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 02/19/2021

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 The survey team entered the facility on 2/16/21 to conduct an unannounced complaint investigation. Additional information was obtained offsite on 2/17/21 through 2/19/21. Therefore, the exit date was 2/19/21. 18 of the 18 complaint allegations were unsubstantiated. Event ID# YUBT11.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		3/19/21

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

Electronically Signed | 03/12/2021

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F 842	Continued From page 1 (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 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 842	The statements included are not an	

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F 842	Continued From page 2 facility failed to transcribe a physician's order, document regarding initiation of a new order, and document treatment provided by the facility into the medical record for 1 of 3 residents reviewed for change in condition (Resident #2). Findings included: Resident #2 was readmitted to the facility on 3/14/18 with medical diagnoses inclusive of Parkinson's disease, other muscle spasm, and other seizures. Resident #2's quarterly Minimum Data Set dated 12/18/20 identified he was severely cognitively impaired. Resident #2's care plan updated on 1/29/21 identified a focus area for at risk for skin breakdown related to incontinence and decreased mobility. Record review of Resident #2's wound evaluation and management summary dated 2/3/21 identified an initial assessment of a wound on the left, dorsal, third toe. The dressing treatment plan for the toe wound was leptospermum honey, apply once daily for thirty days. A wound evaluation and management summary dated 2/10/21 identified Resident #2's wound of the left, dorsal, third toe resolved. Record review of Resident #2's physician orders, medication administration record (MAR) and treatment administration record (TAR) for the month of February 2021 revealed no orders or documentation of treatment for Resident #2's left, third, toe wound. On 2/19/21 at 5:28 PM, an interview was conducted with Nurse #1 who previously was the	F 842	admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The following will be accomplished for residents having been affected by the practice: " Resident #2 was evaluated on 2/17/2021 by the Wound Physician with no new areas identified. Left third toe wound identified on 2/3/2021 was resolved on 2/10/2021. Regional Nurse consultant reviewed 2/17/2021 Wound Physician summary for proper documentation and implementation of recommendation and noted no discrepancies. The following will be accomplished for residents who have the potential to be affected by the practice: " The Nurse Administration (Director of Nursing, Treatment Nurse, and Unit Coordinators) will review current resident Physician Orders for the last 30 days to ensure accurate transcription and initiation. Any identified issues will be corrected immediately. The audit will be	

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F 842	Continued From page 3 facility's treatment nurse. Nurse #1 reported the wound doctor examined all resident's feet during his weekly visits to the facility. On 2/3/21, Nurse #1 stated the wound doctor identified a wound on Resident #2's left, third toe. Nurse #1 also reported she was responsible for transcribing new treatment orders by the wound doctor into the resident's electronic medical record. She could not recall if she had transcribed the new wound orders or documented treatment was provided for Resident #2's left, third, toe wound. Nurse #1 stated she treated Resident #2's left toe wound as ordered and a week later the wound was healed. An interview was conducted with the Director of Nursing on 2/19/21 at 5:49 PM. She stated new orders were processed as written by the provider, documented as a new order in the resident's progress notes and initialed on the TAR. The Administrator was interviewed on 2/19/21 at 5:50PM. She stated nurses should follow the process for transcribing new orders and initialing on the resident's MAR or TAR after completing the task.	F 842	completed by 3/19/2021. " Nursing Administration will review the most recent Wound Physician recommendations to ensure that all recommendations have been addressed and transcribed into the medical record. Any identified issues will be corrected immediately. This audit will be completed by 3/19/2021 " The Nurse Administration conducted a 100% skin audit of all current residents on 3/4/2021 to identify any new skin issues. Any identified skin issues will be checked for appropriate treatment plans to be completed by 3/16/2021. The following measures have been put in place to ensure that the practice does not recur: " Beginning 3/12/2021 all Licensed Nursing Staff will be re-educated on the transcription of Physician orders and ensuring proper documentation of wound treatments by the Staff Development Coordinator education will be completed by 3/19/2021. " On 3/12/2021 the Wound/Treatment Nurse was re-educated by the Staff Development Coordinator on implementation of Wound Physician recommendations. " On 3/11/2021 Nursing Administration was re-educated by the Regional Clinical Consultant on review of Physician orders to ensure accuracy of transcription in to the Electronic Medical Record. The following monitoring system will be	

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F 842	Continued From page 4	F 842	implemented to ensure that the solution is sustained: " Nursing Administration will review Physician Orders in Clinical Morning meeting to ensure accuracy of transcription into the Electronic Medical Record. Audit will be conducted Monday Friday x 12 weeks. " Nursing Administration will review weekly Wound Physician reports to ensure implementation and documentation of recommendations. Audit will be conducted in Clinical Morning Meeting the following day after Wound Physician Rounds weekly x 12 weeks. " The Director of Nursing will be reported and discussed in monthly Quality Assurance and Performance Improvement a review of the audits meetings monthly for 3 months and/or until substantial compliance is maintained. QAPI committee can modify this plan in order to assure substantial compliance. " Effective 3/19/2021 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. The facility alleged full compliance with this plan of correction effective date 3/19/2021	