

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Sardis Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 5151 Sardis Road Charlotte, NC 28270	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934 Based on observation, record review and interviews with a resident and staff, the facility failed to replace a nonfunctioning air conditioner unit in room [ROOM NUMBER]. This failure occurred for on 1 of 4 halls reviewed for a safe, clean, comfortable and home like environment (200 hall). The findings included: An observation and interview with the Resident in room [ROOM NUMBER] occurred on 9/23/24 at 1:45 PM. During the interview, the Resident stated that her air conditioner in her room had not worked for the past three weeks. She said she was currently hot in her room, and she reported this concern to her nurse aide (NA) three weeks ago. The Resident stated that when she reported the concern, the NA checked her air conditioner and said it was not blowing cool air and that she would report it to the maintenance department. The Resident said her air conditioner worked off/on since her admission to the facility in July 2024, but that three weeks ago it stopped blowing cool air completely. The Resident stated no one came to fix it and over the last three weeks, if her room got too hot, she knew she could move to the commons area where it was cooler. An observation of the air conditioner in room [ROOM NUMBER] during the interview revealed it did not blow any air, hot or cold. NA #1 stated in an interview on 9/24/24 at 1:49 PM that the Resident in room [ROOM NUMBER] informed her a week ago, or maybe longer, that she was hot in her room because the air conditioner was not working. NA #1 stated she checked the air conditioner unit in room [ROOM NUMBER] at the same time when the Resident told her it was not working and found that when the unit was turned on, it did not blow any cool air. NA #1 stated she reported to the Maintenance Director, the next day when she saw him in the hallway, that she turned the air conditioner on in room [ROOM NUMBER], but that it did not come on and that the Resident said her room was hot. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Maintenance Director on 9/24/24 at 1:26 PM, he stated that he was notified on Friday, 9/20/24 around 3:00 PM that the air conditioner unit in room [ROOM NUMBER] was not cooling properly, but that he did not recall which staff member told him. He stated that he checked the air conditioner unit on Friday, 9/20/24 around 3:30 PM, just before he left for the day, and determined the air conditioner would need to be replaced, because it was not cooling properly. The Maintenance Director stated he had a supply of air conditioners stored offsite and on Monday, 9/23/24 he drove to the offsite location to get an air conditioner to replace the broken unit in room [ROOM NUMBER]. He stated that he planned to replace the broken air conditioner on Monday, 9/23/24, but that he had not replaced it yet. The Maintenance Director stated that he was not aware that the air conditioner in that room was broken for three weeks, and had he known, he would have replaced it earlier because it only took him 20 minutes to replace an air conditioner. The Maintenance Director further stated that when he determined that the air conditioner would need to be replaced on Friday, 9/20/24, he did not offer the Resident a fan or a room change until he could replace the air conditioner, nor did he check the temperature in the room. A review of outside temperatures according to weather.com from 9/20/24 to 9/24/24 revealed an outside temperature range of 77 to 91 degrees Fahrenheit (F) for the facility's zip code. - 9/20/24 - 85 degrees F - 9/21/24 - 87 degrees F - 9/22/24 - 91 degrees F - 9/23/24 - 77 degrees F - 9/24/24 - 84 degrees F The Maintenance Director reported on 9/24/24 at 1:30 PM that the room temperature in room [ROOM NUMBER] was currently 76 to 78 degrees Fahrenheit. He provided a maintenance repair log for July through September 2024 for review which did not record notification of the broken air conditioner or its repair. The Director of Nursing (DON) was interviewed on 9/25/24 at 11:53 AM and stated the facility had access to an on-call repair service that could assist with the repair or replacement of air conditioners. The DON stated the facility should have provided the Resident with a fan or offered the Resident a room change until the broken air conditioner could be repaired/replaced. The DON stated if a staff member was aware that the air conditioner was broken, this should have been reported to administrative staff or a nursing supervisor immediately. The Administrator stated in an interview on 9/26/24 at 1:52 PM that he expected the broken air conditioner to be addressed timely with either a repair, a replacement of the air conditioner, or the Resident should have been offered a room change until the repair/replacement could be made. The Administrator stated that the facility kept the commons areas of the facility at a comfortable temperature but the air conditioner in each resident's room served the purpose of allowing the resident to maintain a comfortable temperature in their room per the resident's preference.		

