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 01/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to follow their policy for reporting 1 of 3 allegations of abuse (Resident #1). The findings included: A policy titled "Abuse Prevention, Intervention, Reporting and Investigation" dated 11/2016 read in part, "It is the responsibility of employees to promptly report to facility management any incident or suspected incident of neglect or resident abuse from other residents, staff, family or visitors." Resident #1 was admitted to the facility on 02/21/17 with diagnoses that included hemiplegia and dementia. The most recent Minimum Data Set (MDS) dated 10/12/17 specified the resident had severely impaired cognition and required extensive assistance with activities of daily living	F 607	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to continue to improve the quality of life of each resident. F607 Root Cause Analysis Based on root cause analysis by facility administrative staff and facility Director of Nursing, NA #2 did not follow the facility policy and procedure for reporting abuse timely. NA #2 was in serviced 10/30/17 on facility policy/procedures for Abuse,	2/12/18

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

Electronically Signed | 02/15/2018

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 01/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 1 such as bed mobility and transfers. Review of the medical record revealed the resident had history of falls. There was no documentation of a fall on 12/20/17. On 12/26/17 at 4:32 PM the facility faxed a 24-hour initial report of resident abuse for an incident that occurred on 12/20/17 at 11:15 PM. The allegation was that nurse aide (NA) #1 hit Resident #1 in the back of the head two times while helping NA #2 assist Resident #1 off the floor. Review of the investigation completed by the facility on 12/29/17 identified NA #2 failed to report the allegation of abuse in a timely manner. NA #2 wrote a statement (not dated) that she did not want staff to make her job hard for her for reporting a matter of truth as the reason she waited to report the allegation. On 01/25/18 at 8:20 AM NA #2 was interviewed on the telephone and explained she had worked at the facility for a few months. She stated she had received a stack of papers for orientation but knew from previous work experience that she was expected to report an allegation of abuse "immediately" to a head nurse. NA #2 reported that the night of 12/20/17 she was in shock when she observed NA #1 slap the resident twice in the back of the head. She added that she knew NA #1 was friends with Nurse #1 and feared that if she reported the allegation to Nurse #1 staff would make her job difficult. She stated that she did not leave the unit to locate another nurse for fear she would get in trouble for leaving her	F 607	Resident Rights, NC Patients□ Bill of Rights and facility Policy & Procedure for Reporting Suspected Crimes. Immediate Action On 12/26/17 Administrator and Director of Nursing, DON, was notified by letter under their door of abuse allegation. NA #2 was suspended on 12/26/17 for failure to report abuse timely in accordance to facility policy. NA #1 was suspended 12/26/17 pending abuse investigation. DON filed the required 24 hour and 5 day report as required. NA #2 last day of work was 12/25/17 and was terminated 12/29/17 for failure to report suspected abuse incident timely. Identification of Others A 100% audit of all reported resident abuse for the last 60 days was conducted by 2/1/2018 to ensure they were reported timely. There were no concerns with the audit Systemic Changes Measures put into place to ensure the plan of correction is effective and remains in compliance are: Effective 2/10/2018 staff will not be allowed to work without receiving in service on facility policy/procedure Abuse Prevention, Intervention, Reporting and Investigating.	

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 01/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 2 assignment. In the same interview, the nurse aide went on to explain that she tried two consecutive days to meet with the Director of Nursing (DON) to report the allegation of abuse and ended up sitting in the front lobby and wrote her statement on 12/22/17, which she slid under the door of the DON and Administrator's offices the same day. The NA added that on 12/26/17 she received a call from the DON inquiring about the allegation of abuse. The NA stated that she met with the DON on 12/26/17 and was asked to rewrite her statement by removing the date of 12/22/17. The NA reported she was suspended for failing to report an allegation of abuse timely and then terminated. On 01/25/18 at 3:10 PM the Administrator was interviewed and reported he left for Christmas vacation on 12/22/17 at 5:00PM and returned to the facility on 12/26/17 and discovered a letter on the floor of his office. The stated the letter was an allegation of abuse made by NA #2. The Administrator stated he immediately called the DON who stated she had found the same letter in her office when she arrived to work on 12/26/17 and had already called NA #2 to come in for an interview. On 01/25/18 at 3:30 PM the DON was interviewed and stated that she was made aware of an allegation of abuse against NA #1 on 12/26/17 when she found a letter written by NA #2. The DON stated she had also been on Christmas vacation from 12/22/17 through	F 607	The in service will be provided for all active staff, to include full time, part time and as needed employees. The education will be completed by 2/9/2018. Any staff member not educated by 2/9/2018 will not be allowed to work until receiving education. The education will also be added to the new hires orientation process effective 2/1/2018. Starting 2/12/2018 a weekly employee audit form, Employee Abuse/Neglect Reporting, will be conducted weekly for 6 employees. The Employee Abuse/Neglect audit will be conducted by the nursing administrative staff, social service staff, and other facility department heads weekly for 8 weeks or until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. Monitoring Process Starting 2/12/2018 a weekly employee audit form, Employee Abuse/Neglect Reporting, will be conducted weekly for 6 employees. The Employee Abuse/Neglect audit will be conducted by the nursing administrative staff, social service staff and other facility department heads weekly for 8 weeks or until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. Administrator and or the DON will report monthly findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for 3 months or until corrective	

