PRINTED: 05/28/2021 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | | PLETED |
|--------------------------|---|---|---------------------|--|-------|----------------------------|
| | | 345489 | B. WING | | | C / 30/2021 |
| | 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENT | S | F 00 | 00 | | |
| F 690 SS=J | conducted on 04/26. Immediate Jeopardy 04/27/2021. The surfacility on 04/30/202 allegation. Therefor to 04/30/2021. Ever One of the 2 complas substantiated resulting Immediate Jeopardy 483.25 at tag F690 at F690 constitued substantiated Jeopardy was removed on 04/30/2021. Ever Jeopardy 483.25 at tag F690 at Immediate Jeopardy was removed on 04/30/2021. Ever Jeopardy was removed on 04/30/2021. Ever Jeopardy was removed on 04/30/2021. Ever Jeopardy 483.25 (e) (1) Immediate Jeopardy was removed on 04/30/2021. Ever Jeopardy was removed on 04/30/2021. Ever Jeopardy 483.25 (e) (1) The faresident who is contradmission receives amaintain continence condition is or become an incontinence, based comprehensive asset ensure that-(i) A resident who er indwelling catheter is | rvey team returned to the 1 to validate the credible re, the exit date was changed int ID#4B6A11. Initiallegations was ring in deficiency. It was identified at CFR rat a scope and severity of J. Instandard quality of care. It began on 04/17/2021 and rate of 28/2021. A partial extended red on 04/30/2021. Intinence, Catheter, UTI Initiallegations was ring in deficiency. It was identified at CFR rate a scope and severity of J. In the second of the second | F 69 | 90 | | 5/24/21 |
| ABORATORY | DIRECTOR'S OR PROVIDER | R/SUPPLIER REPRESENTATIVE'S SIGNATURE | | TITLE | | (X6) DATE |

Electronically Signed 05/22/2021

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | |
|--|---|--|-------------------------------|--|---|----------------------------|--|
| | | 345489 | B. WING _ | | 04 | C I/30/2021 | |
| | ROVIDER OR SUPPLIER | ILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 | , , | 1 04/00/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE APDEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 690 | indwelling catheter is assessed for rem as possible unless to demonstrates that cand (iii) A resident who is receives appropriate prevent urinary trace continence to the expression of a second prevent urinary trace continence, based comprehensive assensure that a reside receives appropriate restore as much not possible. This REQUIREMENT by: Based on staff, nurinterviews, and receive identify hematuria (laymptom of an indwed complication and fasymptoms of urinary residents who used (Resident #1). This emergency transfer of acute kidney injures vere sepsis second facility staff did not in hematuria as a sympatheter complication. | necessary; nters the facility with an or subsequently receives one oval of the catheter as soon he resident's clinical condition atheterization is necessary; s incontinent of bladder e treatment and services to t infections and to restore ktent possible. | F6 | The statements included are not admission and do not constitute agreement with the alleged deficiencies. The plan of correction is completed in the compliance of federal regulations as outlined. In compliance with all federal an regulations the center has taken take the actions set forth in the fiplan of correction the following procorrection constitutes the center allegation of compliance. All alled deficiencies cited have been or completed by the dates indicate 1. Address how corrective action accomplished for those resident have been affected by the deficiencies cited by the deficient have been affected by the deficient by the deficiencies cited by the deficient by the deficient by the deficient by the deficient completed by the deficient by the deficient completed completed by the deficient completed complet | state and To remain and state a or will following blan of c's eged will be d. a will be as found to | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---------------------------|---|---------------------|---|--------------|-------------------------------|--|
| | | 345489 | B. WING | | | C | |
| NAME OF D | ROVIDER OR SUPPLIER | 0.10.100 | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 4/30/2021 | |
| NAME OF FI | NOVIDER OR SUFFLIER | | | | • | | |
| SATURN N | IURSING AND REHABIL | ITATION CENTER | | 1930 WEST SUGAR CREEK ROAD | | | |
| | | | | CHARLOTTE, NC 28262 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 690 | Continued From page | e 2 | F 69 | 00 | | | |
| | assigned to Resident | #1 did not identify | | practice: | | | |
| | | e condition and immediately | | process. | | | |
| | contact the physician | | | Charge Nurse noted Resident | #1 on | | |
| | | an emergency transfer to | | 4/17/2021 urine contained dar | | | |
| | | bleeding from the indwelling | | Charge nurse failed to immedi | | | |
| | urinary catheter site. | The Immediate Jeopardy | | MD of Hematuria as she felt it | | | |
| | was removed on 04/2 | 28/2021 when the facility | | non-urgent, related to Residen | t #1 history | | |
| | provided an acceptab | ole credible allegation of | | of hematuria. Subsequently, R | esident #1 | | |
| | Immediate Jeopardy | removal. The facility will | | hematuria was communicated | via MD | | |
