PRINTED: 11/07/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345489	B. WING		C 09/29/2022
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262	00/20/2022
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS		F 00	00	
	conducted on 09/21/2 credible allegation of on 9/29/22. Therefor to 09/29/22. 9 of the 4 were substantiated refollowing intakes were NC00193586, NC001 NC00193047, NC001 NC00191777, NC001	mplaint investigation was 2022 to 09/23/2022. The compliance was validated e, the exit date was changed 42 complaint allegations esulting in deficiencies. The e investigated NC00193590, 93350, NC00193220, 93043, NC00192864, 91403, and NC00109602. NC00193586, NC00193220 e jeopardy.Event ID			
	Immediate Jeopardy	was identified at:			
	(K)	600 at a scope and severity			
	The tags F600 and F6	610 constituted Substandard			
F 600 SS=K	removed on 09/24/22 was conducted. Free from Abuse and	began on 07/16/22 and was . A partial extended survey Neglect	F 60	00	10/22/22
	Exploitation The resident has the neglect, misappropria	m Abuse, Neglect, and right to be free from abuse, tion of resident property, efined in this subpart. This lited to freedom from			
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Electronically Signed 10/17/2022

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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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345489	B. WING		C 09/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/23/2022
	10115211 011 001 1 21211			1930 WEST SUGAR CREEK ROAD	
SATURN N	NURSING 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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 600	any physical or chem treat the resident's more state of the second involuntary seclusion; This REQUIREMENT by: Based on observation resident, staff, Physical and/or emotion residents sampled. The separate occasions. The separate occasions of the separate occasions of the separate occasions. The separate occasions of the separate occasions of the separate occasions. The separate occasions of the separate occasions of the separate occasions of the separate occasions. The separate occasions of the separate occasions occasions of the separate occasions of the separate occasions of the separate occasions of the separate occasions occasions of the separate occasions occasio	involuntary seclusion and ical restraint not required to edical symptoms.  y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced  n, record reviews and ician Assistant (PA), and ) interviews, the facility failed ights to be free from onal abuse for 4 of 4 ine abuse occurred on 4 The 53-year-old resident instory of aggressive is ed at and shook Resident in Resident #1 pushed an ident (Resident #4) to the lowed by Resident #1 a 67-year-old female in unched a 60-year-old male in unched a 60-year-old male in the chest, September, and threatened physical communication to a ident (Resident #3) in	F 600	, , , , , , , , , , , , , , , , , , ,	d to ele 22 and ian , ing
	wanderer, to the floor was removed on 09/2 implemented a credib	s a cognitively impaired  The immediate jeopardy  A/22 when the facility  allegation of immediate  facility will remain out of		resident was discharged from the facili on September 23, 2022. Resident remained on continuous 1on1 supervis on September 17, 2022, and this continued until his discharge.	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION		PLETED
		345489	B. WING _				C / <b>29/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	20/2022
				19	30 WEST SUGAR CREEK ROAD		
SATURN N	IURSING AND REHABII	LITATION CENTER		CH	HARLOTTE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From pag	e 2	F 6	000			
		scope and severity "E" (no re monitoring systems are			<ol> <li>Address how the facility will identife other residents having the potential to affected by the same deficient practice</li> </ol>	oe .	
	put into place are em	ective.			anected by the same delicient practice	•	
	The findings included	d:			On September 23, 2022, the Dietary Manager and the Unit manager complete.	eted	
	A review of a Facility	Reported Incident dated			interviews with all residents with a brief		
		indicated Resident #1 hit a			interview for mental status (BIMS) scor		
		3). The 5-Day Working			of 9 and higher on abuse to ensure that	t	
		icated on 09/10/21 Resident			no further incidents of physical and/or		
		a facility NA (unidentified in			emotional abuse. On September 23, 22	2	
		esident #8 and began calling			the Director of Nursing and the floor		
	-	ed both his hands on her and			nurses completed skins audits for any		
	began to shake her.				indications of abuse. No issues were identified.		
	1. Resident #1 was r	e-admitted to the facility on					
	03/23/21 with diagno	sis that included multiple					
	fractures following a	motor vehicle accident			3) Address what measures will be pu	t	
	(MVA).				into place or systemic changes made to ensure that the deficient practice will no		
	A quarterly Minimum	Data Set (MDS) dated			recur:		
	05/09/22 indicated R	esident #1 was cognitively					
		ent for all activities of daily			On 9/23/2022 all facility staff and agen		
		as identified as being			staff have been re-educated on the fac	ility	
		g no hands-on assistance)			policy of abuse to include 1 on 1		
		tance for activities of daily			supervision by the Director of Nursing.		
	living (ADL) and no b	ehaviors indicated.			Education included the facility policy fo		
	a Daaidant #4a	a admitted to the facility on			screening employees and volunteers p	rior	
		s admitted to the facility on			to working with residents. Screening		
	with behavioral distu	sis that included dementia			components include verification of references, certification and verification	of	
	with benavioral distu	ibances.			license and criminal backgrounds chec		
	An annual MDS date	d 05/13/22 indicated			The facility will not knowingly employ o		
	Resident #4 was cog				otherwise engage any individual convid		
		assistance for ambulation			of resident abuse, neglect, exploitation		
	and locomotion.				misappropriation of resident property, of mistreatment by a court of law or report	or	
	Resident #5 was adn	nitted to the facility on			abuse as noted by licensure boards or	.54	
		sis that included bipolar			registries. Resident rights and abuse		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		E SURVEY IPLETED
			A. BOILDING			С
		345489	B. WING		00	0/29/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	72072022
				1930 WEST SUGAR CREEK ROAD		
SATURN N	IURSING AND REHABIL	LITATION CENTER		CHARLOTTE, NC 28262		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 600	Continued From page	e 3	F 60	0		
	disorder.			prevention training for all emplo	oyees is	
				conducted during orientation, a	ind at lease	
	A quarterly MDS date	ed 5/13/22 indicated		annually, and includes review of		
	Resident #5 was cog	nitively intact.		policies and code of conduct, d	lefinitions	
				of abuse, resident's rights, abu	-	
		ted 7/16/22 at 6:35 AM filed		and exploitation policy and crite		
		name indicated Resident #1		assessing risk factors, manage		
		sident #4 out of his room		aggressive behavior, care of co		
	•	n an attempt to remove room which was witnessed		impaired, conflict resolution, str		
				management and signs of burn time of admission, each resider		
		ner girlfriend, (Resident #5) ent in the facility, whom		responsible party is informed or		
		e of a nurse aide (Nurse		resident's rights and the facility		
		ted Resident #4 to his feet		tolerance for any form of abuse		
	and away from Resid			zero-tolerance policy of abuse,		
	,			mistreatment, and misappropris	-	
	An additional inciden	t report dated 7/16/22 at 6:35		with reporting directions, is pos		
	AM filed under Resid	ent #4's name indicated		facility or given to the resident	upon	
	Resident #5 reported	she went to Resident #1's		admission and each employee	at	
		dicated when she started to		orientation. Staff are instructed	•	
		esident #4 in the doorway		any sign of stress from family o		
		up. Resident #5 indicated as		individuals involved with the res	sident that	
		o door to assist him to leave,		may lead to abuse, neglect or		
		ident #4 to get the "F*** out		misappropriation of resident pro		
		ceeded to get up from his		to intervene as appropriate. The	•	
	and Resident #5 imm	ident #4 down to the floor		protects residents and/or famili harm or retaliation during an ab		
	assistance. The incid			neglect investigation. Any pers		
		I this incident to Nurse Aide		persons accused or suspected		
	•	was visualized on all 4's		involvement in resident abuse,		
		the floor in the hallway		misappropriation of resident pro	•	
		1's room where she picked		immediately suspended for the	•	
		small abrasion over his right		the investigation pending the o		
		rovided treatment to the		the investigation. Patient protect		
	area, and Resident#	4 was escorted to the lobby		actions include immediately rer	moving the	
		ocal police department were		patient from contact with allege		
	notified.			during the investigation. If the a	-	
				abuser is not an employee, me		
	An investigation repo	rt document provided by the		taken to provide a safe, secure		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′				
			, Boilest	_		، ا	
		345489	B. WING				29/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	23/2022
					930 WEST SUGAR CREEK ROAD		
SATURN N	NURSING AND REHAB	ILITATION CENTER			CHARLOTTE, NC 28262		
	OLIMAN A PV	DTATEMENT OF DEFICIENCIES			<u> </u>		0.45
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From pag	ge 4	F	600			
	facility indicated on	07/16/22 at approximately			environment for the patient. Action may	,	
		#4 was found on the floor			include patient room change, patient d		
	outside the room of	Resident #1. It indicated			schedule change, visitor restrictions,		
	Resident #5 had ap	proached a Nurse Aide (NA			reporting to other agencies or law		
	#1) to report she ha	d witnessed Resident #1 push			enforcement. Starting 9/23/2022,		
		nis room. Resident #4 was			residents who return into the facility aft	er	
		s and found to have an			hours and are 1 on 1 recipients, the		
		eyebrow and treatment was			receptionist will ensure 1 on 1 placeme		
	•	#4 was taken to the common			is implemented for the resident prior to		
		1:1 for a week due to his high			their entrance back into the facility. The	<b>;</b>	
		nd exit seeking behaviors. partment was alerted of the			receptionist will communicate with the	<b>.</b>	
	· ·	onsite counseled Resident #1			resident's assigned nurse at the time o return into the facility to escort the patie		
		with other residents when			back to their room and assign a	7111	
		termined Resident #1 had			scheduled certified nursing		
		tly since admission and no			assistant/designee to stay with the pati	ent	
		ed nursing care and issued a			until shift change. The receptionist will		
	_	otice to Resident #1 who			the administrator immediately and the		
	appealed the decisi	on for discharge.			administrator will coordinate the sched	ule	
					of 1 on 1 for the returned resident. If th	e	
		7/16/22 written by the former			resident has another leave of absence	'	
		ealed NA #1 stopped her in			the receptionist will call the administrat		
		t 6:15 AM to report that			immediately for instructions. On 9/23/2	022	
		shed Resident #4 to the floor.			all receptionists were educated by the		
	•	NA#1 told her Resident #5			administrator on this responsibility. As		
		room when the incident			staff come into work the Administrator		
		who was present on the hall nen the Administrator was			and/or administrative designee determines which staff have not done		
	made aware.	len the Administrator was			in-servicing using a logged staffing ros	or	
	made aware.				for all staff, all departments and those		
	A statement dated 7	7/16/22 written by NA #1			displayed are provided the necessary		
		Resident #1 yelling when she			education and sign documentation prior	r to	
		what was going on she saw			beginning their shift. Human Resource		
		n the room of Resident #1			will ensure all new hire orientation on		
	"out the door". NA#	t1 asked Resident #1 if he			facility abuse policy during orientation.	On	
	·	I, but he denied it and said he			09/23/2022 Human Resource Manage		
	•	e she asked Resident #5 what			was educated to this responsibility by t	ne	
		dent #5 again verified			Administrator.		
	Resident #1 pushed	d Resident #4 out of his room.					

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		345489	B. WING		C 09/29/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/29/2022
				1930 WEST SUGAR CREEK ROAD	
SATURN I	NURSING AND REHABI	LITATION CENTER		CHARLOTTE, NC 28262	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 600	Continued From pag	e 5	F 60	0	
	Resident #5 indicate at approximately 6:3 #1. While in the room the room and she as she was going to atte Resident #1 yelled a out of here and procepushed Resident #4 get help. The statem saw Resident #4 on and took him to the other and took him to the other and took him to the other are are over A statement written be indicated she heard turned around and sand knees in a crawl down outside of Reswas assessed to have forehead similar to a indicated Resident #4 A statement written be dated 7/18/22 indicated T/18/22 indicated pushing Resident #4 A statement written be dated 7/18/22 indicated pushing Resident #4 Round Sheets" dated 7/23/22, and 7/24/22 Resident #4; however included in these recommends.	t Resident #4 to "get the F*** eeded to get out of bed and to the floor. Then she left to ent further details the NA the floor and helped him up couch to sit down and then to talk to him.  by Nurse #1 dated 7/16/22 a thud on the hallway and aw Resident #4 on his hands ing position with his head ident #1's door. Resident #4 we a small blister on his carpet burn. The note 1 later in the day did admit to because he was in his room.  by the Social Worker (SW) #1 ted Resident #1 was and the Administrator and dent #4 and claimed he elace when he wandered into		4) Indicate how the facility plans to monitor its performance to make susplicted solutions are sustained:  Starting on 09/23/2022 the Administ and or / designee will interview 5 redaily Monday through Friday for 4 vithen 5 residents 3 times a week for weeks and 5 residents weekly for 4 to ensure abuse has not occurred to asking if any staff, other residents, visitors have exhibited aggressive of intimidating behaviors, verbal, or phabuse toward them.  The Director of Nursing and/or Administrative Nurse will complete summary of audit results and present the facility, monthly Quality Assurar Performance Improvement meeting ensure continued compliance.  5) Compliance Date: 10/22/2022	erre that estrator esidents eveeks, 4 eweeks ey or or or hysical  a ent at hoce

