DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2015 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G	_	(X3) DATE SURVEY COMPLETED C
		345489	B. WING _			08/14/2015
NAME OF PROVIDER OR SUPPLIER SATURN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, 1930 WEST SUGAR CR CHARLOTTE, NC 28	EEK ROAD	00/14/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	
F 332 SS=E	RATES OF 5% OR I		F3	32		9/11/15
	by: Based on observation staff interviews and infailed to ensure a more than 5% as evidence opportunities for error observed during the received eye medication error rate #7). The findings include Review of the facility reminders" revealed between administrate eye medications. 1. Resident #3 was 11/11/02 with diagnor glaucoma. Review of Resident physician's orders really and Trusopt 2% one and Trusopt 2% one times daily. (Both miglaucoma; a wait of administration of the	y's undated "medication pass staff were to wait 5 minutes ion of eye drops of 2 different admitted to the facility on		per facility policy Resident #3. Re for 72 hrs for addefects were not Nurse #1 and Nadditional 1:1 edeye drops and wexam and Medic being allowed to passes. All Residents has affected by define medication administration of given a competed during a medical Nursing and State coordinator. No work unless insecompleted. Competency Testing and State coil and state of the	durse #2 Received ducation on administering ducation on administering ducation pass review before complete additional matter process. All serviced on proper feye drops and were ency test and observed tion pass by Director of the process of the pr	d rise ng cy ore hed
	out of the first medic	· · · · · · · · · · · · · · · · · · ·			reviews with eye drops	s
ADODATODY		/SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITI	I E	(X6) DATE

Electronically Signed 09/03/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER SATURN NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 (X5)			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER SATURN NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (X4) ID PREFIX TAG CONTINUED FOR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 332 Continued From page 1 Observation on 08/13/15 at 8:20 AM revealed Nurse #1 administered one drop of Trusopt 2% into each of Resident #3's eyes. Nurse #1 announced she needed to wait 2 minutes before she administered the second eye medication. At 8:22 AM, Nurse #1 administered one drop of Alphagan 0.2% into both of Resident #3's eyes. Interview with Nurse #1 on 08/13/15 at 2:11 PM revealed she usually waited 3 to 5 minutes between eye drops. Interview with the Director of Nursing on 08/14/15 at 8:59 AM revealed she expected staff to wait 3 to 5 minutes before administration of different			345489					
SATURN NURSING AND REHABILITATION CENTER 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	NAME OF D	PU/IDED UD SLIDDI IED	0.10.100		STREET ADDRESS CITY STATE 7ID C		3/14/2015	
CHARLOTTE, NC 28262 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 332 Continued From page 1 Observation on 08/13/15 at 8:20 AM revealed Nurse #1 administered one drop of Trusopt 2% into each of Resident #3's eyes. Interview with Nurse #1 administered one drop of Alphagan 0.2% into both of Resident #3's eyes. Interview with Nurse #1 on 08/13/15 at 2:11 PM revealed she usually waited 3 to 5 minutes before at 8:59 AM revealed she expected staff to wait 3 to 5 minutes before administration of different CHARLOTTE, NC 28262 CHARLOTTE, NC 28262 CHARLOTTE, NC 28262 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Will be conducted on all shifts by nurse managers weekly x 1 month then monthly x 3 miths. The DON and Administrator will review results of reviews and report to the QAPI committee monthly x 3 months. Based on the findings the committee will alter this plan as indicated.	NAME OF F	ROVIDER OR SUFFLIER			, , ,	ODE		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 332 Continued From page 1 F 332 Will be conducted on all shifts by nurse managers weekly x 1 month then monthly x 3 mths. The DON and Administrator will review results of reviews and report to the QAPI committee monthly x 3 months. Based on the findings the committee will alter this plan as indicated.	SATURN I	NURSING AND REHABI	LITATION CENTER					
F 332 Continued From page 1 Observation on 08/13/15 at 8:20 AM revealed Nurse #1 administered one drop of She administered the second eye medication. At 8:22 AM, Nurse #1 administered one drop of Alphagan 0.2% into both of Resident #3's eyes. Interview with Nurse #1 on 08/13/15 at 2:11 PM revealed she usually waited 3 to 5 minutes between eye drops. Interview with the Director of Nursing on 08/14/15 at 8:59 AM revealed she expected staff to wait 3 to 5 minutes before administration of different					CHARLOTTE, NC 28262			
