescheduled several times and somehow some of them were missing. The DON explained the scheduled UDAs disappeared due to a glitch in the computer system. The DON said the AIMS assessment should have been completed on Resident #69. She further explained the AIMS assessment needed to be completed quarterly and with any medication changes, especially on residents that receive antipsychotic medications. On 11/22/2024 at 11:19 AM a telephone interview was conducted with the Psychiatric NP. During the interview the NP said it would be very important to monitor any abnormal bodily movements, especially if the resident was receiving antipsychotic medications. The NP explained the AIMS test should have been completed quarterly on Resident #69 due to her use of antipsychotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on observations, record review, and staff, resident, Nurse Practitioner and Pharmacist interviews, the facility failed to ensure a resident was free of significant medication errors when they failed to administer a monthly dose of Aripiprazole (antipsychotic medication) as prescribed by the physician from July 2024 through November 2024 for 1 of 3 residents reviewed for medication errors (Resident #2). Resident #2 stated she felt like something was wrong a couple of weeks ago because if anyone tried to talk to her, she would break down and cry uncontrollably, even waking up at night with tears running down her face. The findings included: Resident #2 was admitted to the facility on [DATE] with diagnoses that included manic depression (bipolar disorder). A Physician order dated 10/18/23 revealed an order for Lithium Carbonate tablet extended release 450 milligram (mg) give one tablet orally at bedtime related to bipolar disorder, current episode manic severe with psychotic features. Resident #2's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact with no behaviors. Resident #2 did not receive any antipsychotic medication during the assessment period. A Physician order dated 04/16/24 revealed an order for Aripiprazole Intramuscular extended-release suspension prefilled syringe 300 milligram (mg). Inject 300 mg intramuscularly one time a day every 30 days related to bipolar disorder, with episodes of manic severe behaviors and psychotic features. Review of Resident #2's Medication Administration Record (MAR) for July 2024 revealed the medication was scheduled to be administered on 07/15/24 however the block on the MAR was left blank. Review of Resident #2's Medication Administration Record (MAR) for August 2024 revealed the medication was scheduled to be administered on 08/14/24 and was initialed as administered by Nurse #5. On 11/25/24 at 2:43 PM an interview was attempted with Nurse #5 who no longer was an employee of the facility. A return phone call was not received. Review of Resident #2's Medication Administration Record (MAR) for September 2024 revealed the medication was scheduled to be administered on 09/13/24 and was initialed as administered by Nurse #7. On 11/25/24 at 11:10 AM an interview was attempted with Nurse #7 who no longer was an employee of the facility. A return phone call was not received. Review of Resident #2's Medication Administration Record (MAR) for October 2024 revealed the medication was scheduled to be administered on 10/13/24 and was initialed as not administered by coding a 9 on the MAR by Nurse #6. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	On 11/21/24 at 11:54 AM an interview was conducted with Nurse #6. She stated she documented Resident #2's medication as not administered because it was not in the medication cart or in the medication storage room on the date it was scheduled 10/13/24. The interview revealed the nurses were responsible for a lot of tasks during the day and she was unsure if she had contacted the pharmacy regarding reordering the resident's medication. Nurse #6 stated the typical process for the medication was to reorder it monthly. A reorder involved filling out a reorder form that would be faxed to the pharmacy. She stated she would have removed the sticker from the medication (if it had been available) and placed it onto the form. If the medication was not in the facility the orders could be written on the form and sent to the pharmacy requesting, it to be refilled. Nurse #6 stated she would have passed along the information of the resident's medication not being on the cart to the oncoming nurse for second shift (Nurse #8) so she would know to administer the medication once it arrived from pharmacy. Nurse #6 stated she had not observed Resident #2 crying or having any type of behaviors from not receiving her medication. On 11/22/24 at 11:37 AM an interview was conducted with Nurse #8. Nurse #8 stated she had received report from Nurse #6 on 10/13/24. The interview revealed she did not recall Nurse #6 informing her that Resident #2's medication was not in the facility or that she had not received her intramuscular injection. Nurse #6 stated the medication would not have shown on the MAR for her to administer because at 3:00 PM an entire new set of medication shows up in the computer and the first shift medication would no longer be shown on her screen. She stated she was unaware Resident #2 had not received her medication but had not witnessed the resident having any side effects from not receiving it. The interview revealed the resident seemed to be attending activities in the facility and Nurse #8 had not witnessed the resident crying. Review of Resident #2's Medication Administration Record (MAR) for November 2024 revealed the medication was scheduled to be administered on 11/12/24 and was initialed as administered by Nurse #1. On 11/21/24 at 11:53 AM an interview was conducted with Nurse #1. Nurse #1 stated she had initialed the MAR by mistake on the date of 11/12/24 for Resident #2's medication because she knew the medication was not available and in