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  IG	(X3	(X3) DATE SURVEY COMPLETED		
		345489	B. WING			C <b>09/29/2022</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		09/29/2022	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	15-minute (q15 min) staff are to documer designated resident timeline basis.  A review of email co county Ombudsman dated 07/21/22 throu 07/21/22, the facility the Ombudsman to visit to review some facility. The Ombuds visit the facility on 07 correspondence corrup on resources for support at the facility indicated she would answers when they will answers when they will answer to touching FR Resident #1 would not be related to touching FR Resident #4 was conterefore could not be survey.  Resident #5 was no facility and her phonomas no longer a wor could not be intervied.  Resident #6 was 1/28/22 with diagnostic statement with diagnostic statement was not some could not be intervied.	respondence between the and the Facility Administrator ugh 07/28/22 indicated on Administrator reached out to request an in-person facility ongoing concerns of the sman responded she would 7/26/22 at 1:30 PM. Additional attinued on 07/28/22 to follow available law enforcement of which the Ombudsman be back in touch with were available.	F 6				
	A significant change	MDS dated 08/11/22					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345489	B. WING _			C <b>09/29/2022</b>
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		33/20/2322
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA	
F 600	indicated Resident # was independent for Resident #7 was add 5/13/22 with diagnost infarction.  A MDS dated 7/28/2 cognitively intact.  An incident report date Resident #6 reported her wrist and twisted bruising. Resident # slapped him across and the courtyard smoking employee was attern Resident #1 wrote the move so he got the late the area. Resident # slapped him so he go hand up and then let the area written the Resident #6 written with the area the written with the sident #6 smoking courtyard befriends when the mate attempting to blow the blower. Resident #6 running his mouth and conversation off where we have a sked the blower to help. Belower and he began	6 was cognitively intact and all activities of daily living.  mitted to the facility on is that included cerebral  2 indicated Resident #7 was  ated 08/18/22 indicated dathat Resident #1 grabbed it which resulted in visible 1 indicated Resident #6 the face.  by Resident #1 dated e and Resident #6 were in any while the maintenance upting to clean the area. The properties of the face while the maintenance in the properties of the face of the face.  by the SW #1 on behalf of the face	F	600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S					
		345489	B. WING _			09/2	29/2022
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STAT 1930 WEST SUGAR CREEK CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)	<b>I</b>	(X5) COMPLETION DATE
F 600	to "stop that". Reside grabbed her left wrish him to turn her loose Resident #1 told her F***** wrist". Reside Resident #1 on the hand Resident #1 aga and stated if she even he would kill her and entered the building.  A written statement building area cleaning the area employee wrote he wolden Resident #1 in the factean the way so the clear the area becaut ground that needed to the review of documents.	ent #6 stated Resident #1 t and twisted it and she told . Resident #6 stated he would break her "M***** ent #6 admitted she tapped lead trying to get him to stop in threatened Resident #6 or put her hands on him again he rolled off and she to report what happened.  By the Maintenance employee lated he was outside in the lea. The Maintenance witnessed Resident #6 slap loce because he was trying to Maintenance man could lise there was stuff on the loc be picked up.  Its provided by the facility Sheet" with Resident #1's leat top dated 08/18/22,	F	500	EFICIENCY)		
	indicated on the first 08/18/22 at 3:30 PM identified to be in var facility until 6:45 AM page of the documer AM on 08/19/22 and the facility for leave or resident can sign the spend time in the cor 2:15 PM; however, R documentation reflect facility in stable cond and did not indicate with the corresponding to the second stable conditions are second significant.	sheet was initiated on and Resident #1 was ious locations throughout the on 08/19/22. The second in indicated it began at 7:00 indicated Resident #1 left of absence (LOA- where the imselves out of the facility to immunity unsupervised) at Resident #1's nurse sted Resident #1 left the ition at 3:19 PM on 08/19/22 when he returned to the edocument titled, Action					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345489	B. WING		C <b>09/29/2022</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262	1 03/23/2022	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 600	however, did not re on that date. Page Resident #1 did no PM on 8/20/22 and monitored through facility's document should include 8/22 to reflect q15 minut whereabouts from 8/23/22. The Action not indicate the len be placed on 1:1 st A grievance and coa resolution signed contacted due to the Documents provide 08/18/22 indicated were interviewed o comfortable at the residents indicated questionnaires and to the resident's indicated fuestionnaires and to the resident's indicated Resident #6 as we part of the #1 and Resident #6 discuss which part said is correct."  An additional intervent #7 in the presence 08/25/22 indicated Resident #6 exchains which part said is correct.	t being on LOA until 7:00 PM; ifflect he returned to the facility 3 of the document indicated t return to the facility until 5:15 only indicated he was 7:00 PM on this date. The had page 4 missing which 2/22 and continued with page 5 the checks for Resident #1's 7:00 AM until 9:30 AM on a Round Sheets provided did gth of time Resident #1 was to upervision.	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345489	B. WING		,	C <b>)9/29/2022</b>
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		3312312022
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	An interview with Resident #6. The on would provide relate neither decided to relate the incident between #6 on 08/18/22 which the facility while they Resident #6 indicate maintenance employ courtyard using a least incompared to the resident #6 stated for the cut her conversati and told him he was quit interrupting her. Resident #1 asked to use the leaf blower of Resident #1 picked blowing the cigarette Resident #6 causing butts to fly up on Re Resident #6 says she then pointed the it touched her pants.	ated he did not witness esident #6's arm.  esident #1 on 09/21/22 at ne would not discuss the incident between him and ly discussion Resident #1 d to the incident was that ress charges on the other oth "having a bad day."  esident #6 and Resident #7 on M revealed they both recalled in Resident #1 and Resident th occurred in the courtyard of M were all gathered to smoke.	F 60	<u> </u>		
	grabbed her arm and attempt to get Resid open handedly popp the head before he l	d twisted it. In Resident #6's ent #1 to let go, she then led Resident #1 on the side of et go. Resident #6 and led Resident #1 told her he				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	COMF	(X3) DATE SURVEY COMPLETED		
		345489	B. WING		ı	C / <b>29/2022</b>	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	05	23/2022	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 600	letting her go. Immed Resident #6 and Resident #6 and Resident #7 stated Farea of the courtyard didn't like to get involumental personal p	diately following the incident, sident #7 in agreement 1 stated, "If you ever put your e again, I'll kill you." Resident he courtyard to alert staff and desident #1 went to another 1. Resident #7 stated he lived because "that stuff e all of the time, do you e?"  Is admitted to the facility on sis that included dementia, and cerebral infarction.  Sed 08/10/22 indicated initively intact and required	F 60	00			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345489	B. WING _			C 09/29/2022	
	ROVIDER OR SUPPLIER	ILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	An interview with Re 11:15 AM revealed between himself an immediately said, "I him to quit yelling be everyone." He furthelie on me. I don't hu council president ar other residents and repaid. I watch after  An interview with Re AM revealed he recently come into hurt him. Resident # himself if Resident # fearful he would cor Resident #3 commutation for the council was alone because fearful.  Interview with the Among that the courred on the course fearful.	ge 12 counds were made to observe the the remainder of the shift.  esident #1 on 09/21/22 at the recalled the interaction of Resident #3; however, didn't touch him, I just told ecause he was disturbing er vocalized, "the staff always at anyone. I am the resident of I do all kinds of things for staff and this is how I am all of these residents."  esident #3 on 09/22/22 at 9:20 alled Resident #1 making ents and cursing profanity tiple incidents over the last andicated Resident #1 had his room and threatened to the stated he could not defend the was glad Resident to a pipe because he felts are to a pipe because he felts are to a pipe because he felts and they have observed from before but they don't do the esident #3 stated after the 2, he ended up crying after he he felt so frightened and diministrator on 09/22/22 at the was not made aware of the sident #1 towards Resident #3 and they have don't do the felt so frightened and diministrator on 09/22/22 at the was not made aware of the sident #1 towards Resident #3 and they have don't do the felt so frightened and diministrator on 09/22/22 at the was not made aware of the sident #1 towards Resident #3 and they have don't do the felt so frightened and they have don't do the felt so frightened and diministrator on 09/22/22 at the was not made aware of the sident #1 towards Resident #3 and they have don't do the felt so frightened of the sident #1 towards Resident #3 and they have don't do the felt so frightened of the sident #1 towards Resident #3 and they have don't do the felt so frightened of the sident #1 towards Resident #3 and they have don't do the felt so frightened of the sident #1 towards Resident #3 and they have don't do the felt so frightened of the sident #1 towards Resident #3 and they have don't do the felt so frightened of the sident #1 towards Resident #3 and they have don't do the felt so frightened and they have don't do the felt so frightened and they have don't do the felt so frightened and they have don't do they have don't do they have don't do	F				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			l	C <b>29/2022</b>	
	ROVIDER OR SUPPLIER			1930	EET ADDRESS, CITY, STATE, ZIP CODE  WEST SUGAR CREEK ROAD  ARLOTTE, NC 28262	<u>  03/</u>	25/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	meeting and the team Resident #3 because episodes. He stated to #3's roommate at the adjustments at the enthought was correctin 9/14/22 the PA had sathe changes had not it yelling out had increa Administrator stated to issue Resident #1 and unsuccessful in secure d. Resident #2 was 5/12/22 with diagnosist disease, cognitive condysarthria.  The quarterly MDS da Resident #2 was cognimited to extensive as Review of the inciden 10:50 AM indicated Resident #2 in the chart had been adjusted to the HR May 17/22 indicated she she heard yelling compunch Resident #2 in her desk and ran outstands.	y 9/12/22 during morning had the PA to evaluate of his recent yelling he facility moved Resident time and made medication d of August which he g the problem but on aw Resident #3 again and mproved the situation and sed again. The he facility had attempted to ischarge but had been ing him placement.  admitted to the facility on a that included Parkinson's mmunication deficit, and atted 8/22/22 indicated hitively intact and required esistance for ADL.  It report dated 9/17/22 at esident #1 punched est which was witnessed by a Manager (HR) through her is adjacent to one of the retyards.  anager's Statement dated was sitting in her office and hing from Resident #1. She we to witness Resident #1 the chest. She got up from side. She wrote she did not but started calling his	F	500				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDI				
		345489	B. WING			09/2	29/2022
	ROVIDER OR SUPPLIER	BILITATION CENTER	•	STREET ADDRESS, 1930 WEST SUGA CHARLOTTE, N			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B -REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	3:40 PM revealed time of the interact Resident #2 on 09 indicated she hear heard Resident #1 in front of her wind Manager said she what was going or punch Resident #2 she immediately gapproached the sradjacent. The HR the doorway of the #1's name before speaking to him. Soutside to physica because Resident Resident #2. The Resident #1 acknowas when the curr (Scheduling Coordand went outside this room and the Harea and went to redirector and had resident with the resident with the second wi	she HR Manager on 09/21/22 at she was in her office at the tion between Resident #1 and /17/22. The HR Manager d a commotion outside and yelling because they were right low of her office. The HR turned to look outside to see and witnessed Resident #1 in the chest. She indicated of up from her office and noking courtyard which was Manager stated she stood in a courtyard hollering Resident the acknowledged she was the indicated she did not go ally intervene at that time #1 was no longer punching HR Manager said when by ledged her calling his name ent Scheduling Coordinator linator #2) approached the area of tell Resident #2 to go back to HR Manager said she left the eport the incident to the Activity to further involvement in the he Activity Director (AD) on M revealed she was on duty on the HR Manager reported to her are AD indicated she did not between the residents, e Manager on Duty and the	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345489	B. WING _			C <b>09/29/2022</b>	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		03/23/2022	
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	to the facility when sileave her office and in Resident #1 that he canother resident. The stated she immediate courtyard area and puthe doorway and were #2 to leave the courty room.  A progress note date written by the Activity reported to her that Fresident in the chest was removed from the detailed no injuries was removed from the detailed no injuries was refused. He was told same courtyard, but to smoke with supervin the building investit the police and zoome wheelchair while he was told same to the sa	e 15 anding at the front entrance he saw the HR Manager heard her shouting at could not put his hands on e Scheduling Coordinator #2 ely went towards the smoking assed the HR Manager in hit outside and told Resident yard and go back to his  d 9/17/22 at 12:13 PM or Director indicated staff Resident #1 punched another in the courtyard. Resident #2 he area at that time. It further here observed at the time. he was not to smoke in the to go out front and to the left orision. While the police were legating, Resident #1 yelled at ed away from them in his was being interviewed. The Duty and Administrator were	F 6	00			
	11:15 AM revealed h Resident #2 and said him". He did admit he courtyard on 9/17/22 observed Resident # Resident #2 had rem smoking ashtray and cigarette butts when ashtray lid from Resi	e denied punching/hitting If the staff were "lying on was out in the smoking at about 10-11 AM when he coutside. He indicated oved the lid from the was attempting to retrieve he intervened and took the dent #2. Resident #1 stated broached the area after he					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345489	B. WING		C <b>09/29/2022</b>
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262	1 00/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY 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 COMPLETION
F 600	not be digging in the hitting Resident #2. on 1:1 observation to be babysat so he himself out of the faput back on 1:1 unt being called to the hincident that occurred. An interview with R PM revealed he wa 9/17/22 attempting the ashtray because to purchase more. If #1 approached him back/side (flank are ashtray from him ar after this a staff me courtyard and told if Resident #2 said he he was fearful of Rebehavior in the future.	2 out and told him he could e ashtray and accused him of He stated the facility put him that day, but he did not want e called a friend and signed acility. He stated he was not il Monday afternoon following Administrator's office about the ed on 9/17/22.  esident #2 on 09/22/22 at 4:30 s out in the courtyard on to retrieve cigarette butts from e he had no money currently Resident #2 stated Resident punched him in the chest and ea) then grabbed the lid of the ind it fell to the ground. Shortly mber approached the him to go back to his room. e didn't get hurt that day, but esident #1 repeating this re.	F 60		
	11:27 AM revealed Resident #1 and Redid not provide any current status or the the facility was in the Resident #1 dischat A telephone intervier 1:30 PM revealed states	e Administrator on 09/22/22 at the investigation regarding esident #2 was ongoing and further details regarding its e root cause. He simply stated be process of planning to get reged from the facility.  Ew with the PA on 09/22/22 at the was familiar with Resident			
	of care and posed a the facility as a resu She stated she was	not appropriate for skilled level a threat to other residents in all of his aggressive behaviors. It made aware of the incident #1 and Resident #2 when she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _		_	09/2	; 29/2022	
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STA 1930 WEST SUGAR CREEK CHARLOTTE, NC 28262	ROAD	, , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	was 3 days following assessed Resident # find obvious physical not visit Resident #1 was aware he was kn have the ability to hid the Medical Director minimizing a lot of the An interview with the PM revealed he had the interaction betwee #2 which occurred or feel Resident #1 was of care and felt he ned different type of setting functioning abilities. That known outburst is lack of concern for of no way." The MD als physical independent behavior with physical independent behavior with physical towards others he poresidents who remain.  The Administrator, Dimembers of the corpimmediate jeopardy of the facility provided jeopardy plan for remindent in the facility those recipies are likely to suffer, a because of the non-control of the facility failed to part of the fa	g on Tuesday 09/20/22 which the event. She stated she 2 at that the time and did not injuries and stated she did on that date; however, she nown to be manipulative and e his outburst from her and during their visits by details that transpired.  MD on 09/22/22 at 12:57 not yet been made aware of en Resident #1 and Resident a 09/17/22; however, did not appropriate for skilled level eded to be discharged to a neg due to his high physical The MD stated Resident #1 behaviors and a complete hers, "he wants it his way or or indicated due to his se and his disruptive all and verbal aggression sed a risk to all other in the facility at present.  Trector of Nursing, and 2 corate staff were notified of on 09/22/22 at 6:15 PM.  The following immediate noval:	F	500				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING				29/2022
	ROVIDER OR SUPPLIER	ITATION CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	1 00.	
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page		F	600			
		used 4 residents. Residents endured bruising and verbal					
	Dietary Manager/Unit interviews with all res for Mental Status (BIN abuse to ensure no fu Director of Nursing ar skin audits for signs of all residents with a BI	idents with a Brief Interview MS) score of 9 or higher on urther incidents of abuse. In the floor nurses completed of abuse as of 9/23/2022 for MS score of 8 or lower.					
	resident #4 causing ro Nurse #1 immediately confrontation. Nurse is and Resident #4 by h room and Resident #- monitoring by nursing monitoring for Reside Nurse #1 provided as first aid. Police were on 7/16/2022 immedia Police officer interview informed him that he residents. Facility Adn Resident #4 was wan room uninvited. On 7/ Director of Nursing, Sidetermined that Reside Skilled Nursing Level informed Social Work process for Resident Living. On 7/18/2022	#1 separated Resident #1 aving Resident #1 stay in his 4 was placed on 1 on 1 gassistant #1. 1 on 1 ent # 4 was for 72 hours. esistance to Resident #4 and contacted by Administrator ately following notification. wed Resident #1 and cannot push or touch other ministrator determined that dering into Resident #1's /18/2022 Administrator, Social Worker, and Physician dent #1 no longer required care. Administrator er to start discharge #1 for placement in Assisted Social Worker started					
	living facilities for place Administrator had a co	s information to assisted cement. On 7/18/2022 onversation with Resident#1 cies about touching and or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING _				29/ <b>2022</b>
NAME OF PI	ROVIDER OR SUPPLIER		_ l	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 037	23/2022
SATIIDN N	NURSING AND REHABIL	ITATION CENTER		1	930 WEST SUGAR CREEK ROAD		
SAIURNI	TORSING AND REHABIL	HATION CENTER		C	CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page		F	300			
F 600	engaging in confrontal Resident #1 informed understood. Administ supervision with Resistarting 7/16/22 throughthat resident #1 was a related to Resident #4 refusing to leave. As including agency staff abuse policy related to abuse.  On 8/18/2022 it was a that Resident #1 grabiliting her off the grough Resident #1 and Resistent #1 and Resistent #1 and Resident #1 and Resident #1 and 1 supervision on prevent any further in contacted the police of incident on 8/18/2022 notification of incident investigation of the in Beginning on 8/18/20 Nursing, Social Work	ation with other residents.  I Administrator that he rator continued 1 on 1 dent #1 for one week gh 7/24/22 and determined not a risk to other residents 4 entering his room and of 7/21/2022 all staff f were re-educated on facility to preventing and reporting reported to Social Worker obed Resident #6's wrist and in the smoking area. Ident #6 were immediately staff. Facility Administrator 2022 by facility staff of the was immediately placed on 18/18/2022 for 96 hours to cidents. Administrator department of the alleged 2 immediately following to Administrator started the cident on 8/18/2022.  22 Administrator, Director of er and Activities Director		500			
	score of 10 or higher	I residents with a BIMS as well as witness Resident ere in the smoking area at 18/22. During the					
	investigation and witr determined by the Ad had slapped Residen grabbing Resident #6 determined that Residenter residents in the Officer counseled Residents	ness interviews it was ministrator that Resident #6 t #1 prior to Resident #1 s wrist. Administrator dent #1 was not a danger to facility. On 8/18/2022 Police					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING				29/2022
	ROVIDER OR SUPPLIER	LITATION CENTER	•	19	TREET ADDRESS, CITY, STATE, ZIP CODE 930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)			(X5) COMPLETION DATE
F 600	looking for alternate Living facility for Res Director of Nursing reagency staff on facility reporting and prevent On 9/9/22 Resident profanity at Resident stop yelling or he wo nurse #1. Nurse #1 Resident #1 from Recontinued to monitor night to ensure he dir room. Nurse #1 docuwas noted to be with incident.  On 9/17/2022 Resides moking area by Hurpunching Resident #Resource Director im deescalated the resid Director separate Re	e 20 ischarge process and were placement in an Assisted ident #1. Administrator and e-educated all staff to include ty abuse policy regarding ting abuse as of 8/22/2022.  #1 was heard yelling with #3 in Resident #3's room to uld make him shut up by immediately removed sident #3's room. Nurse Resident #1 throughout the d not return to Resident #3's imented that Resident #3 out distress following the ent #1 was seen in the man Resource Manager (HR) 2 in the chest. Human imediately went outside and dents and had the Activity sident #1 and Resident #2. ited the Administrator on	F	600			
	immediately informed Operations of the incomplete Director of Operation Administrator to start Resident #1 until Administrator in Assisted Resident #1 on 1 on 9/17/2022 with no en investigation of allegoracility has continued looking for alternative	1 on 1 supervision of ministrator can get Resident I Living. Administrator placed 1 supervision beginning I date. Administrator began ed incident on 9/17/2022.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345489	B. WING		09/29/2022
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	1 00/20/2022
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 600	removed Resident a immediately and co supervision. Reside outside visit and fact returned at that time Facility receptionist resident requiring 1 Regional Clinical Dino resident with 1 or facility until 1 on 1 eresident into facility. Director of Nursing includes residents wafter hours and are placed back upon refacility.  Specify the action the process or system fadverse outcome frowhen the action will have been re-educated abuse to include 1 or Director of Nursing. Policy for screening prior to working with components include certification and ver criminal background knowingly employ or individual convicted exploitation, misapp property, or mistreal reported abuse as reported abuse as resported abuse as response.	y at Resident #3. Nurse #1 #1 from Resident #3's room ntinued his 1 on 1 ent #1 had returned from cility wasn't aware he had e and 1 on 1 was not in place. has been in-serviced on on 1 supervision by the rector on 9/23/2022 to ensure en 1 in place return into the employee accompanies . All staff in-serviced by on 1 on 1 requirements which who return back to the facility on 1 on 1 and should be esident entrance into the the entity will take to alter the failure to prevent a serious om occurring or recurring, and	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345489	B. WING				C	
NAME OF D	DOVIDED OD CUDDUED	343469	B. WING _	CTDE	TARRESC CITY CTATE ZIR CORE	09/	/29/2022	
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE			
SATURN N	NURSING AND REHA	ABILITATION CENTER			WEST SUGAR CREEK ROAD			
				CHAF	RLOTTE, NC 28262			
(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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	Continued From p	page 22	F	600				
	orientation, and a	t lease annually, and includes						
		policies and code of conduct,						
		se, resident's rights, abuse,						
		itation policy and criteria for						
	assessing risk fac	tors, management of						
	aggressive behav	ior, care of cognitively impaired,						
		, stress management and signs						
		time of admission, each						
	resident and response							
		nd the facility's zero tolerance						
	for any form of ab							
	abuse, neglect, m							
		along with reporting directions, cility or given to the resident						
		nd each employee at						
		s instructed to report any sign of						
		or other individuals involved						
		hat may lead to abuse, neglect						
		on of resident property and to						
		opriate. The facility protects						
	residents and/or fa	amilies from harm or retaliation						
	during an abuse o	or neglect investigation. Any						
		s accused or suspected of						
		sident abuse, neglect or						
		of resident property is						
		ended for the course of the						
		ling the outcome of the						
		ent protection actions include						
		ving the patient from contact						
	_	er during the investigation. If the						
		not an employee, measures are safe, secure environment for						
		n may include: patient room						
	l '	aily schedule change, visitor						
		ting to other agencies or law						
		ting 9/23/2022, residents who						
		ne facility after hours and are 1						
		e receptionist will ensure 1 on 1						
		emented for the resident prior to						

