STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING _____ B. WING _____	R-C 02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING AND REHABILITATION CENTER	**1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/27/18, the Division of Health Service Regulation conducted an onsite revisit. The facility remains out of compliance.	F 000		

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

Electronically Signed | 03/20/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	INITIAL COMMENTS On 2/27/18, the Division of Health Service Regulation conducted a complaint investigation. Past non-compliance was identified at: CFR 483.25 at tag F689 at a scope and severity of G.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on a resident interview, staff interviews, and medical record review, the facility failed to use a gait belt when one staff person transferred Resident #5 from the bed to the wheel chair which resulted in a fractured right shoulder, right shoulder pain, an emergency department (ED) evaluation and orthopedic consult. This occurred for 1 of 3 sampled residents reviewed for safe transfers. The findings included: Resident #5 was admitted to the facility on 10/3/01. Diagnoses included diabetes mellitus 2, diabetic retinopathy, cerebrovascular accident, hemiplegia (left non-dominant side), stiffness of right hand, unsteadiness on feet and chronic pain.	F 689	Past noncompliance: no plan of correction required.	3/13/18

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

Electronically Signed | 03/16/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 1	F 689		

An annual Minimum Data Set, dated 2/15/18 assessed Resident #5 with intact cognition, adequate hearing, impaired vision (required corrective lenses), clear speech, with the ability to be understood and to understand. The Resident required extensive staff assistance of 2 persons with transfers, limited upper extremity range of motion (ROM) on one side and did not attempt a surface to surface transfer during the assessment period.

A Resident Care Guide, updated 2/16/18 recorded Resident #5 required transfer assistance from 2 staff persons.

Review of the facility's Resident Incident Report and Health Care Personnel Registry (HCPR) 24 Hour Initial Report, both dated 2/16/18, documented that on 2/16/18 around 3 PM, Resident #5 complained of right shoulder/arm pain. An X-ray was ordered and the results confirmed a shoulder fracture. The Director of Nursing (DON) interviewed Resident #5 on 2/16/18 around 3:20 PM. Resident #5 stated that nurse aide (NA) #1 from last night (2/15/18) pulled her arm twice, the Resident asked NA #1 to stop, but she didn't. NA #1 was suspended on 2/16/18 pending the outcome of the investigation. The Police Department was notified on 2/16/18 at 4:10 PM, responded and filed a report. Resident #5 was sent to the ED on 2/16/18 for further evaluation and returned with a physician's order to wear a sling and an orthopedic consult.

Review of the electronic medical record for Resident #5 revealed there was no documentation of an incident which involved the Resident on 2/15/18 or 2/16/18.

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Review of the February 2018 electronic Medication Administration Record revealed Resident #5 received Tylenol 325 mg, 2 tablets (650 mg) on 2/16/18 at 2:37 PM for right shoulder pain reported as 6 on a scale of 1 - 10.

Medical record review for Resident #5 revealed the following physician's orders:
2/16/18 for a STAT (immediate) X-ray of right shoulder, right upper arm to rule out fracture
2/16/18 for Tramadol (pain medication) 5 mg twice daily for 3 days due to complaints of right shoulder pain
2/16/18 Send to (named hospital) for right humeral shaft fracture evaluation
2/16/18 Follow up (named orthopedic) within 2 - 4 days
2/20/18 Sling to right shoulder, pad strap if needed due to right minimally displaced proximal humerus fracture, will continue to watch with X-rays every 2 weeks, continue sling. Non weight-bearing right arm.

Review of the HCPR 5 Day Working Report, dated 2/21/18 revealed Resident #5 denied being abused; the investigation unsubstantiated abuse, but NA #1 was terminated due the injury Resident #5 sustained.

An interview on 2/27/18 at 1:00 PM with the DON revealed that on 2/16/18, Resident #5 reported pain to her right shoulder from a transfer on the 11-7 shift the night before to Nurse #2 and the staff development coordinator (SDC). The DON said when she was informed she, and the SDC, went to see the Resident on 2/16/18 around 3:20

