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	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	1930 West Sugar Creek Road Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on observation, record reviews and resident, staff, Physician Assistant (PA), and Medical Director (MD) interviews, the facility failed to protect residents' rights to be free from physical and/or emotional abuse for 4 of 4 residents sampled. The abuse occurred on 4 separate occasions. The [AGE] year-old resident (Resident # 1) had a history of aggressive behavior when he cursed at and shook Resident #8 in September, 2021. Resident #1 pushed an [AGE] year-old male resident (Resident #4) to the floor in July, 2022, followed by Resident #1 grabbing the wrist of a [AGE] year-old female resident (Resident # 6) causing a bruise in August, 2022, then punched a [AGE] year-old male resident (Resident # 2) in the chest, September, 2022, and intimidated and threatened physical harm through verbal communication to a [AGE] year-old male resident (Resident #3) in September, 2022 causing fear. The immediate jeopardy began on 07/16/22 when Resident #1, who was cognitively intact, pushed Resident #4, who was a cognitively impaired wanderer, to the floor. The immediate jeopardy was removed on 09/24/22 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity E (no actual harm) to ensure monitoring systems are put into place are effective. The findings included: A review of a Facility Reported Incident dated 09/10/21 at 9:50 PM indicated Resident #1 hit a resident (Resident #8). The 5-Day Working Report Summary indicated on 09/10/21 Resident #1 was witnessed by a facility NA (unidentified in report) to go up to Resident #8 and began calling her names and placed both his hands on her and began to shake her. 1. Resident #1 was readmitted to the facility on [DATE] with diagnosis that included multiple fractures following a motor vehicle accident (MVA). A quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #1 was cognitively intact and independent for all activities of daily living. Resident #1 was identified as being Supervision (requiring no hands-on assistance) with setup help assistance for activities of daily living (ADL) and no behaviors indicated. a. Resident #4 was admitted to the facility on [DATE] with diagnosis that included dementia with behavioral disturbances. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An annual MDS dated [DATE] indicated Resident #4 was cognitively impaired and required supervision assistance for ambulation and locomotion. Resident #5 was admitted to the facility on [DATE] with diagnosis that included bipolar disorder. A quarterly MDS dated [DATE] indicated Resident #5 was cognitively intact. An incident report dated 7/16/22 at 6:35 AM filed under Resident #1's name indicated Resident #1 allegedly pushed Resident #4 out of his room doorway to the floor in an attempt to remove Resident #4 from his room which was witnessed by Resident #1's former girlfriend, (Resident #5) who was also a resident in the facility, whom summoned assistance of a nurse aide (Nurse Aide #1) whom assisted Resident #4 to his feet and away from Resident #1's room. An additional incident report dated 7/16/22 at 6:35 AM filed under Resident #4's name indicated Resident #5 reported she went to Resident #1's room. Resident #5 indicated when she started to leave, she noticed Resident #4 in the doorway and told him to back up. Resident #5 indicated as she started towards to door to assist him to leave, Resident #1 told Resident #4 to get the F*** out of his room and proceeded to get up from his bed and pushed Resident #4 down to the floor and Resident #5 immediately went to get assistance. The incident further details as Resident #5 reported this incident to Nurse Aide (NA) #1, Resident #4 was visualized on all 4's with his head down to the floor in the hallway outside of Resident #1's room where she picked him up and noticed a small abrasion over his right eyebrow, the nurse provided treatment to the area, and Resident #4 was escorted to the lobby of the unit while the local police department were notified. An investigation report document provided by the facility indicated on 07/16/22 at approximately 5:30 AM, Resident #4 was found on the floor outside the room of Resident #1. It indicated Resident #5 had approached a Nurse Aide (NA #1) to report she had witnessed Resident #1 push Resident #4 out of his room. Resident #4 was assessed for injuries and found to have an abrasion to his right eyebrow and treatment was provided. Resident #4 was taken to the common area and placed on 1:1 for a week due to his high risk for wandering and exit seeking behaviors. The local police department was alerted of the incident and when onsite counseled Resident #1 on his engagement with other residents when upset. They also determined Resident #1 had improved significantly since admission and no longer needed skilled nursing care and issued a 30-day discharge notice to Resident #1 who appealed the decision for discharge. A statement dated 7/16/22 written by the former Staff Scheduler revealed NA #1 stopped her in the hallway at about 6:15 AM to report that Resident #1 had pushed Resident #4 to the floor. She explained that NA#1 told her Resident #5 was present in the room when the incident occurred. Nurse #1 who was present on the hall was informed and then the Administrator was made aware. A statement dated 7/16/22 written by NA #1 revealed she heard Resident #1 yelling when she came around to see what was going on she saw Resident #4 fall from the room of Resident #1 out the door. NA #1 asked Resident #1 if he pushed Resident #4, but he denied it and said he just fell . NA #1 wrote she asked Resident #5 what happened and Resident #5 again verified Resident #1 pushed Resident #4 out of his room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A statement written by Nurse #2 on behalf of Resident #5 indicated on the morning of 7/16/22 at approximately 6:35 AM she went to Resident #1. While in the room, Resident #4 wandered into the room and she asked him to back up. When she was going to attempt to help him out, Resident #1 yelled at Resident #4 to get the F*** out of here and proceeded to get out of bed and pushed Resident #4 to the floor. Then she left to get help. The statement further details the NA saw Resident #4 on the floor and helped him up and took him to the couch to sit down and then the nurse came over to talk to him. A statement written by Nurse #1 dated 7/16/22 indicated she heard a thud on the hallway and turned around and saw Resident #4 on his hands and knees in a crawling position with his head down outside of Resident #1's door. Resident #4 was assessed to have a small blister on his forehead similar to a carpet burn. The note indicated Resident #1 later in the day did admit to pushing Resident #4 because he was in his room. A statement written by the Social Worker (SW) #1 dated 7/18/22 indicated Resident #1 was interviewed by her and the Administrator and denied pushing Resident #4 and claimed he tripped over his shoelace when he wandered into his room around 3:00 AM on 7/16/22. The facility provided documents titled Action Round Sheets dated 7/19/22, 7/20/22, 7/21/22, 7/23/22, and 7/24/22 for 4 residents including Resident #4; however, Resident #1 was not included in these records. Action Round Sheets are a facility developed document to indicate a resident is on either a 1:1 supervision or every 15-minute (q15 min) observation checks where staff are to document an identified location of the designated resident and initial on a q15 min timeline basis. A review of email correspondence between the county Ombudsman and the Facility Administrator dated 07/21/22 through 07/28/22 indicated on 07/21/22, the facility Administrator reached out to the Ombudsman to request an in-person facility visit to review some ongoing concerns of the facility. The Ombudsman responded she would visit the facility on 07/26/22 at 1:30 PM. Additional correspondence continued on 07/28/22 to follow up on resources for available law enforcement support at the facility of which the Ombudsman indicated she would be back in touch with answers when they were available. An interview with Resident #1 on 09/21/22 at 11:15 AM revealed he denied all allegations related to touching Resident #4 on 07/16/22. Resident #1 would not even acknowledge Resident #4 being in his room. Resident #4 was cognitively impaired and therefore could not be interviewed during the survey. Resident #5 was no longer a resident of the facility and her phone number upon discharge was no longer a working number and therefore could not be interviewed during the survey. b. Resident #6 was admitted to the facility on [DATE] with diagnosis that included chronic obstructive pulmonary disease and chronic pain. A significant change MDS dated [DATE] indicated Resident #6 was cognitively intact and was independent for all activities of daily living. Resident #7 was admitted to the facility on [DATE] with diagnosis that included cerebral infarction. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A MDS dated [DATE] indicated Resident #7 was cognitively intact. An incident report dated 08/18/22 indicated Resident #6 reported that Resident #1 grabbed her wrist and twisted it which resulted in visible bruising. Resident #1 indicated Resident #6 slapped him across the face. A statement written by Resident #1 dated 08/18/22 indicated he and Resident #6 were in the courtyard smoking while the maintenance employee was attempting to clean the area. Resident #1 wrote that Resident #6 would not move so he got the blower and started blowing the area. Resident #1 indicated Resident #6 slapped him so he grabbed her wrist and held her hand up and then let her go. A statement written by the SW #1 on behalf of Resident #6 written on 8/18/22 indicated Resident #1 and Resident #6 had been outdoors in the smoking courtyard before lunch and talking with friends when the maintenance employee was attempting to blow the cigarette butts with the leaf blower. Resident #6 indicated Resident #1 began running his mouth and trying to cut her conversation off when she told him he was being rude so he asked the maintenance employee for the blower to help. Resident #1 was provided the blower and he began blowing the cigarette butts towards Resident #6's direction and she told him to stop that. Resident #6 stated Resident #1 grabbed her left wrist and twisted it and she told him to turn her loose. Resident #6 stated Resident #1 told her he would break her M***** F****** wrist. Resident #6 admitted she tapped Resident #1 on the head trying to get him to stop and Resident #1 again threatened Resident #6 and stated if she ever put her hands on him again he would kill her and he rolled off and she entered the building to report what happened. A written statement by the Maintenance employee dated 08/18/22 indicated he was outside in the area cleaning the area. The Maintenance employee wrote he witnessed Resident #6 slap Resident #1 in the face because he was trying to clean the way so the Maintenance man could clear the area because there was stuff on the ground that needed to be picked up. A review of documents provided by the facility titled, Action Round Sheet with Resident #1's name identified at the top dated 08/18/22, 08/19/22, 08/20/22, 8/21/22, and 8/23/22 indicated on the first sheet was initiated on 08/18/22 at 3:30 PM and Resident #1 was identified to be in various locations throughout the facility until 6:45 AM on 08/19/22. The second page of the document indicated it began at 7:00 AM on 08/19/22 and indicated Resident #1 left the facility for leave of absence (LOA- where the resident can sign themselves out of the facility to spend time in the community unsupervised) at 2:15 PM; however, Resident #1's nurse documentation reflected Resident #1 left the facility in stable condition at 3:19 PM on 08/19/22 and did not indicate when he returned to the facility. Page 2 of the document titled, Action Round Sheet reflected staff continued to document Resident being on LOA until 7:00 PM; however, did not reflect he returned to the facility on that date. Page 3 of the document indicated Resident #1 did not return to the facility until 5:15 PM on 8/20/22 and only indicated he was monitored through 7:00 PM on this date. The facility's document had page 4 missing which should include 8/22/22 and continued with page 5 to reflect q15 minute checks for Resident #1's whereabouts from 7:00 AM until 9:30 AM on 8/23/22. The Action Round Sheets provided did not indicate the length of time Resident #1 was to be placed on 1:1 supervision. A grievance and concern dated 8/18/22 indicated a resolution signed 8/22/22 with the police contacted due to the altercation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Documents provided by the facility dated 08/18/22 indicated alert and oriented residents were interviewed on whether they felt safe and comfortable at the facility of which multiple residents indicated No. The documents were questionnaires and did not include further details to the resident's individual fears nor were they signed by the staff conducting the interview. A statement written by SW #1 on 08/25/22 indicated Resident #7 was interviewed and stated he saw part of the interaction between Resident #1 and Resident #6 on 08/18/22, but refused to discuss which part and stated, What Resident #6 said is correct. An additional interview statement with Resident #7 in the presence of the Administrator on 08/25/22 indicated he only saw Resident #1 and Resident #6 exchange words that began in frustration over blowing of trash in the courtyard. The statement indicated he did not witness Resident #1 grab Resident #6's arm. An interview with Resident #1 on 09/21/22 at 11:15 AM revealed he would not discuss the events related to the incident between him and Resident #6. The only discussion Resident #1 would provide related to the incident was that neither decided to press charges on the other because we were both having a bad day. An interview with Resident #6 and Resident #7 on 09/23/22 at 10:15 AM revealed they both recalled the incident between Resident #1 and Resident #6 on 08/18/22 which occurred in the courtyard of the facility while they were all gathered to smoke. Resident #6 indicated on 08/18/22, the maintenance employee was outside in the courtyard using a leaf blower to blow off the sidewalks while several residents were talking. Resident #6 stated Resident #1 kept attempting to cut her conversation off and she turned to him and told him he was being rude and asked him to quit interrupting her. A few minutes later, Resident #1 asked the maintenance employee to use the leaf blower of which he allowed. When Resident #1 picked up the leaf blower, he began blowing the cigarette butts in the direction of Resident #6 causing dirt, mulch, and cigarette butts to fly up on Resident #6's clean white pants. Resident #6 says she told him again to stop and he then pointed the leaf blower directly at her and it touched her pants. She reached out and went to move the blower off her and Resident #1 grabbed her arm and twisted it. In Resident #6's attempt to get Resident #1 to let go, she then open handedly popped Resident #1 on the side of the head before he let go. Resident #6 and Resident #7 indicated Resident #1 told her he would break her M***** F****** wrist before letting her go. Immediately following the incident, Resident #6 and Resident #7 in agreement indicated Resident #1 stated, If you ever put your F****** hands on me again, I'll kill you. Resident #6 immediately left the courtyard to alert staff and Resident #7 stated Resident #1 went to another area of the courtyard. Resident #7 stated he didn't like to get involved because that stuff happens around here all of the time, do you realize where you are? c. Resident #3 was admitted to the facility on [DATE] with diagnosis that included dementia, muscle weakness and cerebral infarction. A quarterly MDS dated [DATE] indicated Resident #3 was cognitively intact and required total dependence with ADL. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nurse progress note dated 09/09/22 indicated Resident #1 was overheard by Nurse #3 yelling and cursing. When she arrived at the room, she overheard Resident #1 communicate to Resident #3, If you don't shut the f*** up yelling all the time, I am going to do something to help you stop yelling. The note indicated she told Resident #1 to leave the room and that he was not supposed to be in Resident #3's room. The note further stated Resident #1 wheeled off down the hallway and Nurse #1 reported the incident to the Director of Nursing (DON). A nurse progress note dated 09/19/22 written by Nurse #4 indicated Resident #1 was again observed by staff using threatening profanity towards Resident #3 after he was told multiple times to stay out of other residents' rooms. An unidentified NA assisted Resident #1 out of the room and frequent rounds were made to observe for behaviors through the remainder of the shift. An interview with Resident #1 on 09/21/22 at 11:15 AM revealed he recalled the interaction between himself and Resident #3; however, immediately said, I didn't touch him, I just told him to quit yelling because he was disturbing everyone. He further vocalized, the staff always lie on me. I don't hurt anyone. I am the resident council president and I do all kinds of things for other residents and staff and this is how I am repaid. I watch after all of these residents. An interview with Resident #3 on 09/22/22 at 9:20 AM revealed he recalled Resident #1 making threatening statements and cursing profanity towards him on multiple incidents over the last couple weeks. He indicated Resident #1 had recently come into his room and threatened to hurt him. Resident #3 stated he could not defend himself if Resident #1 did hit him and he was fearful he would come back and hurt him. Resident #3 communicated he was glad Resident #1 didn't have access to a pipe because he [NAME] like Resident #1 was crazy and in his