SATURN NURSING AND REHABILITATION CENTER

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(F 000) INITIAL COMMENTS

The Division of Health Service Regulation conducted an onsite revisit survey on 4/5/18. The facility was in substantial compliance as of 3/12/18.

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Electronically Signed

04/09/2018

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.
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<th>ID</th>
<th>PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
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<td>There were no deficiencies cited as a result of the complaint investigation. Event ID P4MO11.</td>
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