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 08/09/2019

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SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 08/06/19 through 08/09/19. The facility was found to be in compliance with CFR 483.73, Emergency Preparedness. Event ID #0Q9S11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted 8/6/2019 through 8/9/2019. There were a total of 6 allegations, all of which were unsubstantiated. Event ID #0Q9S11.	F 000		
F 565 SS=B	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 565		9/5/19

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

Electronically Signed | 08/30/2019

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F 565	Continued From page 1 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, 11 residents who attended a Resident Council Meeting (Resident #4, 11, 47, 53, 73, 81, 84, 87, 89, 90, and 98), staff interviews, review of Resident Council Meeting Minutes for 3 months (May - July 2019) and review of facility records, the facility failed to resolve resident grievances communicated during Resident Council meetings and failed to provide privacy during Resident Council meetings. The findings included: A Resident Council (RC) meeting occurred with 11 alert and oriented residents on 08/07/19 at 03:00 PM. During the meeting, residents expressed concerns regarding the following: 1a. Staff enter the dining room where activities are held and stand in the back of the dining room talking loudly during the activity. Residents expressed this often occurred during church services. Review of RC meeting minutes and during discussion with residents, all residents agreed that this was an ongoing occurrence that had been discussed in prior RC meetings in the	F 565	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. Root Cause Analysis: Facility didn't resolve Resident grievances expressed in Resident Council meeting. Facility reviewed past four months of Resident Council concerns, review completed by Executive Director and Director of Nursing, to ensure all issues where addressed and met with Resident Council President to inform that the areas	

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F 565	Continued From page 2 last 3 months but was not resolved. During the RC meeting, staff were observed to interrupt the meeting on 08/07/19 at 3:05 PM when 2 staff members exited the restorative dining room and walked through the main dining room, where the RC meeting was being held. The staff were conversing with one another as they walked through. This also occurred again on 08/07/19 at 3:19 PM and 3:28 PM when dietary staff exited the kitchen, walked into the dining room to obtain items stored in the back of the dining room and then returned to the kitchen. 1b. When the meal trays come from the dietary department to the halls for delivery, there are not enough staff available to promptly distribute the trays. The food is not delivered timely and it is therefore delivered cold. Resident #81 stated this last occurred on 08/03/19 when he received lunch at 1:00 PM instead of 12:30 PM. Residents also expressed they felt rushed during their meals when staff come to take away their meal trays, especially when meals are delivered late and residents have not eaten or completed their meal. Review of RC meeting minutes and during discussion with residents, all residents agreed that this was an ongoing occurrence that had been discussed in prior RC meetings in the last 3 months but was not resolved. c. Staff stand in the hallways talking loudly complaining about their jobs and their responsibilities to care for residents, they tell us it is not in their job description if we ask for their help. This is disrespectful to us. Review of RC Meeting Minutes revealed this concern was not documented in the minutes from the prior 3 months. Resident #81 expressed during the	F 565	where addressed and reviewed plan of correction on 8/28/2019, Resident Council President was in agreement. Education of staff on the following areas: interruptions during activities, meal tray pass, noise level and Resident Rights. Education done by staff development coordinator to be completed by 9/5/2019. Monitoring sheets to be put into place for Interruptions of Activities to be completed by Activity Director and Activity Assistance three times a week for six weeks. System check for meal tray observation to be completed by Nursing Administration Team two times a week to include weekend for six weeks. System Check for noise level observation to be completed by Nursing Administration Team three times a week to include weekend for six weeks. Resident Council minutes and Concerns will be discussed in Daily Stand up Meeting and to be assigned to designate Department Head and to be discussed daily until resolved. The Plan of Correction will be integrated and monitored monthly by the Quality Assurance Committee with necessary changes being made to ensure corrective action is achieved and sustained. The Administrator and or Director of Nursing will be responsible for implementing the plan of correction.	

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meeting that he complained about this during the July 2019 RC meeting. Review of facility records revealed staff were in-serviced July/August 2019 regarding noise levels, discussing their assignments outside resident rooms and dignity/respect. All residents agreed that this was an ongoing occurrence that had been discussed in prior RC meetings in the last 3 months but was not resolved.

On 08/08/19 at 10:48 AM NA#2 was observed and heard, from approximately 20 feet away, to tell another staff member, while standing in the hallway outside resident rooms that "I am tired of making this bed for her when she gets out of the bed. I make the bed then she wants to get back in the bed. So, then I have to make it again when she gets out of the bed." NA #2 was interviewed at the time of this observation and she stated that she worked regularly with the resident she was referring to and described the resident as "confused." NA #2 stated the resident would forget instructions and liked to get in/out of bed causing her to have to keep making up the residents bed. NA #2 stated that at times she just got tired of making up the same bed over and over. NA #2 stated that she attended a recent in-service on customer service and thought that because she did not mention a resident's name that it was ok to talk about the resident in the hallway. Review of in-service records revealed NA #2 attended an in-service 6/27/19 on customer service.