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C 9/29/2022	
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	•	312312022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	will communicate winurse at the time of escort patient back to scheduled certified rostay with patient untime will call administrator administrator will condition the returned reanother leave of about the administrator on this into work the Administrator on the in-servicing using a staff, all departments provided the necess documentation prior Human Resources worientation on facility orientation. On 09/2: Manager was educated the Administrator.  Starting 09/23/2022 and/or Administrator daily Monday through residents 3 times a versidents weekly for	nto the facility. Receptionist th the resident's assigned return back into the facility to their room and assign a nursing assistant/designee to all shift change. Receptionist in immediately and the ordinate the schedule of 1 on sident. If the resident has beence, the receptionist will call mediately for instruction. On onists were educated by the responsibility. As staff come strator and/or administrative is which staff have not done and those not displayed are any education and sign to beginning their shift. Will ensure all new hire a buse policy during 3/2022 Human Resource ted to this responsibility by the Director of Nursing will interview 5 residents he Friday for 4 weeks, then 5 week for 4 weeks and 5 4 weeks to ensure there has and at risk for abuse.	F6				
	placement for Resid contacted shelter re- 9/23/2022 men's she #1 and he will discha Nursing informed Re	lity has secured alternate ent #1. Activities Director garding resident #1. On elter agreed to take Resident arge on 9/23/2022. Director of esident #1 of the discharge and Resident #1 agreed to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C 9/29/2022	
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		9/29/2022	
(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 DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	On 9/29/22 the facility Immediate Jeopardy validated. The validatinterviews, resident in and review of in-serving In-service attendance been in-serviced on Antervention, Reporting One on One Supervisice and Process of volunteers prior to resoft convicted resident misappropriation of remistreatment. Interview Receptionist and Nurnever to leave a resident with the sudifficial one supervised with conducted with staff for disciplines, and interview in the sudifficial of the sudifficial o	pardy removed: 9/24/2022  y's credible allegation of removal date of 9/24/22 was atton was evidenced by staff interviews, record reviews, ice attendance sheets. It is sheets revealed staff had abuse, Prevention, and Investigation and ision. Interviews with staff of screening staff and isident interaction for reports abuse, neglect, exploitation, resident property or rews conducted with the sing staff revealed staff were altern who received one on the staff present. Interviews from all shifts and all views conducted with mowledge of the zero olicy. Resident interviews arough Friday are in place is reviewed.  Abuse/Neglect Policies —(3)	F 6			10/22/22	
	§483.12(b)(1) Prohibineglect, and exploitation of re	icies and procedures that: it and prevent abuse, ion of residents and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345489	B. WING			C 9/29/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		9/29/2022	
				1930 WEST SUGAR CREEK ROAD			
SATURN N	NURSING AND REHABIL	ITATION CENTER		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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 607	Continued From page	e 25	F 6	07			
	to investigate any suc	ch allegations, and					
	paragraph §483.95, This REQUIREMENT by: Based on record rev	e training as required at  is not met as evidenced  iews and staff interviews, the		Address how corrective a			
	area of reporting an a State Agency (SA) wh aware Resident #1 m	ent their abuse policy in the allegation of abuse to the hen the facility was made nade verbal threats towards		accomplished for those reside have been affected by the def practice:	icient		
	another resident (Res residents reviewed fo	•		On 09/09/2022 Nurse #3 docu overheard Resident # 1 yelling and making verbal threats tow	g, cursing		
	The findings included	l:		Resident #3. Nurse #3 reques Resident #1 to leave the room	sted		
	Prevention, Intervent Investigation" dated r alleged violations inve immediately, but not allegation is made. T provided to the facility	revised 02/2021 indicated all olving abuse are reported later than 2 hours after the		out of Resident # 3's room wit 1 adhering to the request. Res was assessed and was found distress. The hallway nurse w about the incident by Nurse # advised her to monitor Reside any further behaviors. The Dir Nursing was made aware of the on 09/09/2022.  On 09/19/2022 Nurse #4 wither	th resident # sident # 3 without any as told 3 who ent #1 for rector of the incident		
	Resident #1 was ove and cursing. When sl overheard Resident # #3, "If you don't shut time, I am going to do yelling." The note ind to leave the room and to be in Resident #2's stated Resident #1 w	e dated 09/09/22 indicated rheard by Nurse #3 yelling the arrived at the room, she #1 communicate to Resident the f*** up yelling all the posomething to help you stop icated she told Resident #1 dd that he was not supposed is room. The note further theeled off down the hallway and the incident to the Director		Resident #1 using threating pit towards Resident 3 after being multiple times to stay out of the room. Resident #1 was assist Resident's #3 room by a nurse facility did not report the allegation abuse to the State Agency who became aware. Both allegation reported to the State Agency of 2.  Address how the facility wother residents having the pot affected by the same deficient	rofanity g told he resident's hed out of he aide. The hation of hen they he were he on 9/23/22.  will identify hential to be		