Observation on 08/13/15 at 8:20 AM revealed Nurse #1 administered one drop of Trusopt 2% into each of Resident #3's eyes. Nurse #1 announced she needed to wait 2 minutes before she administered the second eye medication. At 8:22 AM, Nurse #1 administered one drop of Alphagan 0.2% into both of Resident #3's eyes. Interview with Nurse #1 on 08/13/15 at 2:11 PM revealed she usually waited 3 to 5 minutes between eye drops. Interview with the Director of Nursing on 08/14/15 at 8:59 AM revealed she expected staff to wait 3 to 5 minutes before administration of different	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	ION SHOULD BE THE APPROPRIATE	COMPLETION	
2. Resident #7 was admitted to the facility on 07/18/15 and physician's orders dated 07/30/15 included administration of Prednisolone acetate 1% (to treat inflammation) one drop to the left eye four times daily and ciprofloxacin hydrochloride 0.3% (antibiotic) one drop to the left eye four times daily. (A wait of 3 to 5 minutes before administration of the second eye medication is required to allow absorption and prevent washing out of the first medication.) Observation on 08/13/15 at 9:47 AM revealed Nurse #2 administered one drop of Prednisolone acetate 1% into Resident #7's left eye. Nurse #2 reported he would wait 2 minutes before administration of the second eye medication. At 9:49 AM, Nurse #2 administered one drop of ciprofloxacin hydrochloride 0.3% into Resident #7's left eye. Interview with Nurse #2 on 08/13/15 at 10:20 AM	F 332	Observation on 08/1 Nurse #1 administer into each of Residen announced she need she administered the 8:22 AM, Nurse #1 a Alphagan 0.2% into Interview with Nurse revealed she usually between eye drops. Interview with the Di at 8:59 AM revealed to 5 minutes before a types of eye drop me 2. Resident #7 was 07/18/15 and physic included administrati 1% (to treat inflamm four times daily and 0.3% (antibiotic) one times daily. (A wait administration of the required to allow absout of the first medic Observation on 08/1 Nurse #2 administer acetate 1% into Res reported he would wadministration of the 9:49 AM, Nurse #2 a ciprofloxacin hydroci #7's left eye.	3/15 at 8:20 AM revealed ed one drop of Trusopt 2% at #3's eyes. Nurse #1 ded to wait 2 minutes before expected experienced one drop of both of Resident #3's eyes. #1 on 08/13/15 at 2:11 PM waited 3 to 5 minutes rector of Nursing on 08/14/15 she expected staff to wait 3 administration of different edication. admitted to the facility on ian's orders dated 07/30/15 ion of Prednisolone acetate ation) one drop to the left eye ciprofloxacin hydrochloride expected expected expected expected in the left eye four of 3 to 5 minutes before second eye medication is sorption and prevent washing ation.) 3/15 at 9:47 AM revealed ed one drop of Prednisolone ident #7's left eye. Nurse #2 ait 2 minutes before second eye medication. At administered one drop of inloride 0.3% into Resident	F3	will be conducted on all shi managers weekly x 1 mont x 3 mths. The DON and Administratoresults of reviews and report committee monthly x 3 months findings the committee	fts by nurse th then monthly or will review ort to the QAPI onths. Based on		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C 08/14/2015	
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262)E	00.1.1120.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		N SHOULD BE E APPROPRIA		
F 441 SS=D	revealed he thought to should be 2 minutes. Interview with the Dirat 8:59 AM revealed to 5 minutes before a types of eye drop me 483.65 INFECTION (SPREAD, LINENS) The facility must estal Infection Control Prografe, sanitary and control help prevent the decoration of disease and infection (a) Infection Control Fine facility must estal Program under which (1) Investigates, control in the facility; (2) Decides what program under which (3) Maintains a record actions related to infection determines that a resprevent the spread of isolate the resident. (2) The facility must program unicable disease and infection determines that a respreyent the spread of isolate the resident.	ector of Nursing on 08/14/15 she expected staff to wait 3 dministration of different dication. CONTROL, PREVENT blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on. Program blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections. d of Infection in Control Program ident needs isolation to infection, the facility must prohibit employees with a se or infected skin lesions ith residents or their food, if		332		9/11/15	
	` '	equire staff to wash their ct resident contact for which cated by accepted					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345489	B. WING		C 08/14/2015
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 441			F 44	1	
