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 05/10/2018

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 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		5/18/18

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

Electronically Signed | 05/30/2018

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F 842	Continued From page 1 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to maintain accurate immunization records for 2 of 8 residents (Resident #1 and Resident #7). Findings included: A review of a facility policy titled, "Pneumococcal Vaccine" dated 11/2017 read in part, for residents who receive vaccines, the date of the vaccination, lot number, expiration date, person administering,	F 842	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	

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and the site of the vaccination should be documented in the resident's medical record.

1. Resident #1 was admitted to the facility on 6/25/04 and readmitted on 6/29/16. Diagnoses included anemia, hypertension, cerebral vascular accident (CVA), hemiparesis, depression, asthma, dysarthria, and delusional disorder.

A review of the quarterly Minimum Data Set (MDS) dated 5/7/18 had documentation indicating that Resident #1 was cognitively intact.

A review of the Informed Consent for Pneumococcal Immunization revealed Resident #1 gave a verbal consent to receive the vaccine on 4/4/18 and the verbal consent was witnessed by the Director of Nursing (DON).

A physician's order dated 4/6/18 read to give Prevnar 13 (pneumococcal vaccine) 0.5ml syringe, intramuscularly, one dose, with (body) temperature and injection site recorded.

A review of the Electronic Medication Administration Record (EMar) revealed, on 4/6/18, the initials of Nurse #2 were recorded with a temperature of 98.0 degrees Fahrenheit for Resident #1 at the time of the pneumococcal vaccine administration. The EMar also documented that the pneumococcal vaccination was given to the resident's right deltoid (uppermost part of the arm and the top of the shoulder).

A review of Resident #1's Immunization Record revealed Resident #1 received Prevnar 13 on 4/6/18 to the left upper extremity (LUA) by Nurse #3.

good faith attempts by the provider to continue to improve the quality of life of each resident.

F842
Root Cause Analysis
Based on root cause analysis by facility administrative staff, two facility nurses documented in the facility Immunization Log the opposite arm that the injection was administered.

Immediate Action
On 5/10/2018 the location site of the pneumococcal vaccine given to Residents #1 and #2 were correctly documented in the resident’s medical record. The Immunization Log for both residents was corrected to correspond with the resident’s medical record.
Identification of Others
On 5/10/2018 a 100% audit by nursing administrative staff was conducted for all resident Immunization Logs and medical record immunizations for accuracy. The audit was completed on 5/16/2018 with no further discrepancies.

Systemic Changes
Measures put into place to ensure the plan of correction is effective and remains in compliance are: On 5/10/2018 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) in-serviced all nursing staff on facility policy and procedure for medical record documentation. Nursing staff education

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F 842	Continued From page 3 An interview on 5/10/18 at 4:21pm with Nurse #2 revealed she cared for Resident #1 fulltime for the shift 3pm - 11pm. She stated she had given the pneumococcal vaccination to Resident #1 on 5/6/18. She stated it had been a busy night due to an emergency and had forgotten to write the vaccine information on the Immunization Record for Resident #1. She confirmed that she was the nurse that documented the vaccination on the EMar in the right deltoid. The next morning on 5/7/18 Nurse #2 called Nurse #3, working at the facility during 1st shift, and asked Nurse #3 to transcribe the lot #, expiration, and location of the injection to the Immunization Record and Nurse #3 agreed. Nurse#2 instructed Nurse #3 to document the vaccination was given by Nurse #2 in the right arm. During an interview with Nurse #2 on 5/10/18 at 7:06pm, Nurse #2 stated she remembered administering the pneumococcal vaccine to Resident #1's right deltoid. An interview on 5/10/18 at 7:18pm with Nurse #3 revealed there had been miscommunication between her and Nurse #2 regarding the location of the site where the pneumococcal vaccine was given and the site was written in error on the Immunization Record due to Nurse #3 waiting to record the information in the medical record versus recording the data immediately when Nurse #2 gave her the data to be transcribed. An interview on 5/10/18 at 4:25pm with Resident #1 revealed she had received the vaccine to her right arm. A review of the EMar for Resident #1 dated 5/6/18 revealed Nurse #2 administered the pneumococcal vaccine to the right deltoid.	F 842	will be completed by 5/18/2018. Any nursing staff member not educated by 5/18/2018 will not be allowed to work until receiving education. The education will also be included in the new hires orientation process effective 5/18/2018. Monitoring Process Starting 5/14/2018 a weekly Medical Record Audit Form will be conducted weekly for 10 resident medical records. The Medical Record Audit will be conducted by the nursing administrative 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 until a pattern of compliance is maintained. The Administrator and/or the DON will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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An interview on 5/10/18 at 7:13pm with the Administrator revealed his expectation was for the Immunization Record to be accurate with the correct site. He indicated he would prefer to have only one record to help with the chance of inaccurate documentation.