| | • | ance at a scope and severity | | communication book. Nurse th | | | |
| | | with potential for more than | | 7pm to 11pm documented that | | | |
| | | not immediate jeopardy) to | | #1 received 8pm dose of Eliqu | | | |
| | | stems are in place and the | | (Anticoagulation) as Nurse rep | | | |
| | completion of employ | ee education. | | she was unaware of the hema | • | | |
| | The finalines in alreaded | | | shift nurse on 4/17/2021 docur | | | |
| | The findings included | | | nursing note that Resident #1 continued, MD was not notified | | | |
| | Resident #1 was adm | nitted to the facility on | | interview Night shift nurse stat | - | | |
| | | noses which included middle | | did not recall any mention of s | | | |
| | | t, neurogenic bladder and | | of urine. On 4/18/2021 Charge | | | |
| | history of deep vein the | _ | | documented that Resident#1 | | | |
| | | n orders dated 01/22/2021 | | urine in the catheter bag when | | | |
| | directed Resident #1 | to receive Eliquis 5 | | him that morning, MD was not | | | |
| | milligrams twice daily | . (According to the | | immediately contacted. Charge | | | |
| | pharmaceutical manu | ıfacturer, Eliquis is an | | checked back an hour later to | find no | | |
| | anticoagulant medica | tion to prevent blood clots.) | | urine output and abdomen dist | ended and | | |
| | | | | hard. Charge nurse document | ed in | | |
| | | sion Minimum Data Set | | nursing note that hematuria co | | | |
| | (MDS) dated 02/01/20 | | | with blood coming out of the fo | | | |
| | | ely impaired cognition. The | | insertion site. Blood covered R | | | |
| | | ent #1 used an indwelling | | groin, inner thighs, and pubic a | | | |
| | | daily administration of an | | Resident was sent out to ER fo | | | |
| | anticoagulant. | | | evaluation. Resident #1's eme | 0 , | | |
| | The core plan date 1 | 02/00/2021 for Dooldt #4 | | room evaluation dated 04/18/2 | | | |
| | | 02/09/2021 for Resident #1 | | documented Resident #1's uri | • | | |
| | | s to be free of infection and | | catheter was replaced which re | | | |
| | discomfort related to | catneter placement. d assessment of the color, | | immediate 2700 cubic centime | | | |
| | | of urine and assessment of | | bloody output and subsequent dark yellow colored urine. The | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|--|--|
| | | 345489 | B. WING | | C 04/30/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | 0.0.00 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 04/30/2021 | |
| TO UNE OF TH | TO VIDER OIL OIL OIL I EIER | | | 1930 WEST SUGAR CREEK ROAD | | |
| SATURN N | IURSING AND REHABIL | ITATION CENTER | | CHARLOTTE, NC 28262 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION | |
| F 690 | Continued From page | ÷ 3 | F 690 | | | |
| F 690 | A nurse practitioner (I documented Residen urinary retention. Redistended with no urinobtained 1500 cubic ourine when the indwe The NP ordered scheindwelling urinary catiformation. On 02/08/2021, the N#1's urine culture and urinary tract infection antibiotic therapy. Or documented Residen with clots and catheted Resident #1 was hose 03/26/2021 and the documented urinary catheter was a hydronephrosis which secondary to a urinar (Hydronephrosis occuexcess of fluid due to discharge summary descheduled irrigation of | tract infection. NP) note dated 02/03/2021 t #1 experienced acute sident #1's abdomen was hary output. The NP centimeters (cc) of bloody lling catheter was replaced. duled irrigation of the heter to prevent clot IP documented Resident Is sensitivity result indicated a (UTI) which required in 02/10/2021, the NP t #1's previous hematuria er leakage was resolved. Ditalized from 03/10/2021 to ischarge summary dated Resident #1's indwelling replaced due to bilateral in caused urinary retention y tract infection. Jurs when a kidney has an a backup of urine.) The lid not contain orders for f the indwelling urinary | F 690 | ordered Resident #1's Eliquis to be he The hospital physician documented prenal acute kidney injury with obstruct uropathy, suspected secondary clot we catheter and hyponatremia secondary fluid overload from urinary obstruction Resident #1 was admitted to the hosp for treatment of acute kidney injury, severe sepsis secondary to a urinary infection which required Gentamycin. Resident #1 has not returned to the facility. Facility did not identify hematuria as a symptom of an indwelling urinary cath complication and did not respond nor monitor symptoms of urinary retention Additionally, Resident #1 was receiving anticoagulation therapy which placed at a higher risk of bleeding. Staff assist to Resident #1 did not identify hemature as an acute condition and immediated contact MD for further guidance. All residents with Indwelling Catheters have the potential to be affected by the deficient practice. | ost ive ive iith i to i. iital tract eeter i. ing him igned iria y see | |
| | The NP assessed Re and documented Res catheter contained cle #1 had no bladder dis NP documented nurs | n orders included continued e daily Eliquis. sident #1 on 03/29/2021 ident #1's indwelling urinary ear, yellow urine. Resident stention upon palpation. The ing staff were to monitor d episodes of hematuria. | | 2. Address how the facility will identify other residents having the potential to affected by the same deficient practic An audit of the past 14 days of nursin notes completed 4/27/2021 was revie by the Executive Director, Director of Nursing, Assistant Director of Nursing and Unit Coordinators to identify any residents with documented signs and | be e: g wed | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|---|-------------------------------|--|