An interview with Nurse #1 occurred on 08/08/19 at 11:36 AM. Nurse #1 stated that staff just received an in-service about not standing outside a resident's room and "venting". She further stated "That's something we should do behind

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closed doors. I will go remind them of that, but we were just in-serviced about this, not to talk about residents outside their doors.", Nurse #1 also stated that a resident told her "all the time" that she heard staff talking about residents outside her door and she often thought staff were talking about her.

An interview with the SW occurred on 08/09/19 at 10:23 AM. The SW stated that she was responsible for taking minutes at RC meetings. She reviewed the minutes from the previous meeting at each meeting and residents discussed whether or not their concerns were resolved. The SW stated that she wrote concerns on a grievance form and gave the form to the department head for follow up and resolution. At the next meeting she asked residents if the concern was resolved. The SW further stated that if it was not resolved she completed another grievance form and gave it to the department head for follow up until the concern was resolved. The SW further stated that resident privacy during activities, customer service was an ongoing resident concern.

An interview with the Weekend Supervisor (WS), on 08/09/19 at 11:54 AM revealed he did not recall lunch being delivered to residents late on Saturday, 08/03/19. He further stated he did not recall a concern being brought to his attention regarding insufficient staff available to distribute meals timely.

The Dietary Manager (DM) was interviewed on 08/09/19 at 12:01 PM. During the interview, he stated that he worked weekends on occasions and recalled having to ask staff to assist with delivering meal trays when the trays sat on the

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meal carts after being delivered to the units. The DM could not be specific as to how long the meal carts remained on the units before meals were delivered. The DM stated that during the months of May/June 2019 he worked each weekend and recalled having to ask the WS to get staff assistance to distribute meals.

The DON stated in interview on 08/09/19 at 01:59 PM that staff should not enter the dining room during resident activities like RC or church. The DON stated that on occasion she entered the dining room to obtain ice from the ice machine, but that she did so quietly so as not to disturb the activity. She stated that she agreed with residents that staff should not talk or "vent" outside resident rooms about their concerns with their assignment or nursing care. The DON stated staff were in-serviced in the last 2 months on customer service, noise levels and not to talk in the hallway outside resident rooms and so she thought this was resolved. The DON also stated that she was aware of previous resident complaints in May 2019 regarding having insufficient staff to distribute meals timely and as a result staff were in-serviced. The DON stated there were fewer facility staff available on the weekends but that staff were re-educated regarding distributing meals timely and so she thought this concern was also resolved.

An interview with Nurse Aide #1 (NA #1) occurred on 08/09/19 at 02:45 PM. NA #1 stated that she worked 2 - 3 weekends per month, all shifts and at times she noticed that after the meal trays were delivered to the units from the dietary department, it took longer to distribute them if staff were in the middle of providing nursing care at that time. NA #1 Further stated "Once we

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F 565	Continued From page 6 realize the trays are on the hall we start passing them out." NA #1 also stated that when this happened, the WS would help pass out meal trays. She stated that some residents complained that they had to wait longer for their meals, especially on the weekends at the breakfast meal.	F 565		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to accurately code 4 out of 23 minimum data set assessments related to diagnoses for heart failure and psychosis (Resident #62), anxiety (Resident #76), pain (Resident #12) and intellectual disability (Resident #26). Additionally, the facility failed to code Resident #26 with a Level II Preadmission Screen Resident Review. The findings included: 1. Resident #62 was admitted to the facility on 6/25/04 and readmitted on 6/28/19. Diagnoses included cerebrovascular accident (stroke), hypertension, atherosclerotic heart disease, hyperlipidemia, heart failure and psychosis. Medical record review of Resident #62's October 2018 physician orders revealed orders for Carvedilol 3.125 milligrams (mg) twice daily for heart failure, Lasix 20 mg daily for edema related to heart failure, and Risperidone 0.5 mg daily for	F 641	This plan of correction constitutes a written allegation of compliance. Preparation and submission of the 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. Root Cause Analysis: Root Cause analysis by facility found to be MDS Nurses failed to code Diagnosis on assessments. MDS Nurses will complete 100% audit of past 30 days of OBRA assessments to ensure all diagnosis are coded properly	9/5/19