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F 0677 Level of Harm - Minimal harm or potential for 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** 40476 Based on observations, record review, and staff interviews the facility failed to provide nail care for a dependent resident for 1 of 6 residents reviewed for activities of daily living (ADL) (Resident #12). The findings included: Resident #12 was admitted to the facility on [DATE] with diagnosis' which included hemiplegia (inability to move one side of the body). A review of a care plan dated 03/18/24 revealed Resident #12 had impaired mobility related to left-sided hemiplegia and blindness with interventions which included for staff to encourage Resident #12 to participate in activities of daily living (ADL) care as able and to assist her as needed. A review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #12 was cognitively intact and was not coded for rejection of care. Resident #12 was coded for impairment on one side of her upper extremities and required moderate assistance with personal hygiene. An observation was conducted on 09/23/2024 at 3:46 PM. Resident #12 was observed to have approximately one-inch-long fingernails over the tip of the finger with a brown substance noted under all ten nails on both hands. On 09/23/24 at 3:50 PM an interview was conducted with Resident #12. She stated she was legally blind and needed her nails trimmed badly. Resident #12 stated her nails needed to be trimmed and filed. Resident #12 indicated she had told staff members, however she felt like they never had time to trim her nails. The interview revealed Resident #12 felt like she could not even scratch her arm due to her nail length. A review of the Electronic Health Record shower documentation dated 09/24/2024 revealed Resident #12 received a shower from Nurse Aide (NA) #2. On 09/24/24 at 9:18 AM an interview was conducted with Resident #12. She stated she had received a shower from Nurse Aide #2 the day prior. She stated Nurse Aide #2 did not ask her if she wanted her nails trimmed or cut during the shower. The interview revealed she felt she could not ask Nurse Aide #2 to cut her nails because she stated, if you ask for anything extra the staff get mad. Resident #12 stated she thought if she asked, Nurse Aide #2 would just say no again. An interview was conducted on 09/25/2024 at 2:18 PM with NA #2. NA #2 stated she was assigned Resident #12 on 09/24/24 and had given the resident a shower. She stated nail care was part of the shower, and she had cleaned the resident's nails however did not trim them. She stated she had asked Resident #12 in the past if she wanted them trimmed and she had said no. The interview revealed NA #2 did not ask Resident #12 if she wanted her nails trimmed on 09/24/24. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 09/25/2024 at 9:18 AM. Resident #12 was observed to have one-inch-long fingernails over the tip of the finger for all ten fingers. The nails were no longer observed with a brown substance. An interview was conducted on 09/25/2024 at 1:55 PM with NA #3. NA #3 stated she was responsible for Resident #12 on 09/25/24 and had observed her nails being very long. She stated she thought it was how Resident #12 liked her nails to be and had not asked the resident if she wanted them trimmed. She stated she would go and ask the resident if she wanted them cut. The interview revealed nail care was typically provided on the resident's shower day. A follow up interview was conducted on 09/25/24 at 3:27 PM with Resident #12. She stated NA #3 had come in and cut her nails. She stated, I am so happy I can actually scratch my arm now. Resident #12 stated again, nobody had asked me if I wanted my nails cut. An interview was conducted on 09/26/2024 at 10:59 AM with the Director of Nursing (DON). The DON stated nail care was performed by the Nurse Aide assigned on the resident's shower days. The DON stated NAs and Nurses on the hall could perform nail care, but nail care was primarily completed by the Nurse Aide. The DON stated she was not aware Resident #12 had long, dirty nails. An interview was conducted on 09/26/2024 at 11:38 AM with the Administrator. The Administrator stated he was not aware Resident #12 had long, dirty fingernails but knew that she did not always like to have her fingernails cut.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on observations, record review and staff interviews, the facility failed to provide an environment free from a potential hazard when an insulin syringe was observed lying on Resident #74's beside table with the safety cap off and the needle exposed. This deficient practice occurred for 1 of 4 residents reviewed for accidents (Resident #74). The findings included: Resident #74 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #74 was severely cognitively impaired and received insulin 7 days during the assessment period. A review of Resident #74's physician orders revealed an order dated 9/12/24 for Insulin NPH (intermediate-acting insulin used to control blood sugar) 10 units injected subcutaneously (under the skin) twice a day. A review of Resident #74's medication administration record indicated 10 units of insulin NPH was administered by Unit Coordinator #1 on 9/23/24 at 8:57 AM. An observation conducted on 9/23/24 at 10:17 AM revealed Resident #74 was lying in bed with his eyes closed. Resident #74's bedside table was positioned at the foot