anger would beat him and kill him. Resident #3 stated he has reported this to staff and they have observed Resident #1 in his room before but they don't do anything about it. Resident #3 stated after the incident on 09/19/22, he ended up crying after he was alone because he felt so frightened and fearful. Interview with the Administrator on 09/22/22 at 11:27 AM revealed he was not made aware of the verbal threat by Resident #1 towards Resident #3 that occurred on the night it occurred which was on Friday, 9/9/22, but instead learned of the interaction on Monday 9/12/22 during morning meeting and the team had the PA to evaluate Resident #3 because of his recent yelling episodes. He stated the facility moved Resident #3's roommate at the time and made medication adjustments at the end of August which he thought was correcting the problem but on 9/14/22 the PA had saw Resident #3 again and the changes had not improved the situation and yelling out had increased again. The Administrator stated the facility had attempted to issue Resident #1 a discharge but had been unsuccessful in securing him placement. d. Resident #2 was admitted to the facility on [DATE] with diagnosis that included Parkinson's disease, cognitive communication deficit, and dysarthria. The quarterly MDS dated [DATE] indicated Resident #2 was cognitively intact and required limited to extensive assistance for ADL. Review of the incident report dated 9/17/22 at 10:50 AM indicated Resident #1 punched Resident #2 in the chest which was witnessed by the Human Resources Manager (HR) through her office window which is adjacent to one of the facility's smoking courtyards. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the HR Manager's Statement dated 9/17/22 indicated she was sitting in her office and she heard yelling coming from Resident #1. She looked out her window to witness Resident #1 punch Resident #2 in the chest. She got up from her desk and ran outside. She wrote she did not approach Resident #1 but started calling his name to get his attention. An interview with the HR Manager on 09/21/22 at 3:40 PM revealed she was in her office at the time of the interaction between Resident #1 and Resident #2 on 09/17/22. The HR Manager indicated she heard a commotion outside and heard Resident #1 yelling because they were right in front of her window of her office. The HR Manager said she turned to look outside to see what was going on and witnessed Resident #1 punch Resident #2 in the chest. She indicated she immediately got up from her office and approached the smoking courtyard which was adjacent. The HR Manager stated she stood in the doorway of the courtyard hollering Resident #1's name before he acknowledged she was speaking to him. She indicated she did not go outside to physically intervene at that time because Resident #1 was no longer punching Resident #2. The HR Manager said when Resident #1 acknowledged her calling his name was when the current Scheduling Coordinator (Scheduling Coordinator #2) approached the area and went outside to tell Resident #2 to go back to his room and the HR Manager said she left the area and went to report the incident to the Activity Director and had no further involvement in the interaction. An interview with the Activity Director (AD) on 09/21/22 at 3:55 PM revealed she was on duty on 09/17/22 when the HR Manager reported to her that she witnessed Resident #1 punch Resident #2 in the chest. The AD indicated she did not intervene in the altercation between the residents, but only notified the Manager on Duty and the Administrator of the occurrence. An interview with Scheduling Coordinator #2 on 09/21/22 at 4:00 PM revealed she was on duty on 09/17/22 and was standing at the front entrance to the facility when she saw the HR Manager leave her office and heard her shouting at Resident #1 that he could not put his hands on another resident. The Scheduling Coordinator #2 stated she immediately went towards the smoking courtyard area and passed the HR Manager in the doorway and went outside and told Resident #2 to leave the courtyard and go back to his room. A progress note dated 9/17/22 at 12:13 PM written by the Activity Director indicated staff reported to her that Resident #1 punched another resident in the chest in the courtyard. Resident #2 was removed from the area at that time. It further detailed no injuries were observed at the time. Resident #1 was placed on 1:1 at that time and asked to give up his smoking materials but refused. He was told he was not to smoke in the same courtyard, but to go out front and to the left to smoke with supervision. While the police were in the building investigating, Resident #1 yelled at the police and zoomed away from them in his wheelchair while he was being interviewed. The Clinical Manager on Duty and Administrator were notified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with Resident #1 on 09/21/22 at 11:15 AM revealed he denied punching/hitting Resident #2 and said the staff were lying on him. He did admit he was out in the smoking courtyard on 9/17/22 at about 10-11 AM when he observed Resident #2 outside. He indicated Resident #2 had removed the lid from the smoking ashtray and was attempting to retrieve cigarette butts when he intervened and took the ashtray lid from Resident #2. Resident #1 stated the HR Manager approached the area after he blessed Resident #2 out and told him he could not be digging in the ashtray and accused him of hitting Resident #2. He stated the facility put him on 1:1 observation that day, but he did not want to be babysat so he called a friend and signed himself out of the facility. He stated he was not put back on 1:1 until Monday afternoon following being called to the Administrator's office about the incident that occurred on 9/17/22. An interview with Resident #2 on 09/22/22 at 4:30 PM revealed he was out in the courtyard on 9/17/22 attempting to retrieve cigarette butts from the ashtray because he had no money currently to purchase more. Resident #2 stated Resident #1 approached him punched him in the chest and back/side (flank area) then grabbed the lid of the ashtray from him and it fell to the ground. Shortly after this a staff member approached the courtyard and told him to go back to his room. Resident #2 said he didn't get hurt that day, but he was fearful of Resident #1 repeating this behavior in the future. An interview with the Administrator on 09/22/22 at 11:27 AM revealed the investigation regarding Resident #1 and Resident #2 was ongoing and did not provide any further details regarding its current status or the root cause. He simply stated the facility was in the process of planning to get Resident #1 discharged from the facility. A telephone interview with the PA on 09/22/22 at 1:30 PM revealed she was familiar with Resident #1 and felt he was not appropriate for skilled level of care and posed a threat to other residents in the facility as a result of his aggressive behaviors. She stated she was made aware of the incident between Resident #1 and Resident #2 when she arrived at the building on Tuesday 09/20/22 which was 3 days following the event. She stated she assessed Resident #2 at that the time and did not find obvious physical injuries and stated she did not visit Resident #1 on that date; however, she was aware he was known to be manipulative and have the ability to hide his outburst from her and the Medical Director during their visits by minimizing a lot of the details that transpired. An interview with the MD on 09/22/22 at 12:57 PM revealed he had not yet been made aware of the interaction between Resident #1 and Resident #2 which occurred on 09/17/22; however, did not feel Resident #1 was appropriate for skilled level of care and felt he needed to be discharged to a different type of setting due to his high physical functioning abilities. The MD stated Resident #1 has known outburst behaviors and a complete lack of concern for others, he wants it his way or no way. The MD also indicated due to his physical independence and his disruptive behavior with physical and verbal aggression towards others he posed a risk to all other residents who remain in the facility at present. The Administrator, Director of Nursing, and 2 members of the corporate staff were notified of immediate jeopardy on 09/22/22 at 6:15 PM. The facility provided the following immediate jeopardy plan for removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the non- compliance: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility failed to protect residents' rights to be free from verbal and physical abuse. A cognitively intact resident has abused 4 residents. Residents are fearful and have endured bruising and verbal and physical abuse. All residents are at risk for abuse. On 9/23/2022 Dietary Manager/Unit Manager completed interviews with all residents with a Brief Interview for Mental Status (BIMS) score of 9 or higher on abuse to ensure no further incidents of abuse. Director of Nursing and floor nurses completed skin audits for signs of abuse as of 9/23/2022 for all residents with a BIMS score of 8 or lower. On 7/16/2022 resident #1 allegedly pushed resident #4 causing resident #4 to fall to the floor. Nurse #1 immediately intervened with the confrontation. Nurse #1 separated Resident #1 and Resident #4 by having Resident #1 stay in his room and Resident #4 was placed on 1 on 1 monitoring by nursing assistant #1. 