AND DLAN OF COPPECTION INDENTIFICATION NUMBER:		` ′				SURVEY LETED	
		345489	B. WING _				29/ <b>2022</b>
	ROVIDER OR SUPPLIER	ITATION CENTER		19	TREET ADDRESS, CITY, STATE, ZIP CODE 930 WEST SUGAR CREEK ROAD HARLOTTE, NC 28262	, 55	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	09/19/22 indicated Re observed by staff usir towards Resident #3 times to stay out of of unidentified NA assist room and frequent roof for behaviors through A review of the Facilit log indicated the incide and Resident #3 was during the required tirthe initial report.  Interview with the Adr 11:27 AM revealed he verbal threat by Resident that occurred on the roon Friday, 9/9/22, but interaction on Monday meeting. He indicated reportable incident reallegation of abuse the	e written by Nurse #4 dated	F	607	On September 23, 2022, the Dietary manager and the unit manager completed interviews with all residents with a brief interview for mental status (BIMS) score of 9 and higher on abuse ensure that no further incidents of physical and/or emotional abuse. On 10/16/2022 the facility administrato designee audited all progress notes fro past 30 days to determine there were any unreported abuse/ neglincidents in patient records. No issuidentified.  3) Address what measures will be purinto place or systemic changes made to ensure that the deficient practice will not recur: On 9/23/2022 all facility staff, departments to include agency staff and have been re-educated on the facility policy of abuse to include reporting / response. The facility will ensure that a alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, a reported immediately, but not later than hours after the allegation is made, if events that cause the allegation involve abuse or results in serious bodily injury not later than 24. The Education was completed by the facility's administrato and /or the Director of Nursing. All new hires and agency will be educated prior beginning of their first shift.	e to  r /  om e if lect ues  t o ot all id are a 2 es /, or	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345489	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 1930 WEST SUGAR CREEK RO CHARLOTTE, NC 28262		09/29/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BI ) TO THE APPROPRIA CIENCY)	DATE.	
F 607	Continued From page	ge 27	F	On 10/16/2022 The Director of resident process for the meeting. DON will compatient on incidents are sustained.  On 9/28/2022 the Regionerations are sustained.	Administrator of puse incidents in inistrator after a from staff. gional Director of the Administrator of the Admi	n any for dge all iew ts m nis g / ort hat or dge al iew ts m nis	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _		C 09/29/2022	
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262	1 03/23/2022	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 610 SS=K	CFR(s): 483.12(c)(2)- §483.12(c) In respons neglect, exploitation, of must:	correct Alleged Violation		As of 09/23/2022 the Administrator and designee will interview 5 residents da Monday through Friday for 4 weeks, the 5 residents 3 times a week for 4 weeks and 5 residents weekly for 4 weeks to ensure that Abuse has not occurred, be asking if any staff, other residents or visitors have exhibited aggressive or intimidating behaviors, verbal or physical abuse.  Director of Nursing and/or Administration Nurse will complete a summary of audiand report results of audits to the Qual Assurance and Performance Improvement committee monthly x3 months for review and recommendation until substantial compliance is achieve and maintained.  5) Compliance Date: 10/22/2022	illy en s y cal we its ity	
	violations are thoroug §483.12(c)(3) Prevent	t further potential abuse, or mistreatment while the				
		the results of all administrator or his or her ative and to other officials in				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		345489	B. WING _			l	29/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CATUDNI	UIDONO AND DELIADII	ITATION OFNITED		1	930 WEST SUGAR CREEK ROAD		
SAIURN	NURSING AND REHABIL	HAHON CENTER		С	CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	e 29	F	610			
F 610	accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on resident arreview and policy rev thoroughly investigate residents from further residents reviewed for Resident #4, and Res Resident #1 began exphysically aggressive others in July 2022, the ffective measures to to all interventions plate the facility were temp discontinuation left of potential of abuse. The Adult Protective Servallegations of abuse (Resident #4, and Resand involve law enfor of abuse (Resident #4). The immediate jeopar Resident #1 pushed the facility did not the effective interventions remaining residents in jeopardy was remove facility implemented a jeopardy removal. The compliance at a lowe	e law, including to the State in 5 working days of the eged violation is verified e action must be taken. It is not met as evidenced and staff interviews, record iew, the facility failed to e abuse and protect the r abuse (Resident #2, sident #6). Specifically, when whibiting verbally and behaviors directed towards the facility failed to implement represent further abuse due aced during investigations by orary and their ther residents at risk for the facility also failed to notify dices (APS) for 4 of 4 (Resident #2, Resident #3, sident #6) and failed to notify cement for 2 of 2 allegations and Resident #4).  Try began on 07/16/22 when Resident #4 to the floor and roughly investigate and put the in place to protect the the facility. The immediate and on 09/24/22 when the the credible allegation of the facility will remain out the recope and severity "E" (no ential for harm) to ensure	F 6	610	1) Address how corrective action will accomplished for those residents found have been affected by the deficient practice:  On 7/16/22 Resident #1 allegedly push resident #4 causing him to fall to the flot Nurse #1 immediately intervened with the confrontation. Nurse #1 immediately intervened with the confrontation and separated the residents. Resident #1 will placed 1 on 1. The Administrator contacted the police. An investigation will intitated by the Administrator. The state Agency was notified on 7/16/22 of the allegation. Discharge planning of reside #1 was initiated by the SW. On 8/18/22 was reported to the SW that Resident #1 grabbed Resident #6 by her wrist lifting her off the ground in the smoking area. Resident #1 and #6 were immediately separated. Resident #1 was placed on on 1 supervision for 96 hours. The facility's administrator was notified by facility staff of the incident. The police were notified, and an investigation was initiated. The State was notified of the alleged allegation on 8/18/22. On 9/9/2022 Resident #1 was heard yelling cursing and making verbal threats towaresident #3 in Resident's #3 room. Nursell immediately removed Resident #1 from Resident's #3 room. When the Administrator was made aware of the	ed cor. che vas vas ent et it #1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	' '	E SURVEY IPLETED
			A. BOILDI				С
		345489	B. WING			00	9/29/2022
NAME OF PI	ROVIDER OR SUPPLIER	l		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	7/20/2022
				19	930 WEST SUGAR CREEK ROAD		
SATURN	NURSING AND REHABIL	LITATION CENTER			HARLOTTE, NC 28262		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 610	Continued From pag	e 30	F	310			
	Findings included:				incident an investigation was not initiat	ed	
	i mango moladoa.				The police were not notified. The alleg		
	1. Resident #1 was r	e-admitted to the facility on			incident was not reported to the State		
		sis that included multiple			Agency until 9/23/22. On 9/17/ 22		
		motor vehicle accident			Resident #1 was seen in the smoking		
	(MVA).				area by Human Resources Director		
					punching Resident #2 in the chest.		
		Data Set (MDS) dated			Human Resources immediately		
		esident #1 was cognitively			coordinated separation of Resident #1		
	· ·	ent for all activities of daily			and Resident #2. HR notified the facilit	y's	
	living.				administrator. Resident # 1 was		
					immediately placed on 1 on 1. An		
		ated 7/16/22 at 6:35 AM filed			investigation was initiated, and the poli		
		name indicated Resident #1			were notified. The alleged allegation were reported to the State Agency on 9/17/2		
		sident #4 out of his room in an attempt to remove			On 9/19/22 Resident #1 was heard	.2.	
		room which was witnessed			yelling, cursing and making verbal thre	ats	
		mer girlfriend, (Resident #5)			towards resident #3. Nurse #1 remove		
	_	lent in the facility, which			Resident#1 from Resident's #3 room	<b>-</b>	
		ce of a nurse aide (Nurse			immediately and continued 1 on 1		
		ted Resident #4 to his feet			supervision for Resident #1. When the		
	and away from Resid	dent #1's room.			administrator was made aware of the		
					incident an investigation was not initiat	ed.	
		t report dated 7/16/22 at 6:35			The police were not notified. The State	<b>;</b>	
		lent #4's name indicated			Agency was not notified of the alleged		
		I she went to Resident #1's			incident until 9/23/22		
		dicated when she started to			APS was made aware of the above		
	l ·	esident #4 in the doorway			incidents on 9/29/22. Resident #1 was		
		up. Resident #5 indicated as			discharged from the facility on 9/23/22		
		to door to assist him to leave,					
		sident #4 to get the "F*** out ceeded to get up from his					
		sident #4 down to the floor			2) Address how the facility will identi	fv.	
	and Resident #5 imm				other residents having the potential to		
		lent further details as			affected by the same deficient practice		
		this incident to NA #1,					
		ualized on all 4's with his			On 9/23/2022 the Regional Director of		
		or in the hallway outside of			Operations reviewed all abuse allegati		
		where she picked him up and			for Saturn Health & Rehabilitation for		

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		345489	B. WING		0,0	C	
NAME OF DE	ROVIDER OR SUPPLIER	0.0.00	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	•	/29/2022	
TVAINE OF T	COVIDER OR GOLT EIER				,DL		
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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 610	Continued From page	e 31	F 6	10			
	the nurse provided to Resident #4 was esc while the local police An investigation repo facility indicated on 0	ion over his right eyebrow, eatment to the area, and orted to the lobby of the unit department were notified.  rt document provided by the 7/16/22 at approximately		period 1/01/2022 - 9/23/202 efforts were taken to comple investigation, to prevent reo correct the alleged violation notification to Adult Protectiv and law enforcement if warr unreported notifications to s	ete the ccurrence and to include ve Services anted. All tate agencies		
	outside the room of F Resident #5 had app #1) to report she had	I was found on the floor Resident #1. It indicated roached a Nurse Aide (NA witnessed Resident #1 push s room. Resident #4 was		were emailed to the attentio agency.  3) Address what measures			
	abrasion to his right e provided. Resident #- area and placed on 1	and found to have an eyebrow and treatment was 4 was taken to the common :1 for a week due to his high		into place or systemic change ensure that the deficient pra recur:	ctice will not		
	The local police depaincident and when on on his engagement was upset. On 7/18/22, the made attempts to confacilities to attempt to Resident #4. They alshad improved significano longer needed ski	d exit seeking behaviors. Introduction of the site counselled Resident #1 Introduction of the social Worker (SW #1) Intact other local nursing I locate a secured unit for so determined Resident #1 I antly since admission and led nursing care and issued otice to Resident #1 who in for discharge.		On 9/22/2022 Regional Clin re-educated the Administrate Director of Nursing on Abuse prevention, investigation, an interventions to state agency Regional Director of Operating Regional Director of Clinical included the facility policy for employees and volunteers put with residents. Screening conclude verification of reference certification and verification assistant headstargunds about the surprised backgrounds are supplied to the surprised backgrounds and surprised backgrounds are supplied to the surprised backgrounds.	or and e reporting, id y as well as ons and . Education r screening orior to working emponents nces, of license and		
	Round Sheets" dated 7/23/22, and 7/24/22 Resident #4; however included in these reconstructed at that time at 7/18/22 indicated an encourage resident to and provide staff times.	documents titled "Action 17/19/22, 7/20/22, 7/21/22, for 4 residents including r, Resident #1 was not ords of residents to be although his care plan dated intervention of 1:1-gently o notify staff of any incidents e to provide resolution. are a facility developed		criminal backgrounds check will not knowingly employ of engage any individual conviresident abuse, neglect, expmisappropriation of resident mistreatment by a court of labuse as noted by licensure registries. Resident rights arprevention training for all enconducted during orientation annually, and includes revie	otherwise cted of bloitation, property, or aw or reported boards or and abuse aployees is a, and at lease		