| | | 345489 | B. WING _ | | | C / 30/2021 | |
| NAME OF PR | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZII | | 700/2021 | |
| | | | | 1930 WEST SUGAR CREEK ROAI | D | | |
| SATURN N | IURSING AND REHABI | LITATION CENTER | | 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 ((EACH CORRECTIVE A CROSS-REFERENCED T | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 690 | Continued From page | ge 4 | F 6 | 90 | | | |
| | On 04/02/2021 and documented Reside catheter contained c#1 had no bladder d | 04/05/2021, the NP nt #1's indwelling urinary clear, yellow urine. Resident istention upon palpation. | | symptoms of urinary rete tract infection. No issues Additionally, an assessm Residents with Indwelling completed on 4/27/2021 | identified. nent of all g Catheters was by the Director of | | |
| | Resident #1's indwe contained clear, yell bladder distention up documented on 04/0 Resident #1's indwe | ated 04/08/2021 documented lling urinary catheter ow urine. Resident #1 had no con palpation. The NP 09/2021 and 04/12/2021 that lling urinary catheter ow urine. Resident #1 had no con palpation. | | Nursing to assess for an symptoms of urinary rete complications, or urinary Assessment included ob catheter, urine color, clar abdominal inspection/pa identified. | ention, catheter tract infection. servation of rity and output, | | |
| | Saturday 04/17/202: Resident #1's urine The nurse wrote Re- increased sleepines name in the medical Monday, 04/19/2021 | en by Nurse #1, dated 1 at 6:55 PM documented contained dark red blood. sident #1 was "verbal with s" and placed Resident #1's doctor book to be seen I. There was no description of or vital sign measurement. | | Director of Nursing reviewith Indwelling catheters ensure that each had an plan to assess for color, of urine and to assess for infection and blockages. reviewed to ensure accuracy. | on 4/26/2021 to appropriate care clarity, character or urinary tract Care guides | | |
| | revealed Resident # bed on 04/17/2021 a #1 explained Reside and liked to talk. Na indwelling urinary ca approximately 800 c it was emptied at the NA #1 reported the a #1's usual amount. urine to Nurse #1 wh discolored urine. | | | 3. Address how the facili place or systemic change ensure that the deficient recur: Beginning 4/27/2021, All include Licensed Nurses Aides, and Nurse Aids in re-educated by the Assis Nursing on the monitorin residents with signs and urinary retention and urin infections. To include im | es made to practice will not I nursing staff to c, Certified Nurse Training were stant Director of g and reporting of symptoms of nary tract mediate | | |
| | | w was conducted on PM with Nurse #1. Nurse #1 I from 7:00 AM to 7:00 PM | | notification of hematuria, urine output, pain, abdor pain with abdominal palp | minal distention, | | |

PRINTED: 05/28/2021 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|--|---|-------------------------------|--|
| | | 345489 | B. WING | | | C 4/30/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | _ | STREET ADDRESS, CITY, STATE, ZIP COL | · · | 4/00/2021 | |
| | | | | 1930 WEST SUGAR CREEK ROAD | | | |
| SATURN N | IURSING AND REHABII | LITATION CENTER | | CHARLOTTE, NC 28262 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 690 | 04/17/2021. Nurse # #1 the breakfast mea hours later observed catheter bag. Nurse was 500 cc. Nurse # slept more than usua pain. Resident #1's Nurse #1 explained s name and concern o seen on Monday (04 #1 did not consider t Resident #1 experier | cared for Resident #1 on 1 reported she fed Resident al on 04/17/2021 and several dark red urine in the #1 estimated the amount t1 explained Resident #1 al but did not complain of abdomen was not distended. She placed Resident #1's f hematuria on the list to be /19/2021) by the NP. Nurse the hematuria urgent since finced hematuria in the past. the hematuria to Nurse #2 who | F 69 | urgency, frequency, catheter and or blockage. These char to be communicated via com book. The education will be communicated verbally and t by the Executive Director, Di Nursing and Assistant Direct Nursing/Staff Development of Written education will be avareview prior to the staff memi their assigned shift. Assistan Nursing will utilize a master of to track completion of educat will be allowed to work until ecompleted. | nges are not imunication delephonically rector of or of coordinator. dilable for ber working t Director of employee list tion. No staff | | |