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PM. The DON stated Resident #5 repeated the same story to them as documented in the incident report. She said "her story did not change." The DON stated she asked Resident #5 to demonstrate how her right arm was pulled and she did. The DON and SDC assessed the Resident's right arm, and during the assessment she complained of pain, and grimaced when ROM was attempted and when her arm was pressed. The DON said "she was obviously in pain." The DON further stated that a stat X-ray was obtained with positive results for right shoulder fracture. Resident#5 was sent to the ED for further evaluation and returned with an orthopedic consult. The DON stated that the facility started an abuse investigation because of how Resident #5 described the incident, even though she did not use the word "abuse". The investigation unsubstantiated abuse. NA #1 self-reported to Nurse #3 that she did not transfer Resident #5 with a gait belt as she had been trained and thought she may have injured the Resident. The DON described that Resident #5 could stand/pivot, and that one staff person using a gait belt could safely transfer the Resident despite the MDS assessment which indicated Resident #5 required the transfer assistance of 2 people. The DON stated "I have transferred her many times by myself using a gait belt." The DON stated that since the incorrect transfer resulted in injury to Resident #5, NA #1 was terminated. The DON stated that she expected all staff to have a gait belt when transferring a resident and to use the gait belt if a mechanical device was not used. The DON stated she updated the Resident Care Guide for Resident #5 on 2/16/18 to reflect she needed transfers with 2 staff persons while her right shoulder healed.

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An interview occurred on 2/27/18 at 1:13 PM with Nurse #1 and revealed she worked routinely with Resident #5 on the 7 - 3 PM shift. Nurse #1 said she was informed by NA #2 on 2/16/18 during the 7 - 3 PM shift when Resident #5 complained of pain to her right arm. Nurse #1 said she immediately went to see Resident #5 and the Resident said that NA #1 got her up on the 11-7 AM shift and hurt her arm. Nurse #1 described Resident #5 as alert/oriented. Nurse #1 said when Resident #5 told her this, she gave her Tylenol for pain and informed her supervisor. Nurse #1 confirmed recent in-services on transfers/abuse.

A telephone interview occurred with NA #1 on 2/27/18 at 1:40 PM and revealed she routinely worked with Resident #5 on the 11 - 7 AM shift. NA #1 stated she assisted Resident #5 with a transfer from her bed to her wheel chair towards the end of the 11 - 7 AM shift on 2/16/18. NA #1 stated during the transfer, Resident #5's "legs gave way, she dropped on me, I tried to keep her from hitting the floor, her right arm went up in the air, we heard a pop, and I immediately told the nurse." NA #1 further stated "We were not using gait belts regularly before this, but the SDC started reminding us to use our gait belts." NA #1 stated Resident #5 required 1 staff person assistance with transfers because the Resident could stand and pivot. NA #1 described "I was standing in front of her, I did not use my gait belt to transfer her, like I normally do, it was a lot going on that day, I had the gait belt but I did not use it for her transfer." NA #1 stated that she realized that was a mistake and that using the gait belt could have possibly prevented Resident #5 from getting hurt. NA #1 further stated that she really hated what happened to Resident #5 and

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wished it had not happened.

An interview occurred on 1/27/18 at 1:58 PM with NA #2 and revealed she worked routinely with Resident #5 on the 7 - 3 PM shift. NA #2 described Resident #5 as alert/oriented. NA #2 stated that she was unaware of an incident that occurred with a transfer for Resident #5 until the Resident asked for assistance with incontinence care towards the end of the 7 - 3 PM shift. NA #2 said Resident #5 was in her wheel chair and during the transfer to her bed, the Resident complained of pain to her right shoulder. NA #2 stated she had checked on the Resident throughout the shift that day, but the Resident denied needing any assistance until then. NA #2 stated that Resident #5 did not complain of pain until the transfer from her wheel chair to her bed and she had to move her arm. NA #2 stated she immediately told Nurse #1. NA #2 confirmed she received recent in-services on abuse/transfers.

Resident #5 was interviewed on 2/27/18 at 2:10 PM and observed wearing a right arm sling. During the interview, Resident #5 said that few weeks ago, NA #1 transferred her alone, without a gait belt and during the transfer, the Resident's legs got weak and NA #1 pulled on her arm twice to help her stand. Resident #5 said they heard a pop the second time and NA #1 left out of her room to get the nurse. Resident #5 said Nurse #1 came in and looked at her arm, "But it was not hurting then, I did not have pain right away, it did not start hurting until later in the day when the other NA came to clean me up and put me to bed." Resident #5 confirmed that when she did complain of pain, she was medicated, her arm was assessed, X-rayed and she was sent to the ED for evaluation. Resident #5 also stated that

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NA #1 routinely transferred her alone, sometimes with a gait belt and sometimes without. Resident #5 confirmed she was interviewed by staff about abuse/transfers.