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			A. BOILDII	_	<del></del>	۱ ,	С
		345489	B. WING _				/29/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	29/2022
					930 WEST SUGAR CREEK ROAD		
SATURN N	NURSING AND REHABIL	ITATION CENTER			HARLOTTE, NC 28262		
					<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Continued From page	e 32	F 6	310			
	document to indicate	a resident is on either a 1:1			policies and code of conduct, definition	S	
	supervision or every				of abuse, resident's rights, abuse, negl		
		where staff are to document			and exploitation policy and criteria for		
	an identified location	of the designated resident			assessing risk factors, management of		
		nin timeline basis. Again,			aggressive behavior, care of cognitivel		
	I -	included in the internal			impaired, conflict resolution, stress		
	facility document title	d Action Round Sheets.			management and signs of burnout. At	the	
					time of admission, each resident and		
	There was no eviden	ce that the			responsible party is informed of the		
	resident-to-resident a	ltercation between Resident			resident's rights and the facility's zero		
		vas thoroughly investigated;			tolerance for any form of abuse. A		
	-	aw enforcement or APS.			zero-tolerance policy of abuse, neglect		
		1 supervision put in place			mistreatment, and misappropriation, al		
		ot ensure Resident #1 did			with reporting directions, is posted in the	ie	
		ger to all other residents in			facility or given to the resident upon		
	the facility at the time	of the incident.			admission and each employee at orientation. Staff is instructed to report	any	
	An incident report dat	ted 08/18/22 indicated			sign of stress from family or other		
	_ ·	that Resident #1 grabbed			individuals involved with the resident the	at	
		it which resulted in visible			may lead to abuse, neglect or		
		indicated Resident #6			misappropriation of resident property a		
	slapped him across th	he face.			to intervene as appropriate. The facility	'	
					protects residents and/or families from		
		ts provided by the facility			harm or retaliation during an abuse or		
		Sheet" with Resident #1's			neglect investigation. Any person or		
	name identified at the	•			persons accused or suspected of		
	08/19/22, 08/20/22, 8				involvement in resident abuse, neglect		
		sheet was initiated on			misappropriation of resident property is		
	08/18/22 at 3:30 PM	ious locations throughout the			immediately suspended for the course		
		on 08/19/22. The second			the investigation pending the outcome the investigation. Patient protection	Oi	
		it indicated it began at 7:00			actions include immediately removing t	he.	
	· -	indicated Resident #1 left			patient from contact with alleged abuse		
		of absence (LOA- where the			during the investigation. If the alleged	<b>/</b> 1	
		mselves out of the facility to			abuser is not an employee, measures	are	
	_	nmunity unsupervised) at			taken to provide a safe, secure	a. 0	
	2:15 PM; however, R				environment for the patient. Action may	,	
	i i	ted Resident #1 left the			include: patient room change, patient of		
		ition at 3:19 PM on 08/19/22			schedule change, visitor restrictions.	<i>y</i>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
				-			c	
		345489	B. WING _			09	/29/2022	
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	, ,,		
				1	1930 WEST SUGAR CREEK ROAD			
SATURN N	IURSING AND REHAB	ILITATION CENTER		(	CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 610	Continued From pa	ge 33	F 6	610				
	and did not indicate	when he returned to the			reporting to other agencies or law			
	facility. Page 2 of th	e document titled, Action			enforcement. Human Resources will			
	Round Sheet reflect	ted staff continued to			ensure all new hire orientation on Abu	se		
	document Resident	being on LOA until 7:00 PM;			reporting, prevention, investigation, ar	nd		
	however, did not ref	flect he returned to the facility			interventions to state agency. On			
	on that date. Page	3 of the document indicated			09/23/2022 Human Resource Manage	er		
	Resident #1 did not	return to the facility until 5:15			was educated to this responsibility by	the		
		only indicated he was			Administrator.			
	•	7:00 PM on this date. The						
	facility's document l			Human Resources will ensure all new	hire			
		/22 and continued with page 5			orientation on Abuse reporting,			
	•	e checks for Resident #1's			prevention, investigation, and			
		7:00 AM until 9:30 AM on			interventions to state agencies. On			
		Round Sheets provided did			09/23/2022 Human Resource Manage			
		gth of time Resident #1 was to			was educated to this responsibility by			
	be placed on 1:1 su	pervision.			Administrator. As of 9/23/2022 all facil	ity		
					staff and agency staff have been			
		#1's medical record revealed			re-educated on facility policy of abuse			
		ns implemented to mitigate			include 1 on 1 supervision by the Dire			
		ouse to other residents. The			of Nursing. As staff come into work the	Э		
		ded a duplication of the			Administrator and/or administrative	4		
		with an updated date of			designee determines which staff have			
		ated 1:1-gently encourage			done in-servicing using a logged staffi	•		
	•	aff of any incidents and			roster for all staff, all departments and			
	provide staff time to	provide resolution.			those not displayed are provided the			
	Documents provide	d by the facility dated			necessary education and sign documentation prior to beginning their			
	•	alert and oriented residents			shift. Human Resources will ensure al			
		n whether they felt safe and			new hire orientation on facility abuse	!		
		acility of which multiple			policy during orientation. Indicate how	, the		
		"No." The facility was unable			facility plans to monitor its performance			
		mentation of interventions that			make sure that solutions are sustained			
		e alert and oriented resident			As of 9/23/2022 all reportable events			
	•	were fearful of living at the			be reported to the Regional Director o			
	facility.	a contact and gat and			Operations and/or Regional Director of			
	-···- <i>y</i> -				Clinical immediately following the ever			
	There was no evide	nce that the			the Administrator. Regional Director of		<b> </b>	
		altercation between Resident			Clinical/Regional Director of Operation		<b> </b>	
		was thoroughly investigated;			will review all reportable allegations pr			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		345489	B. WING_			C 9/29/2022
NAME OF P	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP COD	•	312312022
				1930 WEST SUGAR CREEK ROAD		
SATURN	NURSING AND REHABIL	ITATION CENTER		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 610	Continued From page	e 34	F 6	10		
F 61U	reported to APS. The Resident #1 were no ensure they did preveresidents in the facilit Resident #1 was place supervision; howeverest the facility on a leave staff upon return to recevaluate him for conterefore, when he renot monitored to ensure A nurse progress not Resident #1 was over and cursing. When shoverheard Resident #3, "If you don't shut time, I am going to do yelling." The note induction to leave the room and to be in Resident #3 stated Resident #1 wand Nurse #1 reported for Nursing (DON).  A nurse progress not Resident #1 was again threatening profanity he was told multiple for resident #1 out of the was told multiple for the shift.  An interview with Resident #3 statement #1 out of the shift.  An interview with Resident #1 was again threatening statement wards him on multiple for the shift.	e intervenetions placed for to monitored to effectively ented further danger to all ty at the time of the incident. Seed on a temporary 1:1 or, he signed himself out of the of absence and did not alert esume 1:1 supervision or continuation of 1:1 monitoring; eturned to the facility he was sure others safety.  The dated 09/09/22 indicated rheard by Nurse #1 yelling the arrived at the room, she will communicate to Resident the f*** up yelling all the to something to help you stop icated she told Resident #1 did that he was not supposed to room. The note further theeled off down the hallway and the incident to the Director to date of 09/19/22 indicated in observed by staff using towards Resident #3 after times to stay out of other unidentified NA assisted the room and frequent rounds the for behaviors through the	F 6'	to being submitted from 9/23/ ongoing to ensure protective are put into place, and further not reoccur with current inters Reportable incidents will be a weekly x 8 weeks for complet investigation and timely repor State Agency, APS and Law was contacted if required by to Clinical Nurse or the Regiona Operations. Results of Audit or reported monthly by the admit the Quality Assurance Perfort Improvement meeting to ensu continued compliance.  4) Compliance Date: 10/22/	measures r abuse does ventions. The audited tion of rting to the enforcement the Regional al Director of will be inistrator to mance ure	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		COMPLETED
		345489	B. WING			C <b>09/29/2022</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	I	09/29/2022
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 610	hurt him. Resident # himself if Resident # fearful he would com Resident #3 commu #1 didn't have accesslike Resident #1 is obeat him and kill him reported this to staff Resident #1 in his roanything about it. Resident on 09/19/22 was alone because fearful.  Interview with the Ad 11:27 AM revealed him the verbal threat by Resident werbal threat by Resident yelling episodes. He Resident #3's roommedication adjustment which he thought was on 9/14/22 the NP him and the changes had and yelling out had in Administrator stated issue Resident #1 aunsuccessful in section.  There was no evident resident #3 facility; reported to the state of the	is room and threatened to 3 stated he could not defend at did hit him and he was ne back and hurt him.  nicated he was glad Resident as to a pipe because he feels razy and in his anger would at Resident #3 stated he has and they have observed from before but they don't do resident #3 stated after the state after the	F 6	10		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345489	B. WING		C 09/29/2022
	ROVIDER OR SUPPLIER	ILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 610	ensure he did not p #3 or any other resi of the incident. Res be on 1:1 supervision returned to Resider abused Resident #3 Resident #3 to remai Review of the incide 10:50 AM indicated Resident #2 in the of the Human Resourc office window which facility's smoking co Attempts were mad Worker (SW #1) we investigation.  A progress note wri #2) on 09/20/22 at s Manager and the Ad magistrate's office to regarding Resident include a possible a magistrate explaine which the police off initiative which wou magistrate's office.  An investigation rep indicated on 09/20/20 officers and the ma conversation with th magistrate/police of could not arrest Res see the injuries and	colaced for Resident #1 to cose further danger to Resident dents in the facility at the time ident #1 was observed not to con on 09/19/22 when he at #3's room and verbally 8 for a second time causing ain fearful.  The ent report dated 9/17/22 at Resident #1 punched chest which was witnessed by cose Manager (HR) through her a is adjacent to one of the courtyards.  The to contact the former Social are unsuccessful during the civity Director went to the cosee what could be done #1's aggressive behaviors to course or warrant; however, the did the process to facility staff in ficers would have to take and the court by the facility which court by the facility at the time time to the facility at the time time time time time time time tim	F 610		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		345489	B. WING			C <b>09/29/2022</b>
	ROVIDER OR SUPPLIER	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262	1	00/20/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 610	situation legally. The to discharged Resides afety of the other in The resident-to-rese Resident #1 and Resident #1 and Resident (09/17/22); be on 1:1 supervision observed to be make Resident #3 and the separated by the number of the Administrator, Nurse Consultant and Director were notified 09/22/22 at 6:15 PM. The facility provided jeopardy plan for resident in July, the effective measures. After a cognitively in resident in August, effective measures.	e officers advised the facility dent #1 immediately for the residents.  Ident altercation between esident #2 was not reported to the initial report. Resident #1 supervision on the date of the however, was observed not to on on 09/19/22 when he was king verbal threats towards e resident's had to be urse.  Director of Nursing, Regional nd Regional Operations ed of immediate jeopardy on M.  If the following immediate moval:  ents who have suffered, or a serious adverse outcome compliance:  Intact resident abused a facility failed to implement to protect all residents.  Intact resident abused a the facility failed to implement to protect all residents.	F 6			
	resident in Septeml implement effective	oer, the facility failed to measures to protect all was an additional abuse of				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	PLETED
		345489	B. WING _			C <b>29/2022</b>
	ROVIDER OR SUPPLIER	LITATION CENTER		1930 \	ET ADDRESS, CITY, STATE, ZIP CODE WEST SUGAR CREEK ROAD RLOTTE, NC 28262	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From pag		F	810		
	free from verbal and intact resident has al	protect residents' rights to be physical abuse. A cognitively pused 4 residents. Residents endured bruising and verbal				
	Dietary Manager/Uni interviews with all res for Mental Status (BI abuse to ensure no f Director of Nursing a skin audits for signs	sk for abuse. On 9/23/2022 t Manager completed sidents with a Brief Interview MS) score of 9 or higher on urther incidents of abuse. nd floor nurses completed of abuse as of 9/23/2022 for IMS score of 8 or lower.				
	Resident #4 causing floor. Nurse #1 imme confrontation. Nurse and Resident #4 by homeon area of the nursing assistant #1. assessment of Resider were contacted by Administrator determined and push or touch Administrator determined into reside 7/18/2022 Administrator Social Worker, and France Resident #1 no longer Level care. Administrator start discharge proplacement in Assister	dent #1 and first aid. Police dministrator on 7/16/2022 g notification. Police Officer if and informed him that he if other residents. Facility lined that resident #4 was ent #1's room uninvited. On ator, Director of Nursing, Physician determined that her required Skilled Nursing rator informed Social Worker locess for Resident #1 for d Living.				
		Worker started sending ation to assisted living				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	_	(X3) DATE SURVEY COMPLETED
		345489	B. WING _			C 09/29/2022
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY  1930 WEST SUGAR CR  CHARLOTTE, NC 28	REEK ROAD	03/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 610	facilities for placeme Administrator had a on the rules and poli engaging in confront Resident #1 informe understood. Adminis supervision with Resident #1 warelated to Resident #1 refusing to leave. As including agency star abuse policy related abuse.  On 8/18/2022 it was that Resident #1 gral lifting her off the gron Resident #1 and Reseparated by facility was notified on 8/18/incident. Resident #1 on 1 supervision of prevent any further incontacted the police incident on 8/18/202 notification of incider investigation of the inbeginning on 8/18/2 Nursing, Social Worlbegin interviewing al of 10 or higher as we and or staff who wer of incident on 8/18/2 and witness interview. Administrator that Resident #1 prior to Resident #6 wrist. A		F	10		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
		345489	B. WING _			C <b>09/29/2022</b>
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		03/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	counselled Resident time of incident on 8 begun discharge pro alternate placement for Resident #1. Adn Nursing re-educated staff on facility abuse and preventing abuse On 9/9/22 Resident: Resident #3 in Resident #3 in Resident #3 in Resident # 3's room. Resident #1 through not return to Residen no signs of injury to incident.  On 9/17/2022 Resident #1 through not return to Residen #1 through not return to Resident #0 signs of injury to incident.  On 9/17/2022 Resident #1 Resource Director in Resident #1 and Resource Director in Resident #1 and Resource Director of 9/17/2022. Regional instructed Administrator Regional Director of 9/17/2022. Regional instructed Administrator placed supervision beginnin date. Administrator bincident on 9/17/2022 incident on 9/17/	8/2022 Police Officer #1 on social behaviors. At /18/2022 facility had already roess and were looking for in an Assisted Living facility ministrator and Director of all staff to include agency repolicy regarding reporting re as of 8/22/2022.  #1 was heard yelling at dent #3's room to stop yelling m shut up by Nurse #1. ly removed Resident #1 from Nurse continued to monitor out the night to ensure he did not #3's room. Nurse #1 found Resident # 3 following the  ent #1 was seen in the man Resource Director (HR) 2 in the chest. Human mediately separated sident #2. HR Director or on 9/17/2022 following the or immediately informed the Operations of the incident on Director of Operations	F	510		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345489	B. WING		C 09/29/2022
SATURN NURSING AND REHABILITATION CENTER  1930 WEST SUG CHARLOTTE, I  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH		TREET ADDRESS, CITY, STATE, ZIP CODE 030 WEST SUGAR CREEK ROAD HARLOTTE, NC 28262			
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 610	On 9/19/2022 Resident removed Resident resident resident requiring 1 Regional Clinical Dino resident with 1 on 1 on 1 employee acfacility. All staff in-scon 1 on 1 to include after hours for 1 on return to facility.  Specify the action the process or system fadverse outcome from the action will As of 9/23/2022 Residents reviewed all about Health & Rehabilitation 9/23/2022 to ensure complete the invest residents from abus placed on supervise per day as of 9/17/20 As of 9/23/2022 face placement for reside contacted shelter regized residents removed Removed Residents Removed Removed Residents Removed R	lent #1 was heard yelling y at Resident #3. Nurse #1 the from Resident #3's room ntinued his 1 on 1 nt #1 had returned from ility wasn't aware he had the and 1 on 1 was not in place. The has been in-serviced on the intervent on 9/23/2022 to ensure the intervent of acility until companies resident into the rector on 9/23/2022 to ensure the intervent into the facility until the companies resident into the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the complete.  The intervent intervent intervent into for period 1/01/2022 - the all efforts were taken to the gation, prevent and protect all the intervent into the facility the rector of Operations the entity will take to alter the the aillure to prevent a serious the intervent into the facility the rector of Operations the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity will take to alter the the aillure to prevent and the the aillure to prevent a serious the entity will take to alter the the aillure to prevent a serious the entity the the aillure to prevent a serious the entity the the the aillure to	F 610		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	, ,	TE SURVEY MPLETED
		345489	B. WING			C <b>9/29/2022</b>
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	· ·	3/23/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 610	Continued From pag	ge 42	F 61	0		
	Nursing on Abuse reinvestigation, and inwell as Regional Director of the facility policy for volunteers prior to w Screening compone references, certificat and criminal backgronot knowingly emploindividual convicted exploitation, misapp property, or mistreat reported abuse as n registries. Resident training for all emploorientation, and at lereview of: abuse pol definitions of abuse, neglect and exploita assessing risk factor aggressive behavior conflict resolution, si of burnout. At the tin resident and respon resident's rights and for any form of abus abuse, neglect, mist misappropriation, ale is posted in the facili upon admission and orientation. Staff is in stress from family or with the resident that or misappropriation.	ninistrator and Director of sporting, prevention, terventions to state agency as ector of Operations and Clinical. Education included screening employees and orking with residents. Into include verification of ion and verification of license bunds check. The facility will be of otherwise engage any of resident abuse, neglect, ropriation of resident ment by a court of law or oted by licensure boards or rights and abuse prevention yees is conducted during lase annually, and includes icies and code of conduct, resident's rights, abuse, tion policy and criteria for is, management of it, care of cognitively impaired, it is management and signs the of admission, each sible party is informed of the the facility's zero tolerance e. A zero-tolerance policy of reatment, and ong with reporting directions, ty or given to the resident				