1 on 1 monitoring for Resident # 4 was for 72 hours. Nurse #1 provided assistance to Resident #4 and first aid. Police were contacted by Administrator on 7/16/2022 immediately following notification. Police officer interviewed Resident #1 and informed him that he cannot push or touch other residents. Facility Administrator determined that Resident #4 was wandering into Resident #1's room uninvited. On 7/18/2022 Administrator, Director of Nursing, Social Worker, and Physician determined that Resident #1 no longer required Skilled Nursing Level care. Administrator informed Social Worker to start discharge process for Resident #1 for placement in Assisted Living. On 7/18/2022 Social Worker started sending Resident #1's information to assisted living facilities for placement. On 7/18/2022 Administrator had a conversation with Resident#1 on the rules and policies about touching and or engaging in confrontation with other residents. Resident #1 informed Administrator that he understood. Administrator continued 1 on 1 supervision with Resident #1 for one week starting 7/16/22 through 7/24/22 and determined that resident #1 was not a risk to other residents related to Resident #4 entering his room and refusing to leave. As of 7/21/2022 all staff including agency staff were re-educated on facility abuse policy related to preventing and reporting abuse. On 8/18/2022 it was reported to Social Worker that Resident #1 grabbed Resident #6's wrist lifting her off the ground in the smoking area. Resident #1 and Resident #6 were immediately separated by facility staff. Facility Administrator was notified on 8/18/2022 by facility staff of the incident. Resident #1 was immediately placed on 1 on 1 supervision on 8/18/2022 for 96 hours to prevent any further incidents. Administrator contacted the police department of the alleged incident on 8/18/2022 immediately following notification of incident. Administrator started the investigation of the incident on 8/18/2022. Beginning on 8/18/2022 Administrator, Director of Nursing, Social Worker and Activities Director began interviewing all residents with a BIMS score of 10 or higher as well as witness Resident #7 and or staff who were in the smoking area at time of incident on 8/18/22. During the investigation and witness interviews it was determined by the Administrator that Resident #6 had slapped Resident #1 prior to Resident #1 grabbing Resident #6 wrist. Administrator determined that Resident #1 was not a danger to other residents in the facility. On 8/18/2022 Police Officer counseled Resident #1 on social behaviors. At time of incident on 8/18/2022 facility had already begun discharge process and were looking for alternate placement in an Assisted Living facility for Resident #1. Administrator and Director of Nursing re-educated all staff to include agency staff on facility abuse policy regarding reporting and preventing abuse as of 8/22/2022. (continued on next page)

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	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	1930 West Sugar Creek Road Charlotte, NC 28262

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/9/22 Resident #1 was heard yelling with profanity at Resident #3 in Resident #3's room to stop yelling or he would make him shut up by nurse #1. Nurse # 1 immediately removed Resident #1 from Resident #3's room. Nurse continued to monitor Resident #1 throughout the night to ensure he did not return to Resident #3's room. Nurse #1 documented that Resident #3 was noted to be without distress following the incident. On 9/17/2022 Resident #1 was seen in the smoking area by Human Resource Manager (HR) punching Resident #2 in the chest. Human Resource Director immediately went outside and deescalated the residents and had the Activity Director separate Resident #1 and Resident #2. Activity Director notified the Administrator on 9/17/2022 following the incident. Administrator immediately informed the Regional Director of Operations of the incident on 9/17/2022. Regional Director of Operations instructed the Administrator to start 1 on 1 supervision of Resident #1 until Administrator can get Resident #1 placed in Assisted Living. Administrator placed Resident #1 on 1 on 1 supervision beginning 9/17/2022 with no end date. Administrator began investigation of alleged incident on 9/17/2022. Facility has continued 1 on 1 supervision while looking for alternative placement. On 9/19/2022 Resident #1 was heard yelling threatening profanity at Resident #3. Nurse #1 removed Resident #1 from Resident #3's room immediately and continued his 1 on 1 supervision. Resident #1 had returned from outside visit and facility wasn't aware he had returned at that time and 1 on 1 was not in place. Facility receptionist has been in-serviced on resident requiring 1 on 1 supervision by the Regional Clinical Director on 9/23/2022 to ensure no resident with 1 on 1 in place return into the facility until 1 on 1 employee accompanies resident into f [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42090 Based on record reviews and staff interviews, the facility failed implement their abuse policy in the area of reporting an allegation of abuse to the State Agency (SA) when the facility was made aware Resident #1 made verbal threats towards another resident (Resident #2) for 1 of 4 residents reviewed for abuse. The findings included: A review of the facility's policy titled, Abuse Prevention, Intervention, Reporting, and Investigation dated revised 02/2021 indicated all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation is made. These reports must be provided to the facility Executive Director of the facility and to other officials (including the State Agency) A nurse progress note dated 09/09/22 indicated Resident #1 was overheard by Nurse #3 yelling and cursing. When she arrived at the room, she overheard Resident #1 communicate to Resident #3, If you don't shut the f*** up yelling all the time, I am going to do something to help you stop yelling. The note indicated she told Resident #1 to leave the room and that he was not supposed to be in Resident #2's room. The note further stated Resident #1 wheeled off down the hallway and Nurse #1 reported the incident to the Director of Nursing (DON). A nurse progress note written by Nurse #4 dated 09/19/22 indicated Resident #1 was again observed by staff using threatening profanity towards Resident #3 after he was told multiple times to stay out of other resident's rooms. An unidentified NA assisted Resident #1 out of the room and frequent rounds were made to observe for behaviors through the remainder of the shift. A review of the Facility Reported Incident (FRI) log indicated the incident between Resident #1 and Resident #3 was not reported to the SA during the required timeframes for submission of the initial report. Interview with the Administrator on 09/22/22 at 11:27 AM revealed he was not made aware of the verbal threat by Resident #1 towards Resident #3 that occurred on the night it occurred which was on Friday, 9/9/22, but instead learned of the interaction on Monday 9/12/22 during morning meeting. He indicated there was not a facility reportable incident report completed for this allegation of abuse through verbal threats as the facility did not consider this allegation to be abuse.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on resident and staff interviews, record review and policy review, the facility failed to thoroughly investigate abuse and protect the residents from further abuse for three (3) of 4 residents reviewed for abuse (Resident #2, Resident #4, and Resident #6). Specifically, when Resident #1 began exhibiting verbally and physically aggressive behaviors directed towards others in July 2022, the facility failed to implement effective measures to prevent further abuse due to all interventions placed during investigations by the facility were temporary and their discontinuation left other residents at risk for potential of abuse. The facility also failed to notify Adult Protective Services (APS) for 4 of 4 allegations of abuse (Resident #2, Resident #3, Resident #4, and Resident #6) and failed to notify and involve law enforcement for 2 of 2 allegations of abuse (Resident #3 and Resident #4). The immediate jeopardy began on 07/16/22 when Resident #1 pushed Resident #4 to the floor and the facility did not thoroughly investigate and put effective interventions in place to protect the remaining residents in the facility. The immediate jeopardy was removed on 09/24/22 when the facility implemented a credible allegation of jeopardy removal. The facility will remain out compliance at a lower scope and severity E (no actual