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 05/15/2014

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 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff and nurse practitioner interviews, and record review, the facility failed to conduct weekly skin assessments for 1 of 3 sampled residents with pressure sores (Resident #172). The findings included: Resident #172 was admitted to the facility on 03/21/14 with diagnoses which included diabetes mellitus type 2, coronary artery disease and osteoarthritis. Review of Resident #172's admission Minimum Data Set (MDS) dated 03/28/14 revealed an assessment of severely impaired cognition with independence in bed mobility. The MDS coded Resident #172 with frequency or urine and bowel incontinence. The MDS indicated Resident #172 was at risk for pressure sore development with no pressure sores upon admission. Review of Resident #172's care plan dated 04/02/14 revealed a risk for skin integrity	F 314	1. Corrective action for Resident #172 has been accomplished .The resident□s pressure ulcers were re-assessed by the facility Nurse Practitioner (NP) and treatment initiated on 5/15. The nurses are performing weekly skin assessments and documenting on the Treatment record. The Current Physician orders for treatments are being completed daily by the assigned nurse and documented on the Treatment record. Nurse #1 is no longer employed by the facility. Resident # 172 was discharged from the facility on 6/1/2014. 2. Since all Residents have the potential to be affected by alleged deficient practice, 100% of current residents had a full body assessment to ensure there are no newly identified wounds that have not previously identified and treated. This audit will also ensure that each resident in the facility currently has weekly skin assessments completed and	6/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/06/2014

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F 314	Continued From page 1 impairment with a goal of no skin breakdown. Interventions included pressure reduction mattress, wheelchair cushion and weekly skin checks by nurse. Review of Resident #172's skin inspection reports revealed one report dated 04/01/14 which documented intact skin. Review of physician's orders dated 04/11/14 revealed direction to insert an indwelling urinary catheter for urinary retention. Review of Resident #172's April 2014 Treatment Record revealed weekly skin checks scheduled for the 3 to 11 shift every Tuesday. A skin check was initialed as completed on 04/01/14. There were no nurses' initials written on blocked out dates of 04/08/14, 04/15/14, 04/22/14 and 04/29/14. Review of Resident #172's May 2014 Treatment Record revealed weekly skin checks scheduled to be conducted on the 3 to 11 shift every Tuesday. There were no nurses' initial written on the blocked out date of 05/06/14. Review of a nursing note dated 05/12/14 revealed three 0.25 centimeters (cm.) by 0.25 cm. open areas, one 2 cm. by 2 cm. open area and one 1.5 cm. by 1 cm. open area on Resident #172's buttocks. Nurse #2 notified the physician and received orders for treatment of the open areas. Review of the wound assessment report dated 05/13/14 revealed the following descriptions of 5 new open areas: · Stage 2 pressure ulcer on the right buttock with measurements of 1.5 cm. by 2.0 cm. by 0.10 cm.	F 314	documented. These assessments were performed by teams composed on of one Registered Nurse and One Licensed Practical Nurse manager, initiated on 5-21 -14 and completed on 5-29-14. Any identified areas identified as not in compliance will be addressed immediately with Physician and Family notification of changes in condition and treatment interventions identified and implemented. 3. Measures/systems in place to ensure continued compliance are: Skin Risk Reviews will be completed on all new residents by the admitting nurse on the first day of admission with current interventions reviewed and call facility Physician or NP for any additional or change in orders. Every resident will have weekly skin assessments performed by a Nurse and documented on the Treatment record. Certified Nurse Assistants (C.N.A.□s) will observe each assigned resident skin when bathed and document findings on the facility Body Check Form. The nurse will also sign this form. The nurse will also be notified by the C.N.A should any open or unusual areas be identified during Bathing. Resident□s skin and wound issues will be discussed weekly at the facility wound meeting as well as the daily clinical meeting held by the Director of Nursing (DON). The need for physician orders or other nursing interventions will be decided and Care Plans updated. All licensed nurses will be in-serviced by	