the facility on that date. She stated she must have just clicked the box as administered on accident and she would correct the MAR. The interview revealed the process for reordering a medication would include faxing a reorder form to pharmacy or calling them. She stated because it was a monthly injection it would have to be reordered on a monthly basis. Nurse #1 indicated the pharmacy was good about sending the medication with the next delivery upon request. The interview revealed she did not reorder the medication on 11/12/24 when she noticed it was unavailable because she stated the nurses had a lot of tasks in the facility and had just forgotten to call the pharmacy. On 11/18/24 at 11:58 AM an interview was conducted with Resident #2. Resident #2 stated she had been having issues not receiving her medication Aripiprazole and she could not recall the last time she had received the medication. She stated she felt like something was wrong a couple of weeks ago because if anyone tried to talk to her, she would break down and cry uncontrollably. Resident #2 indicated she had voiced her concerns to staff in the facility (names she could not recall) but nobody had told her anything about her medication. Resident #2 stated she was feeling a little better now, but she was taking the medication because she was bipolar. She stated she was waking up in the middle of the night with tears running down her face and knew something was wrong. The interview revealed staff would say they were going to check on the medication but would never return to the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	An interview conducted on 11/25/24 at 10:23 AM with the Activities Director revealed Resident #2 often attended activities in the facility and always attended bingo. She stated Resident #2 had been feeling down and depressed within the last several weeks. The Activities Director stated several weeks ago Resident #2 did not attend bingo, which she never misses. She went to the resident's room to see what was wrong and the resident was tearful saying she was feeling depressed, and that something was wrong. The Activities Director stated she notified Social Worker #1 of the incident. On 11/24/24 at 10:36 AM an interview was conducted with Social Worker (SW) #1. During the interview she stated she was notified several weeks ago by the Activities Director that Resident #2 seemed depressed. She stated she went to the resident's room, and she was tearful, stating she felt down and depressed and had been feeling that way for some time. SW #1 stated she reported the information to nursing staff (names she could not recall) but knew SW #2 had seen the resident following her telling the nursing staff the resident was tearful. On 11/21/24 at 3:15 PM an interview was conducted with Social Worker (SW)# 2. SW #2 stated she was part of the psychiatric therapy program and completed talk therapy with the residents in the facility. The interview revealed she had seen Resident #2 on 11/12/24. Resident #2 had reported to her she had bipolar disorder and had recently been waking up crying. Resident #2 reported to SW#2 that she felt her medication was not working and she was experiencing increased anxiety. SW #2 stated she notified Nurse Practitioner #4 after her visit that Resident #2 would be a good person for her to see during her next visit to the facility. On 11/22/24 at 11:10 AM an interview was conducted with Nurse Practitioner (NP) #4. NP #4 stated she was the facility Psychiatric NP and had taken over the role in October 2024. The interview revealed she had not yet seen Resident # 2, however was notified by SW #2 that the resident needed to be evaluated because she had a question about her medication. NP #4 revealed she had seen Resident #2 the week after being told by SW #2. However, the resident stated to her she no longer had a question about her medication. NP #4 stated if Resident #2 was not getting the medication Aripiprazole, a monthly injection then that would explain why she was having episodes of increased crying. NP #4 indicated symptoms of abruptly stopping intramuscular Aripiprazole include crying, mood swings which would be a problem for the resident. The interview revealed that stopping any antipsychotic medication abruptly would be a significant medication error because the medication must be tapered down under medical supervision. Reducing the dosage by 10-50 % over a duration of 1 to 2 weeks or longer. Otherwise, the resident would have symptoms of withdrawal which could include mood swings, crying, insomnia and trouble falling asleep. On 11/22/24 at 11:44 AM an interview was conducted with the Pharmacist. During the interview he stated Resident #2's Aripiprazole Intramuscular for extended-release suspension prefilled syringe 300 milligram (mg) had not been refilled from the pharmacy since 07/15/24. The Pharmacist stated the facility would not have obtained the medication from any other pharmacy. He stated unless the nursing staff placed a reorder form requesting the medication it would not have triggered for them to refill or brought to their attention. The Pharmacist indicated a result of the resident not receiving the medication could have been a psychotic event. He stated the nurses, and physician should be monitoring closely for any symptoms of a psychotic event such as an increase of behaviors. The interview revealed Resident #2 was also receiving an antimanic medication which would have controlled some of her bipolar depression symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	On 11/22/24 at 10:58 AM an interview was conducted with the Director of Nursing (DON). The DON stated it was the nurse's responsibility to reorder the medication, the sticker had to be pulled, placed on a reorder sheet and faxed to the pharmacy. She stated she had not heard of any issues with Resident #2's medication. After learning of the missed