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F 641	Continued From page 7 psychosis. An annual minimum data set (MDS) assessment dated 10/7/18, did not include the diagnoses heart failure and psychosis as current diagnoses at the time of the assessment. An interview occurred on 08/09/19 at 12:53 PM with MDS Coordinator #1 who stated a MDS Coordinator who no longer worked for the facility completed this MDS in error and failed to include the diagnoses heart failure and psychosis. MDS Coordinator #2 further stated that the diagnoses should have been captured on the MDS because Resident #62 received medication for both diagnoses at the time of the MDS assessment. The Director of Nursing stated on 08/09/19 at 1:45 PM that the MDS should be assessed accurately and include all active diagnoses. 2. Resident #76 was admitted to the facility on 12/18/18. Diagnoses included anxiety disorder. Medical record review of Resident #76's April 2019 physician orders revealed orders for Divalproex DR 125 milligrams (mg) capsules, 2 capsules twice daily for mood disorder/anxiety and Valium 2 mg twice daily as needed for anxiety. A significant change minimum data set (MDS) assessment dated 04/07/19, did not include the diagnosis anxiety disorder as a current diagnosis at the time of the assessment. An interview occurred on 08/09/19 at 1:02 PM with MDS Coordinator #1. She stated that it was her routine practice to review the Medication	F 641	this will include resident number 62,76,12 and 26. Resident number 62, 76, 12 and 26 assessments were corrected on 8/8/2019. Each MDS Nurse will audit one another assessment to ensure diagnosis are accurate and correct this will be done on all assessments as they are completed for six weeks. The Plan of Correction will be integrated and monitored monthly by the Quality Assurance Committee with necessary changes being made to ensure corrective action is achieved and sustained. The MDS Nurses will be responsible for implementing the plan of correction for 6 weeks.	

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Administration Record when completing the MDS assessment to determine current diagnosis that were being treated. MDS Coordinator #1 further stated that Resident #76 received Divalproex DR 125 mg twice daily in April 2019 for anxiety/mood disorder and that she should have included the diagnosis anxiety disorder when she completed the assessment.

The Director of Nursing stated on 08/09/19 at 1:45 PM that the MDS should be assessed accurately and include all active diagnoses.

3. Resident #12 was admitted to the facility on 7/26/18 and readmitted on 8/23/18 with medical diagnosis inclusive of type 2 diabetes mellitus and chronic obstructive pulmonary disease. Resident #12 also had an active diagnosis of pain, unspecified with an onset date of 8/23/18.

Resident #12's significant change minimum data set (MDS) dated 8/30/18 and the last quarterly MDS dated 5/13/19 identified she was receiving an opioid. These assessments did not include the diagnoses of pain, unspecified as current diagnosis.

Resident #12's care plan updated with the last quarterly MDS dated 5/13/19 included a focus area for alteration in comfort/pain related to chronic pain.

A review of August 2019 physician orders and medication administration record for Resident #12 revealed she was prescribed and administered Norco 5-325 one tablet every 8 hours and Norco 5-325 one tablet every 4 hours

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as needed for pain.

During an interview with MDS Coordinator #1 on 8/7/19 at 4:01 PM, she stated a diagnosis of pain, unspecified should have been included on the significant change MDS dated 8/30/18 and the last quarterly MDS dated 5/13/19 for Resident #12. MDS Coordinator #1 stated another MDS staff member who no longer worked for the facility completed the significant change MDS dated 8/30/19 in error and failed to include the diagnoses of pain, unspecified. MDS Coordinator #1 further stated not including a diagnosis of pain, unspecified on the last quarterly MDS was her oversight.

During an interview with the Director of Nursing on 8/9/19 at 1:06 PM, she stated her expectation regarding MDS assessment and coding was that all active medical diagnosis should be coded correctly.

4. Resident #26 admitted to the facility on 6/22/2016. His diagnoses included mental retardation with behavioral disturbance and down syndrome.

Resident #26's annual Minimum Data Set (MDS) dated 4/15/2019 revealed he had severe cognitive impairments. Review of Section A1500 (Preadmission Screening and Resident Review-PASRR) was coded "0" which indicated Resident #26 was considered by the state level II PASRR process to not have a serious mental illness and/or intellectual disability or related condition. Continued review of Section A1510 (Level II Preadmission Screening and Resident Review (PASRR) Conditions) did not code Resident #26 as having an intellectual disability. Further review

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F 641	Continued From page 10 of Section A1550 (Conditions Related to ID/ DD Status) did not code Resident #26 as having Down Syndrome. An interview was completed with the Social Worker on 8/8/2019 at 10:46 AM. The Social Worker revealed she was aware Resident #26 was a level II PASRR and had a diagnosis of mental retardation with behavioral disturbance and down syndrome. The Social Worker explained she did not code sections A1500, A1510, and A1550 on the MDS assessment. An interview was completed with MDS Coordinator #2 on 8/8/2019 at 10:56 AM. The MDS Coordinator #2 stated she would have completed the annual MDS assessment for Resident #26. The MDS Coordinator #2 verbalized she was familiar with Resident #26 and his diagnoses. The MDS Coordinator #2 expressed the coding for section A1500, A1510, and A1550 was an oversight and she would modify the assessment immediately. An interview was completed with the Director of Nursing (DON) on 8/8/2019 at 11:05 AM. The DON expressed her expectation was for the MDS to be coded accurately by the MDS department.	F 641		