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		345489	B. WING _			C <b>9/29/2022</b>
	OVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262		0/20/2022
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 610	during an abuse or neperson or persons and involvement in reside misappropriation of reimmediately suspendinvestigation. Patient immediately removing with alleged abuser of alleged abuser is not taken to provide a sat the patient. Action may change, patient daily restrictions, reporting enforcement. Humannew hire orientation of prevention, investigate state agency. On 09/Manager was educated the Administrator.  As of 9/23/2022 all reference to the Region and/or Regional Director of Clinical/Reference following event by the Direc	ilies from harm or retaliation eglect investigation. Any coused or suspected of ent abuse, neglect or esident property is led for the course of the protection actions include g the patient from contact during the investigation. If the an employee, measures are fe, secure environment for ay include: patient room schedule change, visitor to other agencies or law a Resources will ensure all on Abuse reporting, tion, and interventions to 123/2022 Human Resource ted to this responsibility by exportable events will be onal Director of Operations ctor of Clinical immediately en Administrator. Regional	F6	10		

F 610 Continued From page 44 Administrator and Director of Nursing had been in-serviced on Abuse prevention, intervention, reporting, and investigation. Record review revealed all reportable events from 1/1/2022 to present (9/29/2022) have been reviewed by the Regional Director of Operations. Interviews with staff revealed a process of screening staff and volunteers prior to resident interaction for reports of convicted resident abuse, neglect, exploitation, misappropriation of resident property or mistreatment. Interviews conducted with staff from all shifts and all disciplines revealed staff aware of the facility's zero tolerance for abuse policy, signs of resident stress to monitor/report, and the immediate removal of any resident who has the potential or was harmed during an incident. Interviews conducted with residents indicated their knowledge of the facility's zero tolerance for abuse policy.  F 677 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the Medical Doctor and staff the		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 2862   CALID   SUMMARY STATEMENT OF DEFICIENCY STATE AND CHARLOTTE, NC 2862   CALID   SUMMARY STATEMENT OF DEFICIENCY STATE AND CHARLOTTE, NC 2862   CALID   SUMMARY STATEMENT OF DEFICIENCY STATE AND CHARLOTTE, NC 2862   CALID   SUMMARY STATEMENT OF DEFICIENCY STATE AND CHARLOTTE, NC 2862   FROM CHARL			345489	B. WING _			-
(A4) ID SUMMARY STATEMENT OF DETICIENCIES TAG  SUMMARY STATEMENT OF DETICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 610  Continued From page 44  Administrator and Director of Nursing had been in-serviced on Abuse prevention, intervention, reporting, and investigation. Record review revealed all reportable events from 1/1/20/22 to present (9/29/2022) have been reviewed by the Regional Director of Operations. Interviews with staff revealed a process of screening staff and volunteers prior to resident interaction for reports of convicted resident abuse, neglect, exploitation, misappropriation of resident interaction for reports of convicted resident abuse, neglect, exploitation, misappropriation of resident from the property or mistreatment. Interviews conducted with staff from all shifts and all disciplines revealed staff aware of the facility's zero tolerance for abuse policy, signs of resident stress to monitor/report, and the immediate removal of any resident who has the potential or was harmed during an incident. Interviews conducted with residents indicated their knowledge of the facility's zero tolerance for abuse policy.  F 677  F 677  F 677  F 677  ADL Care Provided for Dependent Residents indicated their knowledge of the facility's zero tolerance for abuse policy.  §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;  This REQUIREMENT is not met as evidenced by:  Based on record review, observations, and interviews with the Medical Doctor and staff the	NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	LOILULL
SUMMARY STATEMENT OF DEFICIENCIES   PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION AND CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION AND CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE PROVIDER'S PLAN OF CROSS-REFERENCED TO THE PROVIDER OF CROSS-REFERENCED TO THE PROVIDER'S PLAN OF CROSS-REFER	SATURN N	NURSING AND REHABII	LITATION CENTER				
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 610  Continued From page 44  Administrator and Director of Nursing had been in-serviced on Abuse prevention, intervention, reporting, and investigation. Record review revealed all reportable events from 1/1/2022 to present (9/29/2022) have been reviewed by the Regional Director of Operations. Interviews with staff revealed a process of screening staff and volunteers prior to resident property or mistreatment. Interviews conducted with staff from all shifts and all disciplines revealed staff aware of the facility's zero tolerance for abuse policy, signs of resident stress to monitor/report, and the immediate removal of any resident who has the potential or was harmed during an incident. Interviews conducted with residents indicated their knowledge of the facility's zero tolerance for abuse policy.  F 677  SS=G  S483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the Medical Doctor and staff the					CHARLOTTE, NC 28262		
Administrator and Director of Nursing had been in-serviced on Abuse prevention, intervention, reporting, and investigation. Record review revealed all reportable events from 1/1/2022 to present (9/29/2022) have been reviewed by the Regional Director of Operations. Interviews with staff revealed a process of screening staff and volunteers prior to resident interaction for reports of convicted resident abuse, neglect, exploitation, misappropriation of resident property or mistreatment. Interviews conducted with staff from all shifts and all disciplines revealed staff aware of the facility's zero tolerance for abuse policy, signs of resident stress to monitor/report, and the immediate removal of any resident who has the potential or was harmed during an incident. Interviews conducted with residents indicated their knowledge of the facility's zero tolerance for abuse policy.  F 677 ADL Care Provided for Dependent Residents indicated their knowledge of the facility's zero tolerance for abuse policy.  S483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:  Based on record review, observations, and interviews with the Medical Doctor and staff the	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE
staff revealed a process of screening staff and volunteers prior to resident interaction for reports of convicted resident abuse, neglect, exploitation, misappropriation of resident property or mistreatment. Interviews conducted with staff from all shifts and all disciplines revealed staff aware of the facility's zero tolerance for abuse policy, signs of resident stress to monitor/report, and the immediate removal of any resident who has the potential or was harmed during an incident. Interviews conducted with residents indicated their knowledge of the facility's zero tolerance for abuse policy.  F 677 SS=G CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:  Based on record review, observations, and interviews with the Medical Doctor and staff the	F 610	Administrator and Di in-serviced on Abuse reporting, and invest revealed all reportab present (9/29/2022)	rector of Nursing had been e prevention, intervention, igation. Record review le events from 1/1/2022 to have been reviewed by the	F 6	310		
SS=G CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:  Based on record review, observations, and interviews with the Medical Doctor and staff the  1.Address how corrective action will be accomplished for those residents found to	E 077	staff revealed a proc volunteers prior to re of convicted resident misappropriation of r mistreatment. Intervi from all shifts and all aware of the facility's policy, signs of resid and the immediate re has the potential or v incident. Interviews indicated their knowl tolerance for abuse p	ess of screening staff and esident interaction for reports abuse, neglect, exploitation, resident property or lews conducted with staff a disciplines revealed staff as zero tolerance for abuse ent stress to monitor/report, removal of any resident who was harmed during an conducted with residents edge of the facility's zero policy.				40/00/00
resident dependent on staff for toilet use and personal hygiene resulting in 2 new areas of moisture associated skin damage being identified for 1 of 3 residents reviewed for activities of daily living (Resident #10).  The findings included:  Inave been affected by the deficient practice: Incontinence care was provided by Certified Nursing Assistant #2 on 9/21/22 for resident #10, the new skin areas on the right groin and left buttocks were assessed by the Regional Nurse and the wound nurse on 9/21/22, the Nurse practitioner was notified, and new		S483.24(a)(2) A resident activities of daily services to maintain personal and oral hy This REQUIREMENT by:  Based on record revinterviews with the Macility failed to provincesident dependent opersonal hygiene resident dependent of a residents reliving (Resident #10)	dent who is unable to carry living receives the necessary good nutrition, grooming, and giene; T is not met as evidenced view, observations, and fledical Doctor and staff the de care for an incontinent on staff for toilet use and sulting in 2 new areas of skin damage being identified eviewed for activities of daily	F	1.Address how corrective action w accomplished for those residents for have been affected by the deficient practice: Incontinence care was proby Certified Nursing Assistant #2 or 9/21/22 for resident #10, the new si areas on the right groin and left but were assessed by the Regional Nu the wound nurse on 9/21/22, the No	und to vided itin ocks se and	10/22/22
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CTZ011 Facility ID: 923538 If continuation sheet Page 45	CODM CMC CCC	-					1. D 15. 155