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 01/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 3 12/26/17. The DON explained that she proceeded with an investigation and suspended both NA #1 and NA #2. The DON added that she spoke with NA #2 and asked her why she waited to report an allegation and the NA offered no real answer but apologized. The DON offered no explanation why the NA stated she was asked to rewrite her statement.	F 607	action is achieved. The QAPI committee can modify this plan to ensure the facility remains in compliance.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to ensure a resident's condition was assessed by a nurse to determine if it was safe to transfer a resident off the floor after a fall from bed. Resident #1 was assisted off the floor without an assessment by two nurse aides after he fell from bed for 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 02/21/17 with diagnoses that included hemiplegia and dementia. The most recent quarterly	F 684	F 684 Based on Root Cause Analysis by facility administrative staff and facility Director of Nursing NA #2 had been trained properly on when, how, and who to notify when there is a resident incident/accident. Employee was non-compliant with facility policy and procedures. Immediate Action Corrective action was accomplished with NA #2 being suspended 12/26/2017, last day worked 12/25/2017, and then terminated 12/29/2017. On 12/25/2017 a scheduled skin assessment was done for resident #1 with no new findings. On	2/12/18

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 01/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4 Minimum Data Set (MDS) dated 10/12/17 specified the resident had severely impaired cognition and required extensive assistance with activities of daily living such as bed mobility and transfers and had one fall with no injury. A care plan developed for Resident #1's risk for falls specified he was to have items close by, bed in low position and room free from clutter. Review of the medical record revealed the resident had history of falls. There was no documentation of a fall on 12/20/17. The facility provided an abuse investigation dated 12/26/17 for Resident #1. Nurse aide (NA) #1 wrote a statement dated 12/26/17 that on 12/20/17 she helped NA #2 lift Resident #1 off the floor. On 01/25/18 at 8:20 AM NA #2 was interviewed on the telephone and explained that on 12/2017 she entered Resident #1's room, found the resident on the floor and notified Nurse #1. The NA added that Nurse #1 entered the room, observed the resident on the floor and walked out of the room after making a derogatory statement about the resident. NA #2 stated she did the next best thing and asked NA #1 for help getting the resident off the floor. NA #2 stated she didn ' t see any obvious injury from the fall. On 01/25/18 at 1:50 PM Nurse #1 was interviewed on the telephone and stated the nurse aides were wrong and that she had not observed Resident #1 in the floor on 12/20/17. The nurse added that there was a protocol for	F 684	12/26/2017 when the DON was made aware, from note under her door from CNA #2, that incident had accrued, resident #1 was assessed by nurse on 12/26/2017 with no findings. Identification of Others On 1/26/2018 administrative staff and Staff Development Coordinator started a 100% audit, Incident/Accident Audit, for resident Incident/Accident reporting timely for the last 90 days. The Incident/Accident Audit was completed 1/29/2018 with no concerns identified. Systemic Changes Measures put into place to ensure the plan of correction is effective and remains in compliance are: A 100% audit of current Incident/Accident reports for the past 90 days to verify procedures and timeliness for reporting resident incident/accident and if possible not moving the resident until assessed. The Incident/Accident audit was completed 1/29/2018 with no concerns identified. Effective 2/10/2018 staff will not be allowed to work without receiving in service on facility policy/procedure for reporting resident Incident/Accident. The in service will be provided for all active staff, to include full time, part time, and as needed employees. The education will be completed by 2/10/2018. Any staff member not educated by 2/10/2018 will not be allowed to work until receiving education. The education will also be added to the new hires orientation process effective 2/10/2018. Starting 2/12/2018 a weekly employee audit form,	

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 01/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5 documenting and assessing a resident's fall and she always followed protocol and she was one of the most thorough nurses. The nurse stated there was no documentation in the medical record about Resident #1 falling on 12/20/17 on the 11 PM to 7 AM shift "because he never fell on my shift." On 01/25/18 at 2:37 PM NA#1 was interviewed on the telephone and explained that on 12/20/17 she was asked by NA#2 to help get Resident #1 off the floor. The NA explained Nurse #1 was at the nurse station and she assumed "she (Nurse #1) had already done her thing" and that it was okay to assist the resident off the floor. On 01/25/18 at 3:30 PM the Director of Nursing (DON) was interviewed and explained she investigated the circumstances on 12/20/17 and NA #1 and NA #2 stated the resident had to be assisted off the floor. She added that when she interviewed nurse #1, the nurse denied the incident ever happened. The DON reported she believed Nurse #1. The DON added a nurse should assess a resident after a fall, document the fall before allowing nurse aides to move a resident. The DON also stated there was no apparent injury from the fall on 12/20/17.	F 684	Resident Incident/Accident Reporting, will be conducted weekly for 6 employees. The Resident Incident/Accident Reporting audit will be conducted by the nursing administrative staff, social service staff, and other facility department heads weekly for 8 weeks or until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. A 100% audit of all Incident/Accidents for timeliness and proper documentation will be done starting 1/29/2018. The Incident/Accident Correctness audit will be conducted by nursing administrative staff for 8 weeks or until a pattern of compliance is maintained. Monitoring Process Starting 1/29/18 a 100% audit by nursing administrative staff for all Incident/Accident reports will be audited for timeliness and proper documentation and last for 8 weeks. Starting 2/12/2018 a weekly employee audit form, Resident Incident/Accident Reporting, will be conducted weekly for 6 employees. The Resident Incident/Accident Reporting audit will be conducted by the nursing administrative staff, social service staff, and other facility department heads weekly for 8 weeks or until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. The Administrator and or DON will report findings monthly for 3 months to the	

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 01/25/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6	F 684	Quality Assurance Committee with necessary changes being made to ensure corrective action is achieved and sustained. The Administrator and DON will be responsible for implementing the plan of correction.	