A telephone interview with Nurse #3 occurred on 2/27/18 at 3:30 PM and revealed she routinely worked with Resident #5 on the 11 - 7 AM shift. She described Resident #5 as alert/oriented. Nurse #3 stated at change of shift on 2/16/18 around 6:45 AM, NA #1 came to her and said "I was transferring (Resident #5), not the way I usually do and I think I hurt her arm." Nurse #3 stated she went immediately and assessed Resident #5, the Resident denied pain and there was no sign of injury when ROM was performed. Resident #5 said she was fine. Nurse #3 said she did not report the incident or document a progress note. Nurse #3 confirmed she received recent in-services on transfers/abuse.

An interview with the Administrator on 2/27/18 at 5:07 PM revealed he expected NA #1 to transfer Resident #5 with a gait belt for safety. The Administrator stated NA #1 had been trained on how to safely transfer a resident with 1 person assistance and she should have followed the facility's policy/procedures on safe transfers. The administrator stated the following corrective action had been completed as of 2/21/18 for Past Non-Compliance:

Quality Assurance Performance Improvement Committee met and developed a plan
All staff were in-serviced on transfers/abuse; any prn (as needed) staff could not work until they were re-educated.
Residents were interviewed regarding safe transfers/abuse

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F 689	Continued From page 7 Resident care guides were audited/updated regarding transfer status Staff compared nurse's notes with incident reports to make sure all incidents were reported timely Management staff monitored transfers and were currently monitoring 6 residents/6 employees each week to ensure they were aware of the procedure for reporting abuse, and conducting safe transfers Staff reviewed orientation packets to make sure it contained up-to-date information regarding abuse/transfers The facility continued to monitor/audit for ongoing compliance The facility provided documentation of training for NA #1 in January 2018 on the use of gait belts with transfers. The facility also provided documentation of corrective action as of 2/21/18 for in-services, audits and monitoring related to safe transfers, resident interviews and updated Resident Care Guides. At the time of the survey, sampled residents were observed transferred safely according to the transfer status documented on their Resident Care Guide. Interviews with alert/oriented residents revealed they were transferred according to the transfer status on their Resident Care Guide and they felt safe. Interviews with staff revealed they were aware of the facility's revised policy/procedures for safe transfers and preventing/reporting abuse.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		3/12/18

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 9 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to document an assessment of range of motion and pain in the medical record after a resident complained of pain to the right shoulder and a staff member reported transferring a resident without the use of a gait belt. This occurred for 1 of 5 medical records reviewed for identifiable information in the medical record (Resident #5). The findings included: Resident #5 was admitted to the facility on 10/3/01. Diagnoses included diabetes mellitus 2, diabetic retinopathy, cerebrovascular accident,	F 842	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to continue to improve the quality of life of each resident.	

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F 842	Continued From page 10 hemiplegia (left non-dominant side), stiffness of right hand, unsteadiness on feet and chronic pain. An annual Minimum Data Set, dated 2/15/18 assessed Resident #5 with clear speech, able to be understood and to understand, intact cognition, and required extensive staff assistance of 2 persons with transfers, limited upper extremity range of motion (ROM) on one side and did not attempt a surface to surface transfer during the assessment period. Review of the facility's Resident Incident Report and Health Care Personnel Registry (HCPR) 24 Hour Initial Report, both dated 2/16/18, documented that on 2/16/18 around 3 PM, Resident #5 complained of right shoulder/arm pain. An X-ray was ordered and the results confirmed a shoulder fracture. The Director of Nursing (DON) interviewed Resident #5 on 2/16/18 around 3:20 PM. Resident #5 stated that nurse aide (NA) #1 from last night (2/15/18) pulled her arm twice, the Resident asked NA #1 to stop, but she didn't. Resident #5 was sent to the ED on 2/16/18 for further evaluation. Review of the electronic medical record for Resident #5 revealed there was no documentation of an incident which involved the Resident on 2/15/18 or 2/16/18. Review of the February 2018 electronic Medication Administration Record revealed Resident #5 received Tylenol 325 mg, 2 tablets (650 mg) on 2/16/18 at 2:37 PM for right shoulder pain reported as 6 on a scale of 1 - 10. An interview on 2/27/18 at 1:00 PM with the DON	F 842	F 842 Root Cause Analysis Based on root cause analysis by facility administrative staff for incident on 2/16/18 with resident #5, facility Nurse #3 did not follow the facility policy/procedures that require written documentation in the resident medical record even though Nurse #3 was trained and in-serviced on 2/8/18. Nurse #3 also did not report to the oncoming nurse #1 about the incident or her assessment in accordance with facility policy/procedures. Immediate Action On 2/16/18 the day of the incident with resident #5, the resident was given pain medication, assessed by the Director of Nursing, X-rays taken, Nurse Practitioner examined resident, Nurse #3 and NA#1 were suspended, police contacted, Ombudsman contacted, Adult Protective Services contacted and 24 hour report sent with 5 day follow up. Identification of Others 100% skin audit compared to nursing documentation and Incident/Accident reports for of all facility residents was done by 2/22/18. There were no other residents identified with a documentation concern compared to skin audits or incident/accident. Systemic Changes Measures put into place to ensure the plan of correction is effective and remains in compliance are: In-service all nursing staff on facility policy/procedure for documentation and reporting to the oncoming nurse or administrative nursing.	