medication, the DON stated the nurses should have alerted her that the medication was not in the building and called the pharmacy. The DON stated the medication could have been delivered from the pharmacy within 2 to 3 hours if it was placed as a STAT (immediate) order refill. The interview revealed the nurses had not placed an order with pharmacy to have the medication refilled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47695 Based on record review, and staff, Nurse Practitioner, and Consultant Pharmacist interviews the facility failed to maintain documentation of the pharmacist's Monthly Medication Reviews (MMRs) in the medical record and available for review for 2 of 5 residents reviewed for unnecessary medications (Resident #9 and Resident #69). The findings included: a. Resident #9 was admitted to the facility on [DATE] with diagnoses that included Post Traumatic Stress Disorder (PTSD), unspecified dementia, anxiety disorder, pseudobulbar effect (sudden uncontrolled and inappropriate crying and/or laughing), and depression. Review of physician orders revealed the following: Lorazepam 0.5 milligrams (MG), (a medication to treat anxiety), to be given three times a day for agitation ordered on 3/27/2024 and last revised on 10/20/2024. Depakote Sprinkles delayed release sprinkles 125 mg, (a medication used as a mood stabilizer), give 2 capsules by mouth three times a day for dementia dated 8/15/2024. Sertraline oral table 50 mg, give 1.5 tablets (a medication used to treat anxiety and depression), by mouth one time a day related to anxiety dated 8/15/2024. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9 had severe cognitive impairment with no behaviors. The MDS was also marked for antianxiety and antidepressant medication use. A review of Resident #9's electronic Medication Administration Record (MAR) for the months of August 2024, September 2024, October 2024, and November 2024 revealed Depakote, Lorazepam, and Sertraline had all been administered daily. There were orders on the MAR to monitor for behaviors and side effects related to the use of the medications. Review of a Pharmacy Medication Regimen Review (MRR) report dated 9/25/2024 showed Resident #9 was receiving Lorazepam 0.5 mg, three times a day for agitation, Sertraline 75 mg, daily for anxiety, and Depakote 125 mg, 2 capsules three times a day for dementia with behavioral disturbance. The report also revealed a dose reduction was contraindicated because the benefits outweighed risks for the resident and a reduction was likely to impair Resident #9's function and/or cause psychiatric instability. The bottom of the form showed the provider reviewed and signed the recommendation. There were no Pharmacy MMR reports for the months of July, August, or October. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	b.Resident #69 was admitted to the facility on [DATE] with diagnoses that included anxiety and major depressive disorder. Review of physician orders revealed the following: Buspirone 5 mg (antianxiety medication), give 3 times a day for anxiety dated 11/4/2024. Quetiapine 300 mg (antipsychotic medication), give 1 tablet at bedtime dated 4/12/2024. Duloxetine capsule delayed release 60 mg (antidepressant medication), give 1 daily for depression dated 8/14/2024. Review of Resident #69's care plan dated 5/2/24 and last revised on 10/7/2024 revealed a care plan in place to monitor for side effects related to the use of psychotropic medications. A review of the quarterly MDS assessment dated [DATE] revealed Resident #69 was cognitively intact and was marked for antipsychotic and antidepressant medication. The MDS was also marked for no gradual dose reduction (GDR)attempted or documented during the review period. Review of Resident #69's MAR for the month of October showed the resident did receive antipsychotic and antidepressant medication daily. A review of Pharmacy Medication Regimen Reviews were not available for the months of July, August, September, October, or November. There were Pharmacy notes dated 8/3/2024, 9/11/2024, 9/24/2024, and 11/6/2024 with no recommendations or GDR attempts due to the use of antipsychotic medication. A telephone interview was conducted on 11:19 AM at 3:36 PM with the Nurse Practitioner (NP). During the interview the NP stated anytime there was a pharmacy recommendation or MRR it was printed off by someone at the facility and placed in her book for review. The NP explained she did not always notice the date when the forms were completed by the pharmacy, but if a MRR had been signed by her then it should be scanned into the system. A telephone interview was completed on 11/25/2024 at 1:12 PM with the Consultant Pharmacist. During the interview the Pharmacist reported the Medication Regimen Reviews were sent to the Director of Nursing (DON), Administrator, and the Corporate Nurse monthly. The Pharmacist said the MMRs needed to be completed monthly. The Pharmacist also explained that the former DON was receiving the reports and passing them along to the physicians, but due to all of the changes including the changes in ownership and in the computer system the facility was using she was not sure why the MMR were not in the system, but they should have been. She did indicate there were notes in the system that showed the medications had been reviewed. The Pharmacist went on to say the physician did not need to sign off on any pharmacy notes unless a recommendation was made. An interview was completed on 11/27/2024 at 9:30 AM with the DON where she indicated if there were pharmacy recommendations then the facility would get them monthly. The DON explained once she received the MRR she would give them to the nurse manager and then they would go to the physician. If there were no recommendations, then there would be no form so therefore there may not be a form for each person each month. A MRR was only written if a medication was changed.