| | Telephone interview at 12:20 PM revealed did not observe Resi 04/17/2021 between Nurse #2 documenter mg. at 8:00 PM. During an interview of 3:25 PM, NA #2 reported she did not amount of Reside emptied the bag at the PM. A nursing note, writte 04/18/2021 at 6:29 A continued with hemat discomfort during the | with Nurse #2 on 04/26/2021 d she was not aware of and dent #1's hematuria on 7:00 PM and 11:00 PM. d administration of Eliquis 5 with NA #2 on 04/26/2021 at wited she cared for Resident 1:00 PM on 04/17/2021. NA not recall the character, color int #1's urine when she ne end of the shift at 11:00 en by Nurse #3, dated M documented Resident #1 turia with no complaints of 11:00 PM to 7:00 AM shift. | | Beginning 4/27/2021, All Lice were educated on Change in Notifications, Signs and Sym when to report to MD. Docum residents with indwelling fole include color, clarity, output, of urine and documentation or redness, swelling, bleeding, discharge, or pain by the Ass Director of Nursing. As well, Nurses were re-educated on responsibility regarding shift-reporting utilizing 24-hour repand giving accurate, clear, tir on coming shifts by the Assis of Nursing. Additionally, all Linurses were re-educated on effects to Anticoagulants which hematuria, monitoring/assessadverse reaction and the imm | a Condition uptoms and nentation for y catheters to consistency of site for warmth, sistant all Licensed their tto-shift cort sheets mely report to stant Director icensed adverse side ch include sing for mediate | | |
| | - | e cared for Resident #1 from | | notification to MD. The educa | ation was | | |

Facility ID: 923538

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL | | | | | | | |
|--|--|---|--------------------|-----|--|-----------------------------------|----------------------------|
| | | 345489 | B. WING | | | l | C 30/2021 |
| NAME OF PE | ROVIDER OR SUPPLIER | 0.0.00 | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 04/ | 30/2021 |
| TO TWIL OF TH | TO VIDER OR GOLF EIER | | | | 930 WEST SUGAR CREEK ROAD | | |
| SATURN N | NURSING AND REHABIL | ITATION CENTER | | | CHARLOTTE, NC 28262 | | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 690 | Continued From page | e 6 | F | 690 | | | |
| F 690 | 04/18/2021. NA #3 recatheter bag containered urine when she e shift. NA #3 reported small amount to Nurs. A telephone interview #3 on 04/26/2021 at explained she was not hematuria until inform AM and 7:00 AM on 0 at Resident #1's clinic #1 documented hema #3 did not recall NA # of urine. Nurse #3 in Nurse #1, of the cont. A nursing note, writte 04/18/2021 at 10:44 / #1's hematuria contin of the catheter inserti Resident #1's groin, i Resident #1's blood pmm/Hg., heart rate of and temperature measurement. Resident #1's lood pmm/Hg., heart rate of and temperature measurement. Resident #1's lood pmm/Hg., heart rate of and temperature measurement. Resident #1's lood and sips of a call #1 held Resident #1's urinary him breakfast at apprint preakfast at appri | eported Resident #1's ed a small amount of dark mptied it at the end of her it the discolored urine and is #3. was conducted with Nurse 6:10 PM. Nurse #3 of aware of Resident #1's ned by NA #3 between 6:30 04/18/2021. Nurse #3 looked cal record and noted Nurse eaturia on 04/17/2021. Nurse #3 report of the small amount formed the oncoming nurse, inued hematuria. In by Nurse #1, dated AM documented Resident nued with blood coming out on site. Blood covered nner thighs and pubic area. In essure measured 137/93 if 103, respiratory rate of 18 is asurement of 97.7 degrees it #1 received an emergency it #1 received an emergency al. Interview on 04/26/2021 at if #1, Nurse #1 reported she is ident #1 the breakfast meal is accepted only a few bites of irbonated beverage. Nurse is medications due to it is a small amount of the protect of the | F | 690 | by the Executive Director, Director of Nursing and Assistant Director of Nursing/Staff Development coordinator Written education was available for rev prior to the staff member working their assigned shift. Assistant Director of Nursing utilized a master employee list track completion of education. All Education was completed on 4/30/202. Effective 4/27/2021 education for management of residents with urinary catheters, including monitoring for complication and how to respond will b included in general orientation by the S Development Coordinator for newly hir Licensed Nurses and Certified Nursing Assistants. 4. Address what measures will be put i place or systemic changes made to ensure that the deficient practice will no recur: Effective 4/27/2021 Nursing Management to include Charge Nurse, Unit Coordinators, Director and Assistant Director of Nursing will review 24-hour report sheets and previous day nurses notes to identify any change in condition for appropriate follow up and notification to MD review will be completed daily. Administrator educated the Nursing Management team to include Charge Nurse, Unit Coordinators, Director and Assistant Director of Nursing on the neurocess of monitoring and responsibility of this plan on 4/27/2021. Monday-Sunday- | to 1. e Staff ed nto ot ent w ies | |
| | #1 held Resident #1's lethargy. Nurse #1 re Resident #1's urinary him breakfast at appr she returned approxii | s medications due to eported there was no urine in catheter bag when she fed | | | Nurse, Unit Coordinators, Director and Assistant Director of Nursing on the ne process of monitoring and responsibilit | w ies | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|--|---------------------------------|-------------------------------|--|
| | | 345489 | B. WING _ | | | 1 | 30/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STI | REET ADDRESS, CITY, STATE, ZIP CODE | 1 04/ | 00/2021 | |