During an interview on 5/10/18 at 7:24pm, the Director of Nursing (DON) stated it was her expectation for the nurse to document the correct site of the injection on the Immunization Record and the EMar. She explained the importance of the correct site in case reactions occur such as swelling and infection. She indicated there was more chance for documentation error since two places needed to be recorded in records to vaccinations for the residents.

2. Review of the facility's Influenza Vaccination Policy and Procedures, dated November 2017, revealed the following, in part, for those who received the vaccine, the expiration date of the vaccination, the lot number and the injection site should be documented in the medical record.

Resident #7 was admitted to the facility on 2/11/10. Diagnoses included diabetes mellitus type 2 with long term insulin use, peripheral vascular disease and complete traumatic amputation of one right lesser toe, among others.

Review of the Informed Consent for Influenza Immunization revealed a verbal consent for the vaccine was given by Resident #7 on 2/13/18.

A physician's order dated 2/13/18 recorded to give Fluvirin (influenza vaccine) 0.5 ml syringe, intramuscularly, 1 dose with temperature and

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injection site recorded, monitor the temperature for 72 hours post influenza vaccination.

Review of the February 2018 medication administration record (MAR) revealed on 2/14/18 the initials of Nurse #1 was recorded with a temperature of 99.6 degrees Fahrenheit for Resident #7 at the time of administration. The MAR also documented that the influenza vaccine was administered to the Resident's left arm.

Review of Resident #7's immunization record revealed she received the influenza vaccine, on 2/14/18 to the right deltoid (right arm) by Nurse #1.

An annual minimum data set dated 4/13/18, assessed Resident #7 with impaired cognition and receipt of the influenza vaccine on 2/14/18.

A telephone interview occurred with Nurse #1 on 5/10/18 at 3:45 PM. Nurse #1 confirmed she administered the influenza vaccine to Resident #7 on 2/14/18. Nurse #1 stated she documented the Resident's temperature at the time of administration and the injection site on the MAR and updated the Resident's immunization record.

Resident #7 was observed seated in her wheel chair on 5/10/18 at 6:00 PM. She confirmed that she had recently received the influenza vaccine, but at the time of the interview, she could not recall the injection site.

An interview with the administrator occurred on 5/10/18 at 7:13 PM and revealed that he expected both the resident's immunization record and the MAR to both accurately record the correct injection site of the vaccine. He further

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stated that he would prefer that the nurses not have to document vaccinations on two records because this contributed to the chance of inaccurate documentation.

An interview with the director of nursing (DON) occurred on 5/10/18 at 7:24 PM. During the interview the DON stated that she expected nurses to document the injection site of the vaccination on the MAR and the immunization record and monitor the resident in the event of an adverse reaction like swelling or an infection at the injection site. The DON also stated that in order for the nurse to monitor the resident for an adverse reaction, the correct site of injection had to be documented. The DON stated that due to nurses documentation in 2 places there was more of a chance for documentation errors.

A follow up telephone interview with Nurse #1 occurred on 5/10/18 at 8:39 PM. Nurse #1 stated she recorded on the MAR that she administered the influenza vaccine to Resident #7's left arm, but recorded the injection site as the right deltoid (right arm) on the immunization record. Nurse #1 stated "It was an oversight. I can't recall right now which arm it was." She stated that it was important to document the location of the injection site so that staff could monitor the correct arm for redness/inflammation or any acute changes. She stated the accuracy of both records was important, otherwise staff would have to monitor both arms since the records did not match.