	by: Based on observation record review, the far and change gloves and administration, after furnishings and during administration prior sampled residents work (Residents #3 and #4) The findings included Review of the facility medication administ hand hygiene shall of application and remiglove use. 1. Observation on Converse #1 entered Review ashed her hands a closed Resident #3 curtain and raised the control with gloved hadministered Resided Nurse #1 administered drop medication. No change gloves after			Residents #3 and #7 were monitored 72 hrs for adverse effects. None were noted. Nurse #1 and Nurse #2 Received additional 1:1 education on administe eye drops and hand hygiene before a after application and removal of steril and non-sterile glove use. Nurse #1 and Nurse #2 were given a competency exam and Medication pareview with demonstration of hand hygiene before and after application a removal of sterile and non-sterile glovuse. Successful demonstration was obserby both nurses prior to being allowed complete additional med passes. All Residents have the potential to be affected by deficient practice during medication administration pass. All Nurses were in-serviced on proper hand hygiene before and after application and removal of sterile and non-sterile glove use. All Nurses were observed during a medication pass by Director of Nursir and Staff Development coordinator and staff Development coordinator and additionator and staff Development coordinator and staff Devel	rring and e ass and are rved to

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		345489	B. WING _		C 08/14/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	•
				1930 WEST SUGAR CREEK ROAD	
SATURN I	NURSING AND REHA	ABILITATION CENTER		CHARLOTTE, NC 28262	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION OF THE APPROPRIATE DATE
F 441	Continued From p	page 4	F 4	141	
	prior to administra medication. Nurs	ation of the second eye drop the #1 discarded the gloves, s and exited the room at 8:23		demonstrated proper techygiene before and after removal of sterile and no use.	application and
	revealed she forg change gloves aff medication and d Resident #3's doc control with glove administration. Interview with the 08/14/15 at 9:00 to wash hands, do drops. The DON and furnishings sigloved hands price. 2. Observation on Nurse #2 washed Nurse #2 administration at 9:47 AM. Nurse medication on Resident was affected to the second state of the second state	rse #1 on 08/13/15 at 2:11 PM of to wash her hands and ter administration of the first eye id not realize she touched or, privacy curtain and bed d hands prior to eye drop Director of Nursing (DON) on AM revealed she expected staff on gloves and administer eye reported resident equipment hould not be touched with or to the eye drop administration. In 08/13/15 at 9:45 AM revealed his hands and donned gloves. Stered eye drops to Resident #7 is #2 placed a topical patch is sident #7's back at 9:48 AM.		Competency Tests will be orientation for all new him hygiene and infection concompleted before New Norientation. Hand hygiene reviews wis be conducted on all shifts managers weekly x 1 mox 3 mths. The DON and Administraresults of reviews and recommittee monthly x 3 mthe findings the committee plan as indicated.	es and hand introl will be urses are out of ith eye drops will is by nurse onth then monthly utor will review port to the QAPI ionths. Based on
	application and di hand sanitizer. N eye drop medicat Nurse #2 discarde and exited the roo Interview with Nu revealed he forgo second glove app Interview with the 08/14/15 at 9:00 a	rse #2 on 08/13/15 at 10:20 AM t to wash his hands prior to the			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER SATURN NURSING AND REHABILITATION CENTER (X4) ID PRETIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) F 441 Continued From page 5 glove change. STRIET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 DI PRETIX TAG CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY F 441 Continued From page 5 glove change.	AND DIAN OF CODDECTION IDENTIFICATION NUMBER:		l l	PLE CONSTRUCTION IG	(X3) DATI COM	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER SATURN NURSING AND REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 5 STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441 Continued From page 5			345489	B. WING		l l	
SATURN NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 5 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 441				1	STREET ADDRESS, CITY, STATE, ZIP CODE	08	/14/2015
CHARLOTTE, NC 28262 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 5 CHARLOTTE, NC 28262 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE)							
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FA41 Continued From page 5 PREFIX CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	SATURN N	NURSING AND REHABIL	ITATION CENTER				
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SECTION SEC	HOULD BE	COMPLETION
	F 441		÷ 5	F 4	41		