| • | | | | | 30 WEST SUGAR CREEK ROAD | | | |
| SATURN N | IURSING AND REHABIL | ITATION CENTER | | | | | | |
| | | | | CF | HARLOTTE, NC 28262 | | ı | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 690 | Continued From page | ÷7 | F6 | 690 | | | | |
| F 690 | blood. Upon further edobserved blood cover thighs with blood com #1 reported Resident distended and hard w #1 stated she immedi #1 to the hospital at a 04/18/2021. Resident #1's emerged 04/18/2021 document urinary catheter was a simmediate 2700 cc of subsequently 1 liter on The hospital physicial acute kidney injury wis suspected secondary hyponatremia second urinary obstruction. If the hospital for treatm and severe sepsis se required intravenous. Interview with the NP revealed staff should physician when Reside to obtain orders for imaginary obstruction. If the hospital for treatm and severe sepsis se required intravenous. Interview with the NP revealed staff should physician when Reside to obtain orders for imaginary of the urexplained Resident # symptoms of infection and complications of Telephone interview won 04/26/2021 at 4:46 would have received immediate discontinual discontinu | examination, Nurse #1 red Resident #1's groin and ling out of the penis. Nurse #1's abdomen was rith no urinary output. Nurse ately transferred Resident approximately 10:30 AM on ency room evaluation dated ted Resident #1's indwelling replaced which resulted in bloody output and f dark yellow colored urine. In documented post renal th obstructive uropathy, clot with catheter and lary to fluid overload from Resident #1 was admitted to ment of acute kidney injury, condary to UTI which Gentamycin (an antibiotic). on 04/26/2021 at 11:14 AM have notified the on-call lent #1's hematuria occurred rigation and probable inary catheter. The NP 1 required monitoring for In, recurrence of blood clots | F 6 | 690 | The Director of Nursing will be report a discussed in monthly Quality Assurance and Performance Improvement a revie of the audit's meetings monthly for 3 months and/or until substantial compliance is maintained. QAPI committee can modify this plan in orde assure substantial compliance. Effective 04/27/2021, the Administrator and Director of Nursing will be ultimate responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance. | e w r to - ly of | | |
| | | occurred. The physician f hematuria was a serious | | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | COMPLETED | |
|--------------------------|--|--|---|---|-----------|----------------------------|
| | | 345489 | B. WING | | | C |
| | ROVIDER OR SUPPLIER | | B. WING | STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 | (| 04/30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 690 | 04/26/2021 at 4:55 I contacted Resident the hematuria first o staff should recogniz of a urinary catheter symptoms of urinary explained Resident due to anti-coagular. The Administrator w Jeopardy on 04/27/2. The facility provided allegation of Immediately notify those recare likely to suffer, a a result of the noncontained dark red be immediately notify I was non-urgent, related hematuria. Subsequivas communicated Nurse that worked 7 Resident #1 receive (Anticoagulation) as unaware of the hem 4/17/2021 document Resident #1 hematunotified. During interthat she did not recamount of urine. On | rector of Nursing (DON) on PM revealed staff should have #1's physician on-call when occurred. The DON reported the hematuria as a symptom complication and monitor or retention. The DON #1 was at risk for bleeding at use. as notified of Immediate 2021 at 1:55 PM. the following credible ate Jeopardy removal: ipients who have suffered, or serious adverse outcome as | F 69 | 90 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | FIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--------------------|---|--------------------------------------|-------------------------------|--|
| | | 345489 | B. WING | | | C | |
| | ROVIDER OR SUPPLIER | BILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIF 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 | CODE | l/30/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN C X (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 690 | checked back an and abdomen dist documented in nu continued with blo catheter insertion groin, inner thighs sent out to ER for emergency room documented Resireplaced which recentimeters of blo Liter of dark yellow ordered Resident hospital physician kidney injury with secondary clot wit secondary to fluid obstruction. Resin hospital for treatm severe sepsis seconfection which rechas not returned to | diately contacted. Nurse #1 hour later to find no urine output lended and hard. Nurse #1 rsing note that hematuria lood coming out of the urinary site. Blood covered Resident #1 lended, and pubic area. Resident was levaluation. Resident #1's levaluation dated 04/18/2021 lendent #1's urinary catheter was sulted in immediate 2700 cubic loody output and subsequently 1 levelored urine. The physician levelored urine. The physician levelored urine obstructive uropathy, suspected levelored the catheter and hyponatremia levelored with a dwitted to the lent of acute kidney injury, levelored gentamycin. Resident #1 lo the facility. | F | 690 | | | |