harm with potential for harm) to ensure monitoring systems are put into place are effective. Findings included: 1. Resident #1 was readmitted to the facility on [DATE] with diagnosis that included multiple fractures following a motor vehicle accident (MVA). A quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #1 was cognitively intact and independent for all activities of daily living. An incident report dated 7/16/22 at 6:35 AM filed under Resident #1's name indicated Resident #1 allegedly pushed Resident #4 out of his room doorway to the floor in an attempt to remove Resident #4 from his room which was witnessed by Resident #1's former girlfriend, (Resident #5) who was also a resident in the facility, which summoned assistance of a nurse aide (Nurse Aide #1) which assisted Resident #4 to his feet and away from Resident #1's room. An additional incident report dated 7/16/22 at 6:35 AM filed under Resident #4's name indicated Resident #5 reported she went to Resident #1's room. Resident #5 indicated when she started to leave, she noticed Resident #4 in the doorway and told him to back up. Resident #5 indicated as she started towards to door to assist him to leave, Resident #1 told Resident #4 to get the F*** out of his room and proceeded to get up from his bed and pushed Resident #4 down to the floor and Resident #5 immediately went to get assistance. The incident further details as Resident #5 reported this incident to NA #1, Resident #4 was visualized on all 4's with his head down to the floor in the hallway outside of Resident #1's room where she picked him up and noticed a small abrasion over his right eyebrow, the nurse provided treatment to the area, and Resident #4 was escorted to the lobby of the unit while the local police department were notified. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An investigation report document provided by the facility indicated on 07/16/22 at approximately 5:30 AM, Resident #4 was found on the floor outside the room of Resident #1. It indicated Resident #5 had approached a Nurse Aide (NA #1) to report she had witnessed Resident #1 push Resident #4 out of his room. Resident #4 was assessed for injuries and found to have an abrasion to his right eyebrow and treatment was provided. Resident #4 was taken to the common area and placed on 1:1 for a week due to his high risk for wandering and exit seeking behaviors. The local police department was alerted of the incident and when onsite counselled Resident #1 on his engagement with other residents when upset. On 7/18/22, the Social Worker (SW #1) made attempts to contact other local nursing facilities to attempt to locate a secured unit for Resident #4. They also determined Resident #1 had improved significantly since admission and no longer needed skilled nursing care and issued a 30-day discharge notice to Resident #1 who appealed the decision for discharge. The facility provided documents titled Action Round Sheets dated 7/19/22, 7/20/22, 7/21/22, 7/23/22, and 7/24/22 for 4 residents including Resident #4; however, Resident #1 was not included in these records of residents to be watched at that time although his care plan dated 7/18/22 indicated an intervention of 1:1-gently encourage resident to notify staff of any incidents and provide staff time to provide resolution. Action Round Sheets are a facility developed document to indicate a resident is on either a 1:1 supervision or every 15-minute (q15 min) observation checks where staff are to document an identified location of the designated resident and initial on a q15 min timeline basis. Again, Resident #1 was not included in the internal facility document titled Action Round Sheets. There was no evidence that the resident-to-resident altercation between Resident #1 and Resident #4 was thoroughly investigated; reported to the local law enforcement or APS. The intervention of 1:1 supervision put in place for Resident #4 did not ensure Resident #1 did not pose further danger to all other residents in the facility at the time of the incident. An incident report dated 08/18/22 indicated Resident #6 reported that Resident #1 grabbed her wrist and twisted it which resulted in visible bruising. Resident #1 indicated Resident #6 slapped him across the face. A review of documents provided by the facility titled, Action Round Sheet with Resident #1's name identified at the top dated 08/18/22, 08/19/22, 08/20/22, 8/21/22, and 8/23/22 indicated on the first sheet was initiated on 08/18/22 at 3:30 PM and Resident #1 was identified to be in various locations throughout the facility until 6:45 AM on 08/19/22. The second page of the document indicated it began at 7:00 AM on 08/19/22 and indicated Resident #1 left the facility for leave of absence (LOA- where the resident can sign themselves out of the facility to spend time in the community unsupervised) at 2:15 PM; however, Resident #1's nurse documentation reflected Resident #1 left the facility in stable condition at 3:19 PM on 08/19/22 and did not indicate when he returned to the facility. Page 2 of the document titled, Action Round Sheet reflected staff continued to document Resident being on LOA until 7:00 PM; however, did not reflect he returned to the facility on that date. Page 3 of the document indicated Resident #1 did not return to the facility until 5:15 PM on 8/20/22 and only indicated he was monitored through 7:00 PM on this date. The facility's document had page 4 missing which should include 8/22/22 and continued with page 5 to reflect q15 minute checks for Resident #1's whereabouts from 7:00 AM until 9:30 AM on 8/23/22. The Action Round Sheets provided did not indicate the length of time Resident #1 was to be placed on 1:1 supervision. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's medical record revealed no other interventions implemented to mitigate the risk of further abuse to other residents. The care plan only included a duplication of the 7/18/22 intervention with an updated date of 8/19/22 which indicated 1:1-gently encourage resident to notify staff of any incidents and provide staff time to provide resolution. Documents provided by the facility dated 08/18/22 indicated alert and oriented residents were interviewed on whether they felt safe and comfortable at the facility of which multiple residents indicated No. The facility was unable to provide any documentation of interventions that were provided to the alert and oriented resident that verbalized they were fearful of living at the facility. There was no evidence that the resident-to-resident altercation between Resident #1 and Resident #6 was thoroughly investigated; reported to APS. The intervenetions placed for Resident #1 were not monitored to effectively ensure they did prevented further danger to all residents in the facility at the time of the incident. Resident #1 was placed on a temporary 1:1 supervision; however, he signed himself out of the facility on a leave of absence and did not alert staff upon return to resume 1:1 supervision or re-evaluate him for continuation of 1:1 monitoring; therefore, when he returned to the facility he was not monitored to ensure others safety. A nurse progress note dated 09/09/22 indicated Resident #1 was overheard by Nurse #1 yelling and cursing. When she arrived at the room, she overheard Resident #1 communicate to Resident #3, If you don't shut the f*** up yelling all the time, I am going to do something to help you stop yelling. The note indicated she told Resident #1 to leave the room and that he was not supposed to be in Resident #3's room. The note further stated Resident #1 wheeled off down the hallway and Nurse #1 reported the incident to the Director of Nursing (DON). A nurse progress note dated 09/19/22 indicated Resident #1 was again observed by staff using threatening profanity towards Resident #3 after he was told multiple times to stay out of other resident's rooms. An unidentified NA assisted Resident #1 out of the room and frequent rounds were made to observe for behaviors through the remainder of the shift. An interview with Resident #3 on 09/22/22 at 9:20 AM revealed he recalled Resident #1 making threatening statements and cursing profanity towards him on multiple incidents over the last couple weeks. He indicated Resident #1 had recently come into his room and threatened to hurt him. Resident #3 stated he could not defend himself if Resident #1 did hit him and he was fearful he would come back and hurt him. Resident #3 communicated he was glad Resident #1 didn't have access to a pipe because he feels like Resident #1 is crazy and in his anger would beat him and kill him. Resident #3 stated he has reported this to staff and they have observed Resident #1 in his room before but they don't do anything about it. Resident #3 stated after the incident on 09/19/22, he ended up crying after he was alone because he felt so frightened and fearful. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the Administrator on 09/22/22 at 11:27 AM revealed he was not made aware of the verbal threat by Resident #1 towards Resident #3 that occurred on the night it occurred which was on Friday, 9/9/22, but instead learned of the interaction on Monday 9/12/22 during morning meeting and the team had the Nurse Practitioner to evaluate Resident #3 because of his recent yelling episodes. He stated the facility moved Resident #3's roommate at the time and made medication adjustments at the end of August which he thought was correcting the problem but on 9/14/22 the NP had saw Resident #3 again and the changes had not improved the situation and yelling out had increased again. The Administrator stated the facility had attempted to issue Resident #1 a discharge but had been unsuccessful in securing him placement. There was no evidence that the resident-to-resident altercation between Resident #1 and Resident #3 was investigated by the facility; reported to the State Agency, Local Law Enforcement, or APS; and there were no interventions were placed for Resident #1 to ensure he did not pose further danger to Resident #3 or any other residents in the facility at the time of the incident. Resident #1 was observed not to be on 1:1 supervision on 09/19/22 when he returned to Resident #3's room and verbally abused Resident #3 for a second time causing Resident #3 to remain fearful. Review of the incident report dated 9/17/22 at 10:50 AM indicated Resident #1 punched Resident #2 in the chest which was witnessed by the Human Resources Manager (HR) through her office window which is adjacent to one of the facility's smoking courtyards. Attempts were made to contact the former Social Worker (SW #1) were unsuccessful during the investigation. A progress note written by the Social Worker (SW #2) on 09/20/22 at 5:17 PM indicated she, the HR Manager and the Activity Director went to the magistrate's office to see what could be done regarding Resident #1's aggressive behaviors to include a possible arrest or warrant; however, the magistrate explained the process to facility staff in which the police officers would have to take initiative which would be handled outside of the magistrate's office. An investigation report by the facility which indicated on 09/20/22 at 12:30 PM, the police officers and the magistrate had a telephone conversation with the facility and the magistrate/police officers advised the facility they could not arrest Resident #1 because they did not see the injuries and magistrate had consulted with the officer's attorney to see how to help the situation legally. The officers advised the facility to discharged Resident #1 immediately for the safety of the other residents. The resident-to-resident altercation between Resident #1 and Resident #2 was not reported to APS at the time of the initial report. Resident #1 was placed on 1:1 supervision on the date of the incident (09/17/22); however, was observed not to be on 1:1 supervision on 09/19/22 when he was observed to be making verbal threats towards Resident #3 and the resident's had to be separated by the nurse. The Administrator, Director of Nursing, Regional Nurse Consultant and Regional Operations Director were notified of immediate jeopardy on 09/22/22 at 6:15 PM. The facility provided the following immediate jeopardy plan for removal: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the non- compliance: After a cognitively intact resident abused a resident in July, the facility failed to implement effective measures to protect all residents. After a cognitively intact resident abused a resident in August, the facility failed to implement effective measures to protect all residents. After a cognitively intact resident abused a resident in September, the facility failed to implement effective measures to protect all residents and there was an additional abuse of another resident in September. The facility failed to protect residents' rights to be free from verbal and physical abuse. A cognitively intact resident has abused 4 residents. Residents are fearful and have endured bruising and verbal and physical abuse. All residents are at risk for abuse. On 9/23/2022 Dietary Manager/Unit Manager completed interviews with all residents with a Brief Interview for Mental Status (BIMS) score of 9 or higher on abuse to ensure no further incidents of abuse. Director of Nursing and floor nurses completed skin audits for signs of abuse as of 9/23/2022 for all residents with a BIMS score of 8 or lower. On 7/16/2022 Resident #1 allegedly pushed Resident #4 causing Resident #4 to fall to the floor. Nurse #1 immediately intervened with the confrontation. Nurse #1 separated Resident #1 and Resident #4 by having Resident #1 taken to common area of the facility and placed on 1:1 by nursing assistant #1. Nurse #1 provided assessment of Resident #1 and first aid. Police were contacted by Administrator on 7/16/2022 immediately following notification. Police Officer interviewed Resident #1 and informed him that he cannot push or touch other residents. Facility Administrator determined that resident #4 was wandering into resident #1's room uninvited. On 7/18/2022 Administrator, Director of Nursing, Social Worker, and Physician determined that Resident #1 no longer required Skilled Nursing Level care. Administrator informed Social Worker to start discharge process for Resident #1 for placement in Assisted Living. On 7/18/2022 Social Worker started sending Resident #1's information to assisted living facilities for placement. On 7/18/2022 Administrator had a conversation with Resident#1 on the rules and policies about touching and or engaging in confrontation with other residents. Resident #1 informed administrator that he understood. Administrator continued 1 on 1 supervision with Resident #1 for one week starting 7/16/22 through 7/24/22 and determined that Resident #1 was not a risk to other residents related to Resident #4 entering his room and refusing to leave. As of 7/21/2022 all staff including agency staff were re-educated on facility abuse policy related preventing and reporting abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/18/2022 it was reported to Social Worker that Resident #1 grabbed Resident #6's wrist lifting her off the ground in the smoking area. Resident #1 and Resident #6 were immediately separated by facility staff. Facility Administrator was notified on 8/18/2022 by facility staff of the incident. Resident #1 was immediately placed on 1 on 1 supervision on 8/18/2022 for 96 hours to prevent any further incidents. Administrator contacted the police department of the alleged incident on 8/18/2022 immediately following notification of incident. Administrator started the investigation of the incident on 8/18/2022. Beginning on 8/18/2022 Administrator, Director of Nursing, Social Worker and Activities Director begin interviewing all residents with a BIM score of 10 or higher as well as witness Resident #7 and or staff who were in the smoking area at time of incident on 8/18/22. During the investigation and witness interviews it was determined by the Administrator that Resident #6 had slapped Resident #1 prior to Resident #1 grabbing Resident #6 wrist. Administrator determined that Resident #1 was not a danger to other residents in the facility. On 8/18/2022 Police Officer counselled Resident #1 on social behaviors. At time of incident on 8/18/2022 facility had already begun discharge process and were looking for alternate placement in an Assisted Living facility for Resident #1. Administrator and Director of Nursing re-educated all staff to include agency staff on facility abuse policy regarding reporting and preventing abuse as of 8/22/2022. On 9/9/22 Resident #1 was heard yelling at Resident #3 in Resident #3's room to stop yelling or he would make him shut up by Nurse #1. Nurse #1 immediately removed Resident #1 from Resident # 3's room. Nurse continued to monitor Resident #1 throughout the night to ensure he did not return to Resident #3's room. Nurse #1 found no signs of injury to Resident # 3 following the incident. On 9/17/2022 Resident #1 was seen in the smoking area by Human Resource Director (HR) punching Resident # 2 in the chest. Human Resource Director immediately separated Resident #1 and Resident #2. HR Director notified Administrator on 9/17/2022 following the incident. Administrator immediately informed the Regional Director of Operations of the incident on 9/17/2022. Regional Director of Operations instructed Administrator to start 1 on 1 supervision of Resident #1 until Administrator can get Resident #1 placed in Assisted Living. Administrator placed Resident #1 on 1 on 1 supervision beginning 9/17/2022 with no end date. Administrator began investigation of alleged incident on 9/17/2022. Facility has continued 1 on 1 supervision while looking for alternative placement. On 9/19/2022 Resident #1 was heard yelling threatening profanity at Resident #3. Nurse #1 removed Resident #1 from Resident #3's room immediately and continued his 1 on 1 supervision. Resident #1 had returned from outside visit and facility wasn't aware he had returned at that time and 1 on 1 was not in place. Facility receptionist has been in-serviced on resident requiring 1 on 1 supervision by the Regional Clinical Director on 9/23/2022 to ensure no resident with 1 on 1 return into the facility until 1 on 1 employee accompanies resident into facility. All staff in-serviced by Director of nursing on 1 on 1 to include residents return to facility after hours for 1 on 1 in place upon resident return to facility. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. As of 9/23/2022 Regional Director of Operations has reviewed all abuse allegations for Saturn Health & Rehabilitation for period 1/01/2022 - 9/23/2022 to ensure all efforts were taken to complete the investigation, prevent and protect all residents from abuse. Resident #1 has been placed on supervised 1 on 1 monitoring 24 hours per day as of 9/17/2022. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	1930 West Sugar Creek Road Charlotte, NC 28262