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F 314	Continued From page 2 · Stage 2 pressure ulcer on the right buttock with measurements of 1.0 cm. by 1.0 cm. by 0.10 cm. · Stage 2 pressure ulcer on the right buttock with measurements of 0.5 cm. by 0.5 cm. by 0.10 cm. · Stage 2 pressure ulcer on the right buttock with measurements of 0.5 cm. by 0.5 cm. by 0.10 cm. · Stage 2 pressure ulcer on the sacrum with measurements of 2.50 cm. by 0.50 cm. by 0.10 cm. Interview with Nurse #1 on 05/14/14 at 9:29 AM revealed she did not complete the assigned weekly skin assessments for Resident #172. Nurse #2 explained she was new to the position and thought she "might have missed a few." Nurse #2 was unable to locate weekly skin check forms. Nurse #2 reported Resident #172 transferred to another nursing unit on 05/09/14. Observation on 05/15/14 at 10:22 AM revealed Nurse #3 changed Resident #172's dressing on the right buttock and sacrum. The soiled dressing contained a small amount of non-odorous yellow drainage. The sacral pressure sore was approximately 2.5 cm. by 1.0 cm by 0.1 cm. The pressure sore on the right buttock was approximately 2.0 cm. by 3.5 cm by 0.10 cm. Telephone interview with Nurse #1 on 05/15/14 at 10:39 AM revealed Nurse Aide (NA) #1 reported the open areas on 05/12/14. Nurse #1 reported she notified the physician and Resident #172's family member. Interview with the Director of Nursing on 05/15/14	F 314	6/14/2014 by the facility RN Staff development Coordinator. The content includes: Admission Assessments and documentation, Weekly Skin checks and documentation, C.N.A. Bathing Records. The Regional Wound Nurse Consultant in serviced Nurses on 6/4/2014 regarding prevention, treatment and staging wounds. This training is also designed to be a train the trainer program so that the SDC, DON or Nurse Managers can in-service other nurses and the C.N.A. staff on prevention techniques that include preventing shearing. All C.N.A.□s will be in serviced by the facility SDC starting 6/4/2014.and ending 6/14/2014 to include prevention of pressure ulcers and observing and reporting changes in resident□s skin condition to the charge nurse. Documentation requirements using the bathing record and communication will also be included in in-service. 4. Monitoring will be done by the Nurse Managers, SDC, week-end nurse supervisor and/or the DON making daily compliance rounds and document findings on the facility skin and wound compliance round prevention form. The Nurse mangers will also audit the documentation of weekly skin assessments and record on an audit tool titled weekly skin assessment documentation Nurses or C.N.A.□s identified as non-compliant will either be re-educated or disciplined as appropriate by the DON. These compliance rounds and audits will be completed daily for one month then	

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F 314	Continued From page 3 at 11:02 AM revealed Resident #172 did not receive a weekly skin assessment. The DON reported he expected the nurse to conduct a weekly skin assessment. The DON explained NAs also checked residents' skin every shower day. The DON provided a shower check sheet dated 05/10/14 which indicated Resident #172 refused a shower and had no skin problems. NA # 2, who completed the shower sheet dated 05/10/14, was not available for interview. Interview with Nurse #4 on 05/15/14 at 11:39 AM revealed four of the five pressure sores changed into one pressure sore on the right buttock since her assessment of the Stage 2 pressure sores on 05/13/14. Nurse #4 reported Resident #172's two Stage 2 pressure sores would be assessed by the Nurse Practitioner (NP). Interview with NA #3 on 05/15/14 at 12:10 PM revealed she cared for Resident #172 prior to the transfer to a new nursing unit of 05/09/14. NA #3 explained Resident #172 required extensive assistance with transfers but did not require repositioning in bed. NA #3 reported she would report any skin changes to the nurse and did not see any changes with Resident #172. Interview with the NP on 05/15/14 at 2:09 PM revealed she examined Resident #172's pressure sores and Resident #172's medical conditions placed her at risk for pressure sore development. The NP explained a likely contributing factor was shearing and then the areas worsened.	F 314	weekly for 3 months then monthly for 3 months. The DON will review the results of the audits and report to the QA&A committee monthly. Based on findings the committee will alter this plan where indicated.	