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345489	B. WING _			C 09/29/2022
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	CODE	0.100
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 677	03/22/12 with diagnor depression.  Review of the quarted dated 08/04/22 assess moderately impaired incontinent of bladders.	dmitted to the facility on oses including dementia and erly Minimum Data Set (MDS) essed Resident #10 as having I cognition and always being er and bowel and totally or transfers, toilet use, and	F6	treatment orders obtained. responsible party was info skin area on 9/21/22. Res assessed by the Medical I 9/23/22. Resident's wheele cushion were cleaned by h on 9/21/22. Certified Nursi #2 and #3 are agency Cer Assistants and no longer of	rmed of the new sident was Director on chair and nousekeeping ing Assistants tified Nursing	
	revealed Resident # breakdown. The goa intact through the ne included provide pro keep the skin clean.  An observation on 0 Resident #10 sitting There was a strong entering the room. F pair of gray shorts th groin area as if wet.  During an interview #2 revealed she just residents to ensure a accounted for. NA # checked Resident #	9/27/22 at 3:23 PM revealed in a wheelchair in his room. odor resembling urine when resident #10 was wearing a nat were darker in color at the on 09/21/22 at 3:45 PM NA arrived and had checked on they were safe and 2 did not reveal she had		2.Address how the facility other residents having the affected by the same defice. Therefore a 100% audit we have Management to ide who are incontinent and reassistance with ADLs. And completed by 10/14/22. An identified had their care play guide updated by nurse management completed on 100% of current skin areas identified the players incompleted, and the care players of the completion date by 10/14/20.	potential to be sient practice: as conducted by ntify residents equire dit was ny residents an and the care anagement. leted a skin residents, any nysician and tified, treatment it was updated.	
	09/21/22 from 3:23 I Resident #10 remain wheelchair. At 4:11 to provide ice and ag	ration was started on PM through 5:15 PM. ned in his room sitting in a PM NA #2 entered the room gain at 4:16 PM and asked if v. The roommate of Resident		3.Address what measures place or systemic changes ensure that the deficient precur: Residents are asse admission, quarterly, and condition for bowel and blaincontinence. Any resident	s made to ractice will not essed upon with changes in adder and	

Facility ID: 923538

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		345489	B. WING _			C <b>09/29/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI	DE	
				1930 WEST SUGAR CREEK ROAD		
SATURN	NURSING 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 THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 677	5:05 PM NA #2 left the showed Med Aide #1 needed for Resident returned to the hall a	and NA #2 left the room. At ne hall. At 5:09 PM this writer incontinence care was #10. At 5:15 PM NA #2 nd began to provide	F 6	incontinence, the care plan a guide are updated. The Direc Nursing educated all current nursing staff and the certified assistant on identifying resid	ctor of licensed I nursing ents requiring	
	#10's gray shorts we and buttocks and the large wet stain with a urine.	Resident #10. Resident re saturated at the front groin wheelchair cushion had a strong odor resembling		assistance with incontinent of timely incontinent care, report changes to the nurse immed nurse initiating treatment, an policy on incontinent care. Li nurses were re-educated to of	rting skin iately, the d the facility censed complete	
	at 5:15 PM revealed red skin involving the During an interview of	on 09/21/22 at 5:25 PM NA		weekly skin checks as sched Education was completed by This education will be include orientation; employees will nepermitted to work until educations	v 10/20/22. ed in ot be ation is	
	known related to inco would have to physic an episode of inconti	t #10 did not make his needs ontinence care and she cally check if the resident had nence. NA #2 revealed she sident #10 for incontinence		completed. Residents with s reviewed weekly during stan-meetings.		
	residents to bed and #10. NA #2 indicated	d she had assisted two other hadn't gotten to Resident she didn't receive report ift NA assigned to Resident		4.Indicate how the facility platits performance to make sure solutions are sustained: The Nursing will Audit 5 residents for 4 weeks, then 5 residents weeks for timely incontinent.	e that e Director of s 5xper week s 3xper for 4	
	Regional Nurse Con- red area of skin on R The Regional Nurse have the Wound Car for any skin issues. T Consultant also obse	on 09/21/22 at 6:15 PM the sultant was informed of the desident #10's left inner thigh. Consultant stated she would be Nurse check Resident #10 The Regional Nurse erved the wet wheelchair he would ensure it would be		identifying new skin areas ar treatment. The Director of Nu report the results of the audit Quality Assurance and Perfo improvement committee mor months for review and recomuntil substantial compliance and maintained.	n initiating ursing will to the ormance onthly x3 onmendations	
		nducted on 09/21/22 at 6:32 Care Nurse. The Wound				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345489	B. WING _				C <b>29/2022</b>
	ROVIDER OR SUPPLIER	ITATION CENTER		193	REET ADDRESS, CITY, STATE, ZIP CODE 30 WEST SUGAR CREEK ROAD HARLOTTE, NC 28262	1 00/	LULL
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	areas on Resident #1 Medical Doctor (MD)  During a second inter AM the Wound Care were received for skir associated skin dama and left buttocks.  An interview was con PM with the MD. The immobile and sitting i contribute to moisture.  An interview was con PM with NA #3 who wand was assigned to #10. NA #3 revealed Resident #10 was alread the wheelchair, and shim for incontinence. Resident #10 before an episode of urinary revealed after that sh for incontinence and sfamily member told he incontinence care and soiled brief and asked	she identified two new 0's skin and would notify the for orders.  view on 09/22/22 at 9:35  Nurse revealed new orders in tears due to moisture age to the inner right groin  ducted on 09/22/22 at 11:03  MD revealed being in a soiled brief would associated skin damage.  ducted on 09/22/22 at 12:34  vorked first shift on 09/21/22  provide care for Resident when she first arrived, eady dressed and sitting in the didn't physically check She did physically check unch and provided care for incontinence. NA #3 e didn't check Resident #10 stated around 2:00 PM a ter they had provided d handed her bag with a	F6	577			
F 758 SS=D	Nursing (DON) on 09 DON revealed she we provide incontinence resident when visibly Free from Unnec Psy	/23/22 at 11:44 AM. The buld expect nursing staff to care for a dependent wet. chotropic Meds/PRN Use	F 7	758			10/22/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		(3) DATE SURVEY COMPLETED
		345489	B. WING _			C <b>09/29/2022</b>
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	1	09/29/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	§483.45(e) (3) A psychaffects brain activities processes and behaviour are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a compreher resident, the facility resident, the facility resident, the facility resident, the medication specific condition as in the clinical record; §483.45(e)(1) Resident psychotropic drugs a unless the medication specific condition as in the clinical record; §483.45(e)(2) Resident processes and behavioral intervention contraindicated, in an drugs; §483.45(e)(3) Resident psychotropic drugs punless that medication diagnosed specific coin the clinical record; §483.45(e)(4) PRN cate in the clinical record; §483.45(e)(5), if the sprescribing practition appropriate for the Prescribing prescribes and prescri	chotropic drug is any drug that is associated with mental vior. These drugs include, drugs in the following  ensive assessment of a must ensure that ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic al dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive entraunt to a PRN order on is necessary to treat a condition that is documented and enders for psychotropic drugs is. Except as provided in attending physician or	F7	758		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345489	B. WING _			09/5	29/ <b>2022</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 03/2	23/2022
					330 WEST SUGAR CREEK ROAD		
SATURN N	NURSING AND REHABIL	ITATION CENTER			HARLOTTE, 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	§483.45(e)(5) PRN or drugs are limited to 1 renewed unless the apprescribing practition the appropriateness of This REQUIREMENT by:  Based on record reviews, resident was free from when a resident (Respector to the psychotropic medicat affects the brain with behaviors) with a diagother mental illness reresidents reviewed for Findings included:  Resident #3 was adm 05/04/22 with diagnos with suicidal ideations cerebral infarction.	ent's medical record and for the PRN order.  Inders for anti-psychotic 4 days and cannot be ttending physician or er evaluates the resident for of that medication.  It is not met as evidenced ew, staff and Physician's the facility failed to ensure a munnecessary medications ident #3) was prescribed ions (a medication that mental processing and gnosis of dementia and no elated diagnosis for 1 of 1 r unnecessary medications.  In the facility on sis that included dementia st, muscle weakness and	F 7	758	1.Address how corrective action will be accomplished for those residents found have been affected by the deficient practice: Resident #3 the Zyprexa was discontinued on September 26, resider was assessed by the Psychologist on October 7, 2022, and a medication reviwas completed by the Psychiatric Nurs Practitioner October 17,2022. Risperdadecreased to 0.5 mg daily down from Ex7 days and then discontinued. The Nu Practitioner provided supporting documentation for the continued use of PRN Ativan Powder.  2.Address how the facility will identify other residents having the potential to be accomplished.	d to  nt  iew e al BID urse f	
	05/04/22 indicated Re Zyprexa 2.5 milligram needed (PRN) related antipsychotic medicar disorders), Depakote to suicidal ideations (	al discharge summary dated esident #3 was ordered (mg) every 6 hours as d to suicidal ideations (an tion used to treat mental 250 mg twice daily related an anticonvulsant d for mood disorders), and			affected by the same deficient practice 100% audit was completed by the facili pharmacist of all residents receiving psychotropic medications. Audit was completed on October 14, 2022. Any residents identified without a supporting diagnosis, or the appropriate behaviors being monitored the physician and/or the	g s	
	Trazadone 50mg dail antidepressant medic	y at night for insomnia (an ation often used for sleep).  m Data Set (MDS) dated			Nurse Practitioner were notified by nurse management.		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION		E SURVEY PLETED
		345489	B. WING _			1	C // <b>29/2022</b>
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	112912022
					930 WEST SUGAR CREEK ROAD		
SATURN N	IURSING AND REHABI	LITATION CENTER			CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ETATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From pag	ge 50	F 7	758			
	•	esident #3 had no psychosis			3.Address what measures will be put in	nto	
	present and exhibite	· •			place or systemic changes made to	110	
	procent and extinate	a ne benaviere.			ensure that the deficient practice will n	ot	
	A pharmacy consult	dated 05/29/22			recur: The facility 's Pharmacy will		
		rder for Zyprexa be evaluated			complete a medication regimen review	for	
		to the PRN order. The			each resident receiving psychotropic		
		D) recommended continue			medication for the appropriate diagnos	is,	
	the medication with	a signature, but the document			and the appropriate behaviors are beir		
	was not dated.				monitor and documented upon admiss	ion	
					and monthly. Any resident identified		
		ication Administration Record			during the regimen review without the		
	` '	022 indicated Resident #3			appropriate diagnosis or behaviors, the		
		5 mg on 06/01/22 at 6:39 PM			pharmacist will make a recommendation		
		4:19 PM for behaviors. The			for supporting documentation from the		
	-	did not indicate any			physician, dose reduction or discontinu		
	behaviors present o	n either 06/01/22 or 06/03/22.			medication. Nurse management will ve	-	
	A 1	1.1.10/04/00			that the recommendations are complet	e.	
		dated 6/21/22 recommended			The Director of Nursing educated the		
		a be discontinued due to			Licensed nursing staff to verify with the		
		itation to 14 days for all PRN ations. The Medical Director			physician the appropriate diagnosis up	OH	
		ontinue the medication			admission and with any medication changes related to psychotropic use,		
	effective 06/28/22.	onlinue the medication			document behaviors on the medication	,	
	enective 00/20/22.				administration record and the progress		
	A progress note writ	ten by Physician Assistant			notes. Report any changes in behavior		
		ed Zyprexa PRN was			the physician. Education was complete		
		ek per psychiatry nurse			by 10/22/22. Nurse Management will	, u	
		endations. The note further			review new admissions and new		
	•	\$\frac{1}{3}\$ had occasional irritability			psychotropic medication orders during		
	which was redirecta	ble and referenced behaviors			clinical meeting daily 5xper week. for the		
	occur when he is lef	t in his room alone and calm			appropriate diagnosis and the appropr	iate	
	when staff enter.				behaviors are being documented.		
		itten by the MD dated					
		ne was compliant with staff			4.Indicate how the facility plans to mor	iitor	
		ed behavioral outburst or			its performance to make sure that		
	aggressive behavior	S.			solutions are sustained: The Director of		
					Nursing and/or the Unit manager will a	udit	
	A review of the MAF	R dated July 2022 indicated			new admissions with psychotropic		

Facility ID: 923538

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		LETED
		345489	B. WING _				29/2022
	ROVIDER OR SUPPLIER	ITATION CENTER	•	19	TREET ADDRESS, CITY, STATE, ZIP CODE 030 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 PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	07/16/22 and 07/30/2 the specific behaviors A pharmacy progress indicated Zyprexa PR 7/1/22 and no behavi A review of the MAR Resident #3 exhibited 08/06/22, and 08/27/2 the specific behaviors A review of the physic 2022 indicated a new medication: 8/30/22: Buspar 10m A quarterly MDS date Resident #3 was cog total dependence with psychosis and exhibit A nurse progress not 08/31/22 indicated Rehave episodes of yell another (unidentified) A review of the MAR indicated Resident #3 symptoms on 09/06/2 09/21/22, 09/22/22; 0 Behaviors by Resident	d a behavior identified on 2. The MAR did not identify a nor did it provide a legend.  Inote dated 07/25/22 IN was discontinued on ors noted.  dated August 2022 indicated d a behavior on 08/03/22, 22. The MAR did not identify a nor did it provide a legend.  cian's orders dated August order for the following  ag every 8 hours for anxiety.  d 08/10/22 indicated intively intact and required in ADL, and with no ited no behaviors.  ded written by Nurse #5 dated desident #3 was noted to ing out due to agitation with	F7	758	medication and new or changed psychotropic medications for the appropriate diagnosis and behavior documentation 5xper for 4 weeks, ther 3xper for 4 weeks. The Director of Nursing will report the results of the auto the Quality Assurance and Performance Committee monthly x3 months for review and recommendatio until substantial compliance is achieve and maintained.	dit	
	on these days to clari exhibited by Residen A review of the physic						