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	As of 9/23/2022 facility has secured alternate placement for resident #1. Activities Director contacted shelter regarding Resident #1. On 9/23/2022 men's shelter agreed to take Resident #1 and he will discharge on 9/23/2022. Director of Nursing informed Resident #1 of the discharge plans on 9/23/2022 and Resident #1 agreed to planned discharge. On 9/22/2022 Regional Clinical Director re-educated the Administrator and Director of Nursing on Abuse reporting, prevention, investigation, and interventions to state agency as well as Regional Director of Operations and Regional Director of Clinical. Education included the facility policy for screening employees and volunteers prior to working with residents. Screening components include verification of references, certification and verification of license and criminal backgrounds check. The facility will not knowingly employ of otherwise engage any individual convicted of resident abuse, neglect, exploitation, misappropriation of resident property, or mistreatment by a court of law or reported abuse as noted by licensure boards or registries. Resident rights and abuse prevention training for all employees is conducted during orientation, and at lease annually, and includes review of: abuse policies and code of conduct, definitions of abuse, resident's rights, abuse, neglect and exploitation policy and criteria for assessing risk factors, management of aggressive behavior, care of cognitively impaired, conflict resolution, stress management and signs of burnout. At the time of admission, each resident and responsible party is informed of the resident's rights and the facility's zero tolerance for any form of abuse. A zero-tolerance policy of abuse, neglect, mistreatment, and misappropriation, along with reporting directions, is posted in the facility or given to the resident upon admission and each employee at orientation. Staff is instructed to report any sign of stress from family or other individuals involved with the resident that may lead to abuse, neglect or misappropriation of resident property and to intervene as appropriate. The facility protects residents and/or families from harm or retaliation during an abuse or neglect investigation. Any person or persons accused or suspected of involvement in resident abuse, neglect or misappropriation of resident property is immediately suspended for the course of the investigation pending the outcome of the investigation. Patient protection actions include immediately removing the patient from contact with alleged abuser during the investigation. If the alleged abuser is not an employee, measures are taken to provide a safe, secure environment for the patient. Action may include: patient room change, patient daily schedule change, visitor restrictions, reporting to other agencies or law enforcement. Human Resources will ensure all new hire orientation on Abuse reporting, prevention, investigation, and interventions to state agency. On 09/23/2022 Human Resource Manager was educated to this responsibility by the Administrator. As of 9/23/2022 all reportable events will be reported to the Regional Director of Operations and/or Regional Director of Clinical immediately following event by the Administrator. Regional Director of Clinical/Regional Director of Operations will review all reportable allegations prior to being submitted from 9/23/2022 ongoing to ensure protective measures are put into place. Date Immediate Jeopardy removed: 9/24/2022 (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/29/22 the facility's credible allegation of Immediate Jeopardy removal date of 9/24/22 was validated. The validation was evidenced by staff interviews, resident interviews, record reviews, and review of in-service attendance sheets. In-service attendance sheets revealed the 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.

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on record review, observations, and interviews with the Medical Doctor and staff the facility failed to provide care for an incontinent 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: Resident #10 was admitted to the facility on [DATE] with diagnoses including dementia and depression. Review of the quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #10 as having moderately impaired cognition and always being incontinent of bladder and bowel and totally dependent on staff for transfers, toilet use, and personal hygiene. Review of the care plan last revised on 05/13/22 revealed Resident #10 was at risk for skin breakdown. The goal was for the skin to remain intact through the next review. Interventions included provide prompt incontinence care to keep the skin clean and dry as possible. An observation on 09/27/22 at 3:23 PM revealed Resident #10 sitting in a wheelchair in his room. There was a strong odor resembling urine when entering the room. Resident #10 was wearing a pair of gray shorts that were darker in color at the groin area as if wet. During an interview on 09/21/22 at 3:45 PM NA #2 revealed she just arrived and had checked on residents to ensure they were safe and accounted for. NA #2 did not reveal she had checked Resident #10, and he needed incontinence care. A continuous observation was started on 09/21/22 from 3:23 PM through 5:15 PM. Resident #10 remained in his room sitting in a wheelchair. At 4:11 PM NA #2 entered the room to provide ice and again at 4:16 PM and asked if everything was okay. The roommate of Resident #10 responded yes, and NA #2 left the room. At 5:05 PM NA #2 left the hall. At 5:09 PM this writer showed Med Aide #1 incontinence care was needed for Resident #10. At 5:15 PM NA #2 returned to the hall and began to provide incontinence care for Resident #10. Resident #10's gray shorts were saturated at the front groin and buttocks and the wheelchair cushion had a large wet stain with a strong odor resembling urine. An observation of incontinence care on 09/27/22 at 5:15 PM revealed Resident #10 had an area of red skin involving the left buttocks. During an interview on 09/21/22 at 5:25 PM NA #2 revealed Resident #10 did not make his needs known related to incontinence care and she would have to physically check if the resident had an episode of incontinence. NA #2 revealed she had not checked Resident #10 for incontinence until asked and stated she had assisted two other residents to bed and hadn't gotten to Resident #10. NA #2 indicated she didn't receive report from the previous shift NA assigned to Resident #10. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/21/22 at 6:15 PM the Regional Nurse Consultant was informed of the red area of skin on Resident #10's left inner thigh. The Regional Nurse Consultant stated she would have the Wound Care Nurse check Resident #10 for any skin issues. The Regional Nurse Consultant also observed the wet wheelchair cushion and stated she would ensure it would be cleaned. An interview was conducted on 09/21/22 at 6:32 PM with the Wound Care Nurse. The Wound Care Nurse revealed she identified two new areas on Resident #10's skin and would notify the Medical Doctor (MD) for orders. During a second interview on 09/22/22 at 9:35 AM the Wound Care Nurse revealed new orders were received for skin tears due to moisture associated skin damage to the inner right groin and left buttocks. An interview was conducted on 09/22/22 at 11:03 PM with the MD. The MD revealed being immobile and sitting in a soiled brief would contribute to moisture associated skin damage. An interview was conducted on 09/22/22 at 12:34 PM with NA #3 who worked first shift on 09/21/22 and was assigned to provide care for Resident #10. NA #3 revealed when she first arrived, Resident #10 was already dressed and sitting in the wheelchair, and she didn't physically check him for incontinence. She did physically check Resident #10 before lunch and provided care for an episode of urinary incontinence. NA #3 revealed after that she didn't check Resident #10 for incontinence and stated around 2:00 PM a family member told her they had provided incontinence care and handed her bag with a soiled brief and asked her to discard it. An interview was conducted with the Director of Nursing (DON) on 09/23/22 at 11:44 AM. The DON revealed she would expect nursing staff to provide incontinence care for a dependent resident when visibly wet.