| | of an indwelling undid not respond not respond not retention. Additionanticoagulation the higher risk of blee #1 did not identify | entify hematuria as a symptom rinary catheter complication and for monitor symptoms of urinary nally, Resident #1 was receiving erapy which placed him at a ding. Staff assigned to Resident hematuria as an acute nediately contact MD for further | | | | | |
| | | Indwelling Catheters have the ected by the deficient practice. | | | | | |
| | 2) Specify the acti | on the entity will take to alter | | | | | |

| | OF DEFICIENCIES F CORRECTION | | | (X3) DATE SURVEY COMPLETED | | | |
|--------------------------|---|--|---------------------|-------------------------------|--|------|----------------------------|
| | | 345489 | B. WING _ | | | | C / 30/2021 |
| | ROVIDER OR SUPPLIER | LITATION CENTER | | 1930 | EET ADDRESS, CITY, STATE, ZIP CODE WEST SUGAR CREEK ROAD ARLOTTE, NC 28262 | 1 04 | 3072021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFII TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 690 | Continued From pag | e 10 | F | 690 | | | |
| | | m failure to prevent a serious m occurring or recurring, and be complete: | | | | | |
| | completed 4/27/202 Executive Director, Director of Nursing, a identify any residents symptoms of urinary infection. No issues assessment of all Recatheters was comp Director of Nursing to symptoms of urinary complications, or urin Assessment included urine color, clarity and | nary tract infection. d observation of catheter, | | | | | |
| | Indwelling catheters each had an appropi color, clarity, charact urinary tract infectior reviewed to ensure a | eviewed residents with on 4/26/2021 to ensure that riate care plan to assess for the form of the care plan to assess for and blockages. Care guides accuracy. No concerns noted. | | | | | |
| | Licensed Nurses, Ce Nurse Aids in Trainin Assistant Director of and reporting of resid symptoms of urinary infections. To include hematuria, decrease abdominal distention palpation, odor, urge | , All nursing staff to include ertified Nurse Aides, and g will be re-educated by the Nursing on the monitoring dents with signs and retention and urinary tract entition in urine output, pain, pain with abdominal ency, frequency, catheter blockage. These changes | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|---|-------------------------------|----------------------------|
| | | 345489 | B. WING | | | C |
| | ROVIDER OR SUPPLIER | | B. WING | STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 | 04 | 4/30/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| F 690 | are not to be communioned. The education overbally and telephon Director, Director of Nursing/Scoordinator. Written ereview prior to the state assigned shift. Assist utilize a master employ of education. No staff education is complete. Beginning 4/27/2021, educated on Change Signs and Symptoms Documentation for reurinary catheters to inconsistency of urine a redness, swelling, ble or pain by the Assistate well, all Licensed Nurtheir responsibility regreporting utilizing 24-ligiving accurate, clear shifts by the Assistan Additionally, all Licen re-educated on adver Anticoagulants which monitoring/assessing the immediate notificated. | nicated via communication will be communicated ically by the Executive lursing and Assistant aff Development ducation will be available for ff member working their ant Director of Nursing will be allowed to work until ed. All Licensed Nurses to be In Condition Notifications, and when to report to MD. sidents with indwelling aclude color, clarity, output, and documentation of site for reding, warmth, discharge, ant Director of Nursing. As ses to be re-educated on garding shift-to-shift nour report sheets and timely report to on coming to Director of Nursing. Sed Nurses to be se side effects to | F 69 | · · | | |
| | Assistant Director of I coordinator. Written e review prior to the state assigned shift. Assist utilize a master emplo | Nursing/Staff Development ducation will be available for for member working their ant Director of Nursing will byee list to track completion will be allowed to work until | | | | |

| C | | |
|--|--|--|
| 04/30/2021 | | |
| 1 04/00/2021 | | |
| CTION (X5) ULD BE COMPLETION ROPRIATE DATE | | |
| | | |
| ι | | |

| | NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | | |
|--|--|--|-------------------------------|-----|---|------|----------------------------|
| | | 345489 | B. WING | | | | C 30/2021 |
| NAME OF PROVIDER OR SUPPLIER SATURN NURSING AND REHABILITATION CENTER | | | • | 19 | TREET ADDRESS, CITY, STATE, ZIP CODE 930 WEST SUGAR CREEK ROAD HARLOTTE, NC 28262 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 690 | interviews revealed re- identification and resp catheters. The facility monitor residents with reviewed by nursing r | ion and blockages. Staff eceipt of education regarding ponse to indwelling urinary implemented audit tools to nindwelling urinary catheters management. | | 690 | | | |
| F 757 SS=D | CFR(s): 483.45(d)(1)- §483.45(d) Unnecess Each resident's drug | eary Drugs-General. regimen must be free from An unnecessary drug is any essive dose (including by); or | F | 757 | | | 5/24/21 |
| | §483.45(d)(4) Withou use; or | t adequate monitoring; or tadequate indications for its | | | | | |