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SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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F 842	Continued From page 11 revealed Resident #5 reported to Nurse #2 and the staff development coordinator (SDC) on to 2/16/18 pain to her right shoulder from a transfer on the 11-7 shift the night before. The DON said when she was informed, she and the SDC, went to see the Resident on 2/16/18 around 3:20 PM. The DON stated Resident #5 repeated the same story to them as documented in the incident report. NA #1 self-reported to Nurse #3 that she did not transfer Resident #5 with a gait belt as she had been trained and thought she may have injured the Resident and Nurse #3 went immediately to assess the Resident. The DON further stated that when she investigated this she determined that Nurse #3 did not document her assessment or report to the oncoming nurse what occurred. An interview occurred on 2/27/18 at 1:13 PM with Nurse #1 and revealed she worked routinely with Resident #5 on the 7 - 3 PM shift. Nurse #1 said she did not receive a report from Nurse #3 on 2/16/18 regarding an incident during a transfer. Nurse #1 said she was informed by NA #2 on 2/16/18 during the 7 - 3 PM shift when Resident #5 complained of pain to her right arm. Nurse #1 said she immediately went to see Resident #5 and the Resident said that NA #1 got her up on the 11-7 AM shift and hurt her arm. Nurse #1 described Resident #5 as alert/oriented. Nurse #1 said when Resident #5 told her this, she gave her Tylenol for pain and informed her supervisor. A telephone interview occurred with NA #1 on 2/27/18 at 1:40 PM and revealed she routinely worked with Resident #5 on the 11 - 7 AM shift. NA #1 stated she assisted Resident #5 with a transfer from her bed to her wheel chair on the 11 - 7 AM shift on 2/16/18, but did not use a gait belt,	F 842	All nursing staff to include full time, part time and as needed will receive the in-serviced by 3/9/18. Any staff member not educated by 3/9/18 will not be allowed to work until receiving in-service. The education will also be added to the new hires orientation process effective 3/9/18 Monitoring Process Starting 3/12/18 a weekly audit using the Documentation of Incident/Accident form will be used weekly for 10 residents. The audit will be conducted by the nursing administrative staff weekly for 8 weeks or until a pattern of compliance is maintained. Any negative findings will be addressed immediately with staff for corrective action. The Administrator and or the DON will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING _____ B. WING _____	C 02/27/2018

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F 842	Continued From page 12	F 842		

heard a pop and thought she may have hurt the Resident's arm. NA #1 stated she immediately told Nurse #3.

Resident #5 was interviewed on 2/27/18 at 2:10 PM and observed wearing a right arm sling. During the interview, Resident #5 said that few weeks ago, NA #1 transferred her alone and without a gait belt and during the transfer, the Resident's legs got weak and NA #1 pulled on her arm twice to help her stand. Resident #5 said they heard a pop the second time and NA #1 left out of her room to get the nurse. Resident #5 said Nurse #3 came in and looked at her arm, but it was not hurting then, and did not start hurting until later in the day when she received assistance from NA #2.

A telephone interview with Nurse #3 occurred on 2/27/18 at 3:30 PM and revealed she routinely worked with Resident #5 on the 11 - 7 AM shift. She described Resident #5 as alert/oriented. Nurse #3 stated at change of shift on 2/16/18 around 6:45 AM, NA #1 came to her and said "I was transferring (Resident #5), not the way I usually do and I think I hurt her arm." Nurse #3 stated she went immediately and assessed Resident #5, the Resident denied pain and there was no sign of injury when ROM was performed. Nurse #3 said she did not report this to the oncoming nurse, write a note in the 24 hour communication book or document a progress note in the medical record because it seemed there was no injury. Nurse #3 stated "I did not give a report, I inadvertently forgot, I got busy giving insulin and checking blood sugars."

An interview with the Administrator on 2/27/18 at 5:07 PM revealed he expected the nurse who

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F 842	Continued From page 13 failed to document the incident should have taken credit for the assessment she completed and at least documented a nurse's note regarding her assessment of the Resident so that the medical record would document what occurred.	F 842		