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on record review, staff and Physician's Assistant interviews, the facility failed to ensure a resident was free from unnecessary medications when a resident (Resident #3) was prescribed psychotropic medications (a medication that affects the brain with mental processing and behaviors) with a diagnosis of dementia and no other mental illness related diagnosis for 1 of 1 residents reviewed for unnecessary medications. Findings included: Resident #3 was admitted to the facility on [DATE] with diagnosis that included dementia with suicidal ideations, muscle weakness and cerebral infarction. A review of the hospital discharge summary dated 05/04/22 indicated Resident #3 was ordered Zyprexa 2.5 milligram (mg) every 6 hours as needed (PRN) related to suicidal ideations (an antipsychotic medication used to treat mental disorders), Depakote 250 mg twice daily related to suicidal ideations (an anticonvulsant medication often used for mood disorders), and Trazadone 50mg daily at night for insomnia (an antidepressant medication often used for sleep). An admission Minimum Data Set (MDS) dated [DATE] indicated Resident #3 had no psychosis present and exhibited no behaviors. A pharmacy consult dated 05/29/22 recommended the order for Zyprexa be evaluated for a necessity due to the PRN order. The Medical Director (MD) recommended continue the medication with a signature, but the document was not dated. A review of the Medication Administration Record (MAR) dated June 2022 indicated Resident #3 received Zyprexa 2.5 mg on 06/01/22 at 6:39 PM and on 06/03/22 at 4:19 PM for behaviors. The behavior monitoring did not indicate any behaviors present on either 06/01/22 or 06/03/22. A pharmacy consult dated 6/21/22 recommended the order for Zyprexa be discontinued due to requirements for limitation to 14 days for all PRN psychotropic medications. The Medical Director (MD) agreed to discontinue the medication effective 06/28/22. A progress note written by Physician Assistant dated 7/5/22 indicated Zyprexa PRN was discontinued last week per psychiatry nurse practitioner recommendations. The note further indicated Resident #3 had occasional irritability which was redirectable and referenced behaviors occur when he is left in his room alone and calm when staff enter. A progress noted written by the MD dated 07/14/22 indicated he was compliant with staff and had not exhibited behavioral outburst or aggressive behaviors. A review of the MAR dated July 2022 indicated Resident #3 exhibited a behavior identified on 07/16/22 and 07/30/22. The MAR did not identify the specific behaviors nor did it provide a legend. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pharmacy progress note dated 07/25/22 indicated Zyprexa PRN was discontinued on 7/1/22 and no behaviors noted. A review of the MAR dated August 2022 indicated Resident #3 exhibited a behavior on 08/03/22, 08/06/22, and 08/27/22. The MAR did not identify the specific behaviors nor did it provide a legend. A review of the physician's orders dated August 2022 indicated a new order for the following medication: 8/30/22: Buspar 10mg every 8 hours for anxiety. A quarterly MDS dated [DATE] indicated Resident #3 was cognitively intact and required total dependence with ADL, and with no psychosis and exhibited no behaviors. A nurse progress noted written by Nurse #5 dated 08/31/22 indicated Resident #3 was noted to have episodes of yelling out due to agitation with another (unidentified) resident. A review of the MAR dated September 2022 indicated Resident #3 exhibited behavioral symptoms on 09/06/22, 09/07/22; 09/09/22, 09/21/22, 09/22/22; 09/25/22 and 09/26/22. Behaviors by Resident #3 were not identified on the MAR and there were no nurse progress notes on these days to clarify what behaviors were exhibited by Resident #3. A review of the physician's order dated 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 0.5 mg twice a day 09/26/22: Lorazepam Powder (Ativan 0.5mg/Benadryl 12.5mg/Haldol 1mg gel- apply to the inner wrist every 8 hours as needed for agitation. An initial psychiatric evaluation progress note dated 09/20/22 indicated Resident #3 was being evaluated which identified the assessment was for dementia, depression/anxiety, and insomnia. Listed under the section headed dementia the note indicated Resident #3 was prescribed Depakote for behaviors related 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 [DATE] 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. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 09/22/22 at 11:27 AM revealed while investigating a resident-to-resident interaction between Resident #3 and another resident in the facility, the altercation was attributed to the yelling out by Resident #3. Therefore, the facility asked the provider to evaluate Resident #3 to decrease the behavior of frequently yelling out for help instead of using his call light which he had knowledge and ability to use. The Administrator stated he was aware medications changes had been made but did not elaborate on what the changes included. An interview with the Physician Assistant on 09/22/22 at 1:30 PM revealed she was not familiar with the repeated interaction between Resident #3 and another resident when she was asked to evaluate him for behaviors of yelling out. The PA indicated she initially contributed the behaviors concerns with a roommate over the use of the air conditioner unit which had negative physical feelings for Resident #3 when he got too cold. The PA stated to her knowledge the behaviors had decreased when he did not have a roommate and the behaviors returned when another resident was moved in the room. She stated the facility then alerted psychiatric services on 09/20/22 and Resident #3's medications regimen was modified.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37538 Based on record review, observations, and interviews with staff the facility failed to implement their infection control policy and procedure for hand hygiene when Nurse Aide #2 failed to remove and discard gloves and perform hand hygiene after providing incontinence care and before touching surfaces and frequently used items for 1 of 2 staff members reviewed for infection control. The findings included: Review of the facility's policy titled, Hand Hygiene revised July 2021 read in part; The facility considered hand hygiene the primary means to prevent the spread of infections and must be performed after touching body fluids, excretions, and contaminated items and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment, and the environment. Staff will perform hand hygiene before and after touching the resident or the resident's surrounding, after a body fluid exposure risk, and before and after performing resident care. During an observation on 09/27/22 at 5:15 PM NA #2 donned a pair of clean gloves without performing hand hygiene and entered the shared bathroom in Resident #10's room to wet a washcloth. Using the wet washcloth and a peri cleanser spray NA #2 began care for urinary incontinence and wiped the front peri area of Resident #10. Wearing the same gloves used to wipe the front peri area NA #2 grabbed the bathroom doorknob then turned the water on using the sink faucet handle. NA #2 rinsed the washcloth, turned the water off and closed the bathroom door and returned to the bedside and continued to wipe the front peri area of Resident #10. Wearing the same gloves NA #2 moved the privacy curtain out of her way, and again grabbed the doorknob to enter the bathroom and turn the water on to rinse the washcloth. NA #2 turned the water off, closed the bathroom door and returned to the bedside and wiped Resident #10's buttocks, applied a barrier cream to areas she had cleaned, then placed a clean brief on the resident. NA #2 removed and discarded her gloves in the trash. An interview was conducted on 09/27/22 at 6:22 PM with NA #2. NA #2 confirmed she didn't remove her gloves or perform hand hygiene after she had wiped Resident #10 clean from an episode of urinary incontinence and before touching other surfaces or frequently used items. NA #2 stated she wasn't thinking about removing her gloves or hand hygiene because she was providing care to the same resident. NA #2 revealed she did receive training to remove gloves and perform hand hygiene after a dirty process when there was a possibility of contact with body fluids such as urine. An interview was conducted on 09/23/22 at 11:44 AM with the Director of Nursing (DON). The DON revealed she expected NA #2 to follow protocol and wash her hands before gloves were donned and after removed. The DON stated she expected staff to remove gloves and perform hand hygiene after incontinence care was provided before touching other surfaces and frequently used items in the room.