| | section. This REQUIREMENT by: Based on staff and precord review, the fact anticoagulation medicin the urine) occurred | indicate the dose should be led; or mbinations of the reasons (d)(1) through (5) of this is not met as evidenced hysician interviews, and cation after hematuria (blood | | | Address how corrective action will accomplished for those residents found have be affective by the deficient practic Resident #1 was administered anticoagulation medication on 4/17/21 | d to | |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|------------------------------|-------------------------|--|---------------------|---|---|-------------------------------|----------------------------|
| | | 345489 | B. WING_ | | | | C (30/2021 |
| NAME OF PROVIDER OR SUPPLIER | | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 04/ | 30/2021 |
| | 101.52.1.01.100.1.2.2.1 | | | | 1930 WEST SUGAR CREEK ROAD | | |
| SATURN N | NURSING AND REHABIL | ITATION CENTER | | | CHARLOTTE, NC 28262 | | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 757 | Continued From page | e 14 | F7 | 757 | | | |
| | (Resident #1). | | | | after hematuria (blood in the urine) wa | s | |
| | (| | | | noted in catheter bag. Resident was | _ | |
| | The findings included | l: | | | transferred to the hospital on 4/18/202 | 1. | |
| | Resident #1 was adm | nitted to the facility on | | | 2. Address how the facility will identi | fy | |
| | 01/22/2021 with diag | | | other residents having the potential to | be | | |
| | neurological disorder | | | affected by the same deficient practice | <i>:</i> - | | |
| | | y infarct, neurogenic bladder, | | | | | |
| | | hrombosis, and seizure | | | Beginning on May 17th, 2021 Nursing | | |
| | | s ordered upon admission | | | Management, to include Director of | | |
| | | ligrams (mg.) twice daily. gulant medication to prevent | | | Nursing, Assistant Director of Nursing/Staff Development Coordinate | or. | |
| | , . | ticoagulants thin blood, the | | | conducted an audit of current resident | | |
| | | nends observation for signs | | | anticoagulation therapy documentation | | |
| of bleeding.) | | | | | the prior 14 days to ensure no adverse | | |
| | J , | | | | side effects were noted related to of | | |
| | Resident #1's admiss | sion Minimum Data Set | | | medication use. Additionally, Nurse | | |
| | (MDS) dated 02/01/2 | 021 documented an | | | Management observed residents on | | |
| | | ely impaired cognition. The | | | anticoagulation therapy for any signs a | ınd | |
| | MDS indicated Resid | | | | symptoms of adverse side effects rela | | |
| | anticoagulant medica | tion. | | | to medication use. No concerns noted. Audit was completed on 5/17/21. | | |
| | Resident #1's care pl | an dated 02/09/2021 | | | Nursing Management will review curre | nt | |
| | documented Residen | | | | residents on anticoagulation therapy to | | |
| | | entions included monitoring | | | ensure the care plan includes | | |
| | of signs and sympton | ns of bleeding and bruising | | | anticoagulation use and risk, to include | e for | |
| | with report of abnorm | al findings to the physician. | | | monitoring for signs and symptoms of | | |
| | | | | | bleeding, bruising with report of any | | |
| | | pitalized from 03/10/2021 to | | | abnormal findings to the physician. Au | dit | |
| | | ion physician's orders | | | will be completed on 5/21/2021. Any | | |
| | included continuance | of Eliquis 5 mg. twice daily. | | | identified issues will be corrected immediately. | | |
| | | ation aide #1 on 04/26/2021 | | | | | |
| | | Resident #1 did not have | | | 3. Address what measures will be pu | | |
| | | administered the Eliquis at | | | into place or systematic changes made | | |
| | 8:00 AM on 04/17/20 | 21. | | | ensure that the deficient practice will n recur | ot | |
| | A nursing note, writte | n by Nurse #1, dated | | | | | |
| | | M documented Resident | | | Effective 4/27/2021, All Licensed Nurs | es | |

| | | IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|---------------|--|--|--|--|------------|-------------------------------|--|
| | | 345489 | B. WING | | | C 4/30/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODI | | 4/30/2021 | |
| | (0.11) | | | 1930 WEST SUGAR CREEK ROAD | - | | |
| SATURN N | IURSING AND REHABIL | LITATION CENTER | | CHARLOTTE, NC 28262 | | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF COI | RRECTION | (X5) | |
| PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | COMPLETION DATE | |
| F 757 | Continued From page | e 15 | F 75 | 57 | | | |
| | #1's urine contained | dark red blood. | | were educated on Change in | Condition | | |
| | | | | Notifications, Signs and Symp | | | |
| | Resident #1's electro | nic medication | | when to report to MD. Addition | nally, all | | |
| | | revealed documentation of | | Licensed Nurses were re-edu | cated on | | |
| | | PM on 04/17/2021 by Nurse | | adverse side effects to Anticoa | agulants | | |
| | #2. | | | which include hematuria, | | | |
| | | | | monitoring/assessing for adve | | | |
| | A telephone interview | v was conducted on PM with Nurse #1. Nurse #1 | | and the immediate notification when there are abnormal findi | | | |
| | | from 7:00 AM to 7:00 PM | | education was communicated | | | |
