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 _____	C 08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of the medication pass, staff interviews and record review, the facility failed to ensure a medication error rate of less than 5% as evidenced by 2 errors out of 26 opportunities for error for 2 of 2 residents observed during the medication pass who received eye medication which resulted in a medication error rate of 7.6% (Residents #3 and #7). The findings included: Review of the facility's undated "medication pass reminders" revealed staff were to wait 5 minutes between administration of eye drops of 2 different eye medications. 1. Resident #3 was admitted to the facility on 11/11/02 with diagnoses which included glaucoma. Review of Resident #3's August 2015 monthly physician's orders revealed medication included Alphagan 0.2% one drop into each eye twice daily and Trusopt 2% one drop into both eyes three times daily. (Both medications are used to treat glaucoma; 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.)	F 332	Medication Error reports were completed per facility policy for Residents #7 and Resident #3. Residents were monitored for 72 hrs for adverse effects. No adverse effects were noted. Nurse #1 and Nurse #2 Received additional 1:1 education on administering eye drops and were given a competency exam and Medication pass review before being allowed to 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 administration of eye drops and were given a competency test and observed during a medication pass by Director of Nursing and Staff Development coordinator. No nurse will be allowed to work unless inservice and exams are completed. Competency Tests will be given during orientation for all new hires and medication pass check off sheet will be completed before New Nurses are out of orientation. Medication pass reviews with eye drops	9/11/15

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

Electronically Signed | 09/03/2015

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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 types of eye drop medication. 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	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.	

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F 332	Continued From page 2 revealed he thought the time between eye drops should be 2 minutes. 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 types of eye drop medication.	F 332		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		9/11/15

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F 441	Continued From page 3 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to wash hands and change gloves prior to eye drop medication administration, after touching a door and resident furnishings and during eye drop medication administration prior to changing gloves, for 2 of 2 sampled residents who received eye medication (Residents #3 and #7). The findings included: Review of the facility's undated "glove use during medication administration" procedure revealed hand hygiene shall occur before and after application and removal of sterile and non-sterile glove use. 1. Observation on 08/13/15 at 8:15 AM revealed Nurse #1 entered Resident #3's room. Nurse #1 washed her hands and donned gloves. Nurse #1 closed Resident #3's door, pulled the privacy curtain and raised the head of the bed with a bed control with gloved hands. At 8:20 AM, Nurse #1 administered Resident #3 eye drops. At 8:22 AM, Nurse #1 administered Resident #3 a second eye drop medication. Nurse #1 did not wash hands or change gloves after she touched the resident's door, privacy curtain and head of bed control and	F 441	Residents #3 and #7 were monitored for 72 hrs for adverse effects. None were noted. Nurse #1 and Nurse #2 Received additional 1:1 education on administering eye drops and hand hygiene before and after application and removal of sterile and non-sterile glove use. Nurse #1 and Nurse #2 were given a competency exam and Medication pass review with demonstration of hand hygiene before and after application and removal of sterile and non-sterile glove use. Successful demonstration was observed by both nurses prior to being allowed to 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 Nursing and Staff Development coordinator and all	

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F 441	Continued From page 4 prior to administration of the second eye drop medication. Nurse #1 discarded the gloves, washed her hands and exited the room at 8:23 AM. Interview with Nurse #1 on 08/13/15 at 2:11 PM revealed she forgot to wash her hands and change gloves after administration of the first eye medication and did not realize she touched Resident #3's door, privacy curtain and bed control with gloved hands prior to eye drop administration. Interview with the Director of Nursing (DON) on 08/14/15 at 9:00 AM revealed she expected staff to wash hands, don gloves and administer eye drops. The DON reported resident equipment and furnishings should not be touched with gloved hands prior to the eye drop administration. 2. Observation on 08/13/15 at 9:45 AM revealed Nurse #2 washed his hands and donned gloves. Nurse #2 administered eye drops to Resident #7 at 9:47 AM. Nurse #2 placed a topical patch medication on Resident #7's back at 9:48 AM. Nurse #2 changed gloves after the topical application and did not wash his hands or use hand sanitizer. Nurse #2 administered a second eye drop medication to Resident #7 at 9:49 AM. Nurse #2 discarded the gloves, washed his hands and exited the room. Interview with Nurse #2 on 08/13/15 at 10:20 AM revealed he forgot to wash his hands prior to the second glove application. Interview with the Director of Nursing (DON) on 08/14/15 at 9:00 AM revealed she expected staff to wash hands or use hand sanitizer with each	F 441	demonstrated proper technique of hand hygiene before and after application and removal of sterile and non-sterile glove use. Competency Tests will be given during orientation for all new hires and hand hygiene and infection control will be completed before New Nurses are out of orientation. Hand hygiene reviews with eye drops 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.	

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F 441	Continued From page 5 glove change.	F 441		