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  C 09/29/2	29/2022
SATURN NURSING AND REHABILITATION CENTER  1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758  Continued From page 52  September 2022 indicated new orders for the following psychotropic medications:  09/20/22: Discontinue Zyprexa 2.5 mg every 6 hours PRN behaviors and agitation. 09/21/22: Risperdal 0.5mg daily x 7 days then increase to Risperdal 0.5mg daily x 7 days then increase to Risperdal 0.5 mg taliy x 7 days then increase to Risperdal 0.5 mg taliy x 7 days then increase to Risperdal 0.5 mg taliy x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily x 7 days then increase to Risperdal 0.5 mg daily agg evaluated which identified the assessment was for dementia, depression/anxiety, and insommia. Listed under the section headed dementia the note indicated Resident #3 was prescribed Depakote for behaviors resulted to dementia and staff had reported he had exhibited behaviors such as yelling out and verbally aggressive towards staff and the yelling became disturbing to other residents.  A quarterly MDS dated 09/20/22 indicated Resident #3 had no psychosis but exhibited behaviors daily which were not directed towards others.  A nurse progress note written by (Nurse #5) dated 09/20/22 indicated Resident #3 had frequently yelled out "Someone help me." Resident #3 was unable to vocalize what his needs were at the time. Nurse #5 attempted to re-educate Resident #3 on how to use the call light system. He indicated "Yeah I know how to use it."  An interview with the Administrator on 09/22/22 at	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		TE SURVEY MPLETED
		345489	B. WING _			C 19/29/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262	1 0	312312022
(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 CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINCE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 758	11:27 AM revealed w resident-to-resident ir #3 and another reside altercation was attributed Resident #3. Therefore provider to evaluate a behavior of frequently of using his call light was ability to use. The Ad aware medications of did not elaborate on which was a stated to evaluate him the PA indicated she behaviors concerns which was a stated the facility there on 09/20/22 and Res regimen was modified infection Prevention 8	hile investigating a nteraction between Resident ent in the facility, the uted to the "yelling out" by re, the facility asked the Resident #3 to decrease the yelling out for help instead which he had knowledge and ministrator stated he was nanges had been made but what the changes included.  Physician Assistant on revealed she was not ated interaction between the resident when she was not for behaviors of yelling out. initially contributed the with a roommate over the ener unit which had negative Resident #3 when he got too to her knowledge the ased when he did not have a shaviors returned when moved in the room. She in alerted psychiatric services ident #3's medications d. & Control (2)(4)(e)(f)	F 7			10/22/22
	The facility must esta infection prevention a designed to provide a comfortable environm	blish and maintain an and control program a safe, sanitary and nent and to help prevent the asmission of communicable				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE COMP	
		345489	B. WING _			09/	29/2022
	ROVIDER OR SUPPLIER	ITATION CENTER		STREET ADDRESS, CITY, STATE  1930 WEST SUGAR CREEK RO  CHARLOTTE, NC 28262			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B ID TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 880	program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A system reporting, investigatin and communicable distaff, volunteers, visite providing services unarrangement based u conducted according accepted national stal	blish an infection prevention (IPCP) that must include, at ving elements:  IPCP) the faction prevention (IPCP) that must include, at ving elements:  IPCP)	F	380			
	but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility: (ii) When and to whor communicable diseast reported; (iii) Standard and trant to be followed to prev (iv) When and how iscoresident; including but (A) The type and durate depending upon the initial involved, and (B) A requirement that least restrictive possible circumstances. (v) The circumstances	can spread to other n possible incidents of se or infections should be asmission-based precautions ent spread of infections; alation should be used for a t not limited to:					

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	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345489	B. WING		09/29/2022
	ROVIDER OR SUPPLIER	LITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1930 WEST SUGAR CREEK ROAD  CHARLOTTE, NC 28262	09/29/2022
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 880	contact with resident contact will transmit (vi)The hand hygiend by staff involved in displaying the staff infection.  §483.80(e) Linens. Personnel must hand transport linens so a infection.  §483.80(f) Annual resident the staff infection conduction in the staff infection control in the staff infection control in the staff infection control.  The findings include Review of the facility Hygiene" revised Jufacility considered has	skin lesions from direct ts or their food, if direct the disease; and e procedures to be followed irect resident contact.  Item for recording incidents facility's IPCP and the ken by the facility.  Idle, store, process, and s to prevent the spread of  Eview. In the facility of its seir program, as necessary.  It is not met as evidenced  It policy and procedure for  Nurse Aide #2 failed to gloves and perform hand and incontinence care and acces and frequently used members reviewed for	F 88	1) Address how corrective action w accomplished for those residents fou have been affected by the deficient practice:  NA #2 is contractual staff mem for Saturn Nursing and Rehab as of October 9, 2022, they no longer work the facility therefore education was neprovided.  2) Address how the facility will iden other residents having the potential to affected by the same deficient practice.	bers for ot tify be
		after touching body fluids, aminated items and when to avoid transfer of		All residents have the potential to be affected. After the facility was aware deficient practice on 9/27/22. The Dir	

Facility ID: 923538

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY LETED
		345489	B. WING_		00/	29/2022
NAME OF P	ROVIDER OR SUPPLIER	1 1 1 1		STREET ADDRESS, CITY, STATE, ZIP CODE	091	29/2022
				1930 WEST SUGAR CREEK ROAD		
SATURN N	NURSING AND REHABIL	LITATION CENTER				
				CHARLOTTE, NC 28262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From pag	e 56	F 8	30		
F 000	microorganisms to of equipment, and the eperform hand hygien the resident or the rebody fluid exposure reperforming resident of the performing resident of the performing an observation #2 donned a pair of the performing hand hygical bathroom in Resident washcloth. Using the cleanser spray NA #2 incontinence and wip Resident #10. Wearing the front perior and bathroom doorknob to using the sink faucet washcloth, turned the bathroom door and recontinued to wipe the #10. Wearing the sar privacy curtain out of the doorknob to ente water on to rinse the water off, closed the to the bedside and with buttocks, applied a binad cleaned, then plaresident. NA #2 remogloves in the trash.  An interview was cor PM with NA #2. NA #remove her gloves of she had wiped Reside episode of urinary incompared to the perior of the plant	ther residents, personnel, environment. Staff will e before and after touching sident's surrounding, after a risk, and before and after care."  In on 09/27/22 at 5:15 PM NA clean gloves without iene and entered the shared at #10's room to wet a wet washcloth and a peri 2 began care for urinary bed the front peri area of ang the same gloves used to ea NA #2 grabbed the chen turned the water on handle. NA #2 rinsed the enterned to the bedside and a front peri area of Resident me gloves NA #2 moved the finer way, and again grabbed or the bathroom and turn the washcloth. NA #2 turned the bathroom door and returned iped Resident #10's arrier cream to areas she acced a clean brief on the oved and discarded her  anducted on 09/27/22 at 6:22 to 2 confirmed she didn't reperform hand hygiene after lent #10 clean from an continence and before	F 8	of Nursing begin infection contron 9/27/2022 to include proper hygiene. Director of Nursing to hand hygiene re-education with staff and agency staff as of 10/Address what measures will be place or systemic changes madensure that the deficient practic recur:  On 10/07/2022 the Director Services/ designee-initiated ed current facility staff, to include a hand hygiene. Staff will perforn hygiene according to CDC guid the "10 moments for hand hygiconsists of: When coming on dompleting duty; Before and aftouching the resident or the resurrounding; Before, during, and eating or handling food; After gotolet, sneezing, coughing into help blowing or wiping nose; After reclothes; When hands are visibly Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing	hand complete a all facility 22/2022. e put into de to ce will not  of Nursing ucation for agency on a hand delines and ene" which uty and ter sident's ad after oing to the hands, emoving y soiled; y invasive essing defore and on orming deltion date  or started staff on the CMS YouTube rocedures for	
	During an observation #2 donned a pair of operforming hand hyg bathroom in Resident washcloth. Using the cleanser spray NA #2 incontinence and wip Resident #10. Wearing wipe the front peri are bathroom doorknob to using the sink faucet washcloth, turned the bathroom door and recontinued to wipe the #10. Wearing the sar privacy curtain out of the doorknob to ente water onto rinse the water off, closed the to the bedside and with buttocks, applied a bind cleaned, then plained to the plain in the water off. An interview was cored provided in the trash.  An interview was cored provided in the water off was applied a bind cleaned, then plained in the trash.  An interview was cored provided in the trash with NA #2. NA #2 remove her gloves of she had wiped Resident episode of urinary into touching other surface.	on on 09/27/22 at 5:15 PM NA clean gloves without iene and entered the shared it #10's room to wet a wet washcloth and a peri 2 began care for urinary bed the front peri area of ing the same gloves used to ea NA #2 grabbed the chen turned the water on handle. NA #2 rinsed the ewater off and closed the eturned to the bedside and it front peri area of Resident in egloves NA #2 moved the finer way, and again grabbed if the bathroom and turn the washcloth. NA #2 turned the bathroom door and returned in ped Resident #10's arrier cream to areas she acced a clean brief on the oved and discarded her		Address what measures will be place or systemic changes made ensure that the deficient practic recur:  On 10/07/2022 the Director Services/ designee-initiated ed current facility staff, to include a hand hygiene. Staff will perform hygiene according to CDC guid the "10 moments for hand hygiconsists of: When coming on dompleting duty; Before and aft touching the resident or the resurrounding; Before, during, and eating or handling food; After gotoliet, sneezing, coughing into be blowing or wiping nose; After reclothes; When hands are visible Before and after performing and procedure (e.g., fingerstick, druchange etc. Blood sampling); Before and after performing entering isolation precauting settings; Before and after performing to resident care. Education computed to the current facility hand sanitation using the recommended "Clean Hands" New York and the procedure of the current facility hand sanitation using the recommended "Clean Hands" New York and the place of t	e put into de to de to de will not  r of Nursing ucation for agency on n hand delines and ene" which uty and ter sident's id after oing to the nands, emoving y soiled; y invasive essing defore and on orming deletion date  or started staff on the CMS YouTube rocedures for	

Facility ID: 923538

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345489	B. WING			1	C <b>29/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 097.	29/2022
CATUDAL	UIDOINO AND DELLADII	ITATION OFNITED		193	30 WEST SUGAR CREEK ROAD		
SAIURNI	NURSING AND REHABIL	ITATION CENTER		CH	HARLOTTE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	providing care to the revealed she did rece gloves and perform h process when there with body fluids such.  An interview was con AM with the Director revealed she expected and wash her hands and after removed. The expected staff to remain hand hygiene after in	ygiene because she was same resident. NA #2 vive training to remove and hygiene after a dirty was a possibility of contact as urine.  ducted on 09/23/22 at 11:44 of Nursing (DON). The DON at NA #2 to follow protocol before gloves were donned the DON stated she ove gloves and perform continence care was hing other surfaces and	F 8	880	designee will continue the education which will be completed on 10/19/2022 This training will be a part of the nest staff orientation. No employee, includin agency will be allowed to work will education after 10/19/2022.  The Administrator and Director of Nursi will complete Module 7: Hand Hygiene the CDC Infection Prevention training to CDC TRAIN to improve their ability to the staff on proper hand hygiene and monification and the staff on proper hand hygiene. Training will be completed by 10/19/2022.	ew ig ithout ing of hru rain tor	
					monitor its performance to make sure to solutions are sustained: The Director of Nursing / Unit Manager Wound Care Nurse will perform hand hygiene audits during incontinent and Acare randomly on 5 employees weekly weeks, 3 employees weekly x 4 weeks then 5 employees monthly for 1 month.  On 10/21/2022, Administrator will implement more surveillance rounds to ensure the staff is complying with hand hygiene procedures while assigning members of the facility management te to perform hand hygiene observations during weekly ambassador rounds for a total of 10 observations weekly x 4 week.  The Administrator will report the results the observational hand hygiene audits	ADL x 4 ,	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345489	B. WING _			C <b>09/29/2022</b>	2
NAME OF P	ROVIDER OR SUPPLIER	0.0.00	<del>-                                    </del>	STREET ADDRESS, CITY, STATE, ZII	P CODE	09/29/2022	
				1930 WEST SUGAR CREEK ROAI			
SATURN	NURSING 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 ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIA		ETION
F 880	Continued From page	÷ 58	F8	weekly to QAPI Committed proper hand hygiene is been the QAPI Committee will audits monthly for 3 months for any need improvement. The QAPI modify this plan to ensur remains in compliance. If the review will be kept by Administrator in the QAPI (Compliance Date: 16)	peing performe Il review the oths then quarte ded Committee ca e the facility Documentation the Il book.	erly n	