| | | cared for Resident #1 on | | and telephonically by the Exec | • | | |
| | | 1 observed dark red urine in | | Director, Director of Nursing a | | | |
| | the catheter bag seve | eral hours after she fed | | Director of Nursing/Staff Deve | | | |
| | Resident #1 the breakfast meal. Nurse #1 explained Resident #1 slept more than usual but | | | coordinator. Education was co | | | |
| | | | | 4/28/2021. | | | |
| | | ain. Resident #1's abdomen | | | | | |
| | | Nurse #1 explained she | | Certified nursing assistants we | | | |
| | • | name and concern of | | re-educated by the Assistant [| | | |
| | | to be seen on Monday | | Nursing on notification to nurs | | | |
| | , , , | NP. Nurse #1 did not | | _ | | | |
| | consequence of Eliqu | ria urgent or an adverse | | completed on 4/28/2021. | | | |
| | | ria in the past. Nurse #1 | | All newly hired employees will | | | |
| | | ria to Nurse #2 who came on | | education in new hire orientati | | | |
| | duty at 7:00 PM. | | | employee will be allowed to w | | | |
| | , | | | the education. | | | |
| | Telephone interview | with Nurse #2 on 04/26/2021 | | | | | |
| | at 12:20 PM revealed | d she was not aware of and | | | | | |
| | | dent #1's hematuria. Nurse | | 4.Indicate how the facility plan | | | |
| | | inistration of Eliquis 5 mg. at | | their performance to make sur | | | |
| | 8:00 PM. | | | solutions are sustained and co | orrective | | |
| | A 4-1 | orriging and advised width Missing | | action will be complete. | | | |
| | | wwas conducted with Nurse 11:00 PM on 04/17/2021 to | | Effortive 5/24/2021 Nursing N | Managament | | |
| | | 21, on 04/26/2021 at 6:10 | | Effective 5/24/2021, Nursing Notes to include, Director of Nursing | • | | |
| | | ed she was not aware of | | Director of Nursing and Unit M | | | |
| | | uria until informed by NA #3 | | review the 24-hour report she | | | |
| | | O AM on 04/18/2021. Nurse | | previous days nursing notes to | | | |
| | | oming nurse, Nurse #1 of the | | any change in condition as it r | | | |

| | OF DEFICIENCIES CORRECTION | | | | ATE SURVEY DMPLETED | | |
|--|---|---|--------------------|-----|--|----------------------------|----------------------------|
| | | | A. BOILDI | _ | | (| c |
| | | 345489 | B. WING _ | | | 04/ | 30/2021 |
| NAME OF P | ROVIDER OR SUPPLIER | • | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SATURN NURSING AND REHABILITATION CENTER | | | | 19 | 930 WEST SUGAR CREEK ROAD | | |
| SAIURNI | TORSING AND REHAD | EHAHON CENTER | | С | HARLOTTE, NC 28262 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 757 | #1, dated 04/18/202 8:00 AM medication mg. were held due t documented Reside with blood coming o site. Blood covered thighs and pubic are pressure measured of 103, respiratory re measurement of 97. | cation notes, written by Nurse 11 documented Resident #1's 12 s which included Eliquis 5 13 o lethargy. Nurse #1 15 hematuria continued 16 ut of the catheter insertion 17 Resident #1's groin, inner 18 Resident #1's blood 18 mm/Hg. With heart rate 19 ate of 18 and temperature 19 degrees Fahrenheit. 10 dan emergency transfer to | | 757 | anticoagulation therapy and monitoring. This Audit will take place Monday-Friday during clinical morning meeting and documented on the daily clinical round checklist. Monday-Friday for 12 weeks or until a pattern of compliance is maintained. Effective 5/24/21, Nursing Management to include, Director of Nursing, Assistant Director of Nursing and Unit Mangers will conduct staff questionnaires to address employee knowledge of adverse effects of anticoagulation therapy. Audit to include 15 staff members per week for 2 weeks, 10 staff members per week for 4 weeks, 5 | | |
| | 04/18/2021 docume treatment for post re obstructive uropathy with catheter and hy overload from urinar physician ordered R held. During a telephone 04/26/2021 at 12:48 did not administer R Eliquis and other molethargy. Telephone interview on 04/26/2021 at 4:48 should not have recoccurred. The physician occurred the Elicitical street occurred to the street occurred to compare the street occurred to | | | | staff members per week for 6 weeks or until a pattern of compliance is maintained. The Director of Nursing will be report a discussed in monthly Quality Assurance and Performance Improvement a review of the audit□s meetings monthly for 3 months and/or until substantial compliance is maintained. QAPI committee can modify this plan in order assure substantial compliance. Effective 5/25/2021 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. The facility alleged full compliance with | nd e w r to nd | |
| | | irector of Nursing (DON) on PM revealed staff should have | | | this plan of correction effective date 5/24/2021. | | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | I ' ' | PLE CONSTRUCTION 3 | (X3) DATE SURVEY COMPLETED |
|--|--|--|---------------------|--|-------------------------------|
| | | 345489 | B. WING | | C 04/30/2021 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262 | | | | 04/30/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE COMPLETION |
| F 757 | contacted Resident # the hematuria occurre 8:00 PM Eliquis. The | e 17 1's physician on-call when ed and not administer the DON explained Resident eding due to anti-coagulant | F 75 | 57 | |