of his bed, not within his reach, and a syringe (used to inject medication) was lying on top of the bedside table with the safety cap off and the needle exposed. An interview conducted with Unit Coordinator #1 on 9/23/24 at 10:30 AM revealed she was the nurse assigned to Resident #74 due to a call out. She indicated she administered Resident #74's insulin around 9:00 AM but was unaware she left the used syringe on his bedside table with the needle exposed. Unit Coordinator #1 stated when she left Resident #74's room she should have taken the used syringe and placed it into a sharps (puncture resistant) container, but she forgot. An interview conducted with the Director of Nursing (DON) on 9/25/24 at 9:02 AM indicated sharps containers were located on each of the medication carts for the safe disposal of syringes and needles. The DON stated that after a syringe or needle was used it should be placed into a sharps container and it should not be left at the resident's bedside. An interview conducted with the Administrator on 9/26/24 at 11:38 AM revealed used syringes and needles should be disposed of immediately into a sharps container and should not be left at a resident's bedside.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on observations, record review and staff interviews, the facility failed to ensure an opened bottle of tube feeding formula was labeled with the date and time the formula was hung for 1 of 2 residents reviewed for tube feeding (Resident #74). The findings included: Resident #74 was admitted to the facility 6/07/24 with diagnoses that included dysphasia (difficulty swallowing) and gastrostomy (surgical procedure to insert a tube into the stomach to provide nutritional support). A review of the physician orders revealed an order dated 6/07/24 for Resident #74 to receive Glucerna 1.5 (nutritional formula used for tube feeding) at 55 milliliters per hour (ml/hour) and water at 50 ml/hour continuously. A review of the care plan dated 6/17/24 indicated Resident #74 required a permanent feeding tube due to a diagnosis of dysphagia and an inability to take any nutrition by mouth. The interventions included administering tube feedings and water flushes as ordered by the physician. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #74 was severely cognitively impaired and required extensive assistance with activities of daily living. The MDS further revealed Resident #74 received tube feedings during the assessment period. An observation conducted on 9/23/24 at 10:40 AM revealed Resident #74 was receiving tube feeding at 55 ml/hour and water at 50 ml/hour through a pump. The bottle of tube feeding formula was not labeled with the date or time the formula was hung. An interview conducted with Unit Coordinator #1 on 9/23/24 at 10:45 AM indicated she was the current nurse assigned to Resident #74 due to a call out. She stated she was not aware the bottle of tube feeding had not been labeled with the date and time it was changed. She stated Resident #74's tube feeding was changed by the 3rd shift (11:00 PM to 7:00 AM) Nurse (Nurse #1) and she should have labeled the tube feeding bottle with the time and date. A phone interview was conducted with Nurse #1 on 9/27/24 at 5:57 PM. Nurse #1 confirmed she was the assigned nurse for Resident #74 on 9/23/24 and changed his tube feeding at 6:00 AM. She stated she should have labeled the tube feeding bottle with the date and time, but she forgot. An interview conducted with the Director of Nursing (DON) on 9/25/24 at 9:02 AM revealed that when a resident's tube feeding was changed the bottle of tube feeding should be labeled with the time and date.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49366 Based on observations, record review, and staff interviews the facility failed to post cautionary and safety signage outside of resident rooms that indicated the use of oxygen for 4 of 4 residents (Residents #73, #52, #15, and #37) reviewed for respiratory care. The findings included: 1. Resident #73 was admitted to the facility on [DATE] with acute chronic respiratory failure with hypoxia. A review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #73 was coded for receiving oxygen. A review of Resident #73's physician orders revealed an order dated 6/20/24 for oxygen to be administered continuously via nasal cannula at 5 liters per minute (l/min). An observation on 9/23/24 at 1:00 PM revealed Resident #73 was lying in bed wearing a nasal cannula with oxygen being administered at 5 l/min. There was no cautionary or safety signage posted at the entrance to Resident #73's room to indicate oxygen was in use. An observation of Resident #73 conducted on 9/25/24 at 9:56 AM revealed she was lying in bed with oxygen being administered via nasal cannula at 5 l/min. There was no safety signage posted at the entrance to Resident #73's room to indicate oxygen was in use. An interview with the Director of Nursing (DON) was conducted on 9/26/24 at 11:21 AM. She stated the facility was a non-smoking campus and oxygen use would be documented for each resident in their medical record and a visitor would know if a resident used oxygen by the supplies found in the resident's room. The DON explained the facility has never had oxygen in use signs posted in the facility. An interview was conducted with the Administrator on 9/26/24 at 1:48 PM. He stated the facility had oxygen signage at each storage room to indicate oxygen storage and a sign at the front entrance, the only entrance visitors used, which indicated the facility was a smoke free campus. The Administrator explained the facility did not have signs related to oxygen in use at each resident's door. 20934 2. Resident #52 admitted to the facility on [DATE]. Diagnoses included hypoxia, obstructive sleep apnea, and congestive heart failure. A physician order for Resident #52 dated 8/20/24 recorded O2 (oxygen) at 2 L/M (liters per minute) prn (as needed) for SOB (shortness of breath)/hypoxia. Continuous at bedtime due to hypoxia with laying down. Use with Bipap (bilevel positive airway pressure noninvasive machine). Flow rate 2 L/M. May increase flow rate to 4 L/M. Keep SpO2 (oxygen saturation in the blood) greater than 92%. Wean as tolerated to maintain SpO2 greater than 92%. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #52's cognition was intact, and she received supplemental oxygen therapy. During an observation and interview on 9/23/24 at 12:40 PM, Resident #52 stated that she received supplemental oxygen via a nasal cannula as needed, but primarily at night due to difficulty breathing when she laid down. An oxygen concentrator was observed in her room at the time of the interview but was not in use. There was no cautionary signage at or in the room of Resident #52 or on the unit to indicate the use of oxygen. The Director of Nursing stated in an interview on 9/26/24 at 11:23 AM that each resident who received supplemental oxygen would have a physician order in their medical record, but the facility did not post cautionary signage at the resident's door or in their room regarding the use of oxygen because the facility was a tobacco free campus and this signage was posted at the front entrance/exit where visitors would see it. On 9/26/24 at 1:39 PM, the Administrator stated in an interview that the facility was a tobacco free campus and therefore did not post oxygen in use signage at each resident's room where oxygen was in use because according to the life safety regulation additional signage was not required. He stated the facility posted signage at the entrance/exit that it was a tobacco free campus and to his knowledge this signage met the regulatory requirements. During a follow-up interview with the Administrator on 9/26/24 at 1:48 PM, he stated that that facility had oxygen signage at each storage room to indicate the rooms used to store oxygen and the facility had a sign at the front entrance related to being a tobacco free campus which was the only entrance visitors used, but that the facility did not have signs related to oxygen in use at each resident's door. 3. Resident #15 admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD) and chronic bronchitis. A physician order for Resident #15 dated 8/29/24 recorded O2 at 2 L/M prn for hypoxia due to COPD. Flow rate 2 L/M. May increase flow rate to 4 L/M. Keep SpO2 greater than 92%. Wean as tolerated to maintain SpO2 greater than 92%. An admission MDS assessment dated [DATE] indicated that Resident #15's cognition was intact, and he received supplemental oxygen therapy. During an observation and interview on 9/24/24 at 10:09 AM, Resident #15 was observed in his room and received supplemental oxygen from an oxygen concentrator at 2 L/M via a nasal cannula. He stated that he received supplemental oxygen via a nasal cannula continuously due to his diagnosis of COPD. A second observation occurred on 9/26/24 at 11:22 AM of Resident #15 in his room and he received supplemental oxygen from an oxygen concentrator at 2 L/M via a nasal cannula. There was no cautionary signage at or in the room of Resident #15 or on the unit at the time of these observations to indicate that oxygen was in use. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing stated in an interview on 9/26/24 at 11:23 AM that each resident who received supplemental oxygen would have a physician order in their medical record, but the facility did not post cautionary signage at the resident's door or in their room regarding the use of oxygen because the facility was a tobacco free campus and this signage was posted at the front entrance/exit where visitors would see it. On 9/26/24 at 1:39 PM, the Administrator stated in an interview that the facility was a tobacco free campus and therefore did not post oxygen in use signage at each resident's room where oxygen was in use because according to the life safety regulation additional signage was not required. He stated the facility posted signage at the entrance/exit that it was a tobacco free campus and to his knowledge this signage met the regulatory requirements. During a follow-up interview with the Administrator on 9/26/24 at 1:48 PM, he stated that that facility had oxygen signage at each storage room to indicate the rooms used to store oxygen and the facility had a sign at the front entrance related to being a tobacco free campus which was the only entrance visitors used, but that the facility did not have signs related to oxygen in use at each resident's door. 49160 4. Resident #37 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease. A review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #37 was coded for receiving oxygen therapy during the assessment period. A review of Resident #37's physician orders revealed an order dated 7/17/24 for oxygen to be administered continuously via nasal cannula at 3 liters per minute (l/min). An observation on 9/26/24 at 10:55 AM revealed Resident #37 was lying in bed wearing a nasal cannula with oxygen being administered at 3 l/min. There was no cautionary or safety signage posted at the entrance to Resident #37's room to indicate oxygen was in use. An interview conducted with the Director of Nursing (DON) on 9/26/24 at 11:21 AM indicated they did not post cautionary or safety signage to indicate the use of oxygen at the main entrance or outside of resident rooms. The DON stated because they were a non-smoking facility she was not aware the safety signage for oxygen use was required. An interview conducted with the Administrator on 9/26/24 at 1:48 PM revealed they were a non-smoking facility and there were no-smoking signs posted at the main entrance. He stated they did not post cautionary or safety signage to indicate oxygen was in use at the main entrance or outside of resident rooms. The Administrator further stated because they were a non-smoking facility, he was not aware that safety signage for oxygen use was required.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934 Based on observations, record review and interviews with the Corporate Support Dietary Manager, and staff, the facility failed to perform hand hygiene prior to plating food, wear a hair and beard restraint, maintain a working thermometer in the reach-in refrigerator, remove expired foods from frozen storage, and store potentially hazardous foods in sealed containers with a label that recorded the date of storage and the use by date in four of six cold storage units. This failure had the potential to affect food served to 85 of 92 residents. The findings included: 1. A continuous observation of the lunch meal tray line occurred on [DATE] from 12:00 PM until 12:10 PM. During the continuous observation, Dietary Aide (DA) #2 was observed to wear the same pair of gloves to place insulated dome lids on meal trays, place condiments and crackers on resident's meal trays, open/close the reach-in refrigerator to remove cold items, and placed meal trays on a metal cart. On [DATE] at 12:10 PM, DA #2 used the same gloves, without performing hand hygiene, to plate French Fries with her right gloved hand. The state surveyor intervened. When the Kitchen Supervisor asked DA #2 why she still had on the same gloves, DA #2 stated that she did not remember to wash her hands before she plated the French fries. The Kitchen Supervisor stated in an interview on [DATE] at 12:31 PM that dietary staff were provided an in-service in [DATE] about hand hygiene and that DA #2 should have allowed the cook to plate the French fries with tongs. The Kitchen Supervisor provided the Employee Health Foodservice Notification dated [DATE] which was signed by DA #2 and recorded I have read or had explained to me and understand the requirements concerning my responsibilities under the (named) Employee Health Policy and Employee Health Foodservice Notification to comply with good hygienic practices. The Administrator stated in an interview on [DATE] at 1:32 PM that the dietary concerns identified were not the practice he expected for the dietary department. He stated that the dietary department should perform hand hygiene. 2. A continuous observation of the walk-in refrigerator, the reach-in refrigerator, the reach-in freezer and the walk-in freezer occurred on [DATE] from 9:58 AM until 10:14 AM with the Corporate Support Dietary Manager. The following food storage concerns were observed during this continuous observation: - A ten-pound box of sausage patties was observed stored in the walk-in refrigerator in a cardboard box that was open to air and no label to record the date opened. - A plastic bag of meatballs was observed stored in the walk-in freezer. The bag was open to air with no label to record the date opened or the use by date. - A plastic bag of cookie dough was observed stored in the walk-in freezer on the shelf, not in the original packaging, with no label to record the date of storage or a use by date. The bag was open to air. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Sardis Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 5151 Sardis Road Charlotte, NC 28270	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A plastic bag of carrots that was wrapped in plastic wrap was observed on the shelf in the walk-in freezer and had a label that recorded a use by date of [DATE]. - A twenty-pound cardboard box of hamburger patties was observed stored in the walk-in freezer. The box was open to air. There was no label to record the date opened or the use by date. - The reach-in refrigerator was observed without a thermometer inside. The digital reading on the exterior thermometer was broken, and the temperature could not be read. - The reach-in freezer was observed with a cardboard box of cookie dough. The box was open to air. There was no label to record the date opened or the use by date. An interview occurred on [DATE] at 12:31 PM with the Kitchen Supervisor. She stated that she conducted daily rounds in the kitchen to monitor for thermometers and food properly stored in cold storage. The Kitchen Supervisor stated that she conducted her daily rounds on the morning of [DATE], but these storage concerns were missed. An interview with the Corporate Support Dietary Manager occurred on [DATE] at 12:33 PM. She stated that she rounded the dietary department two to three time per week to spot check dates, labels and to make sure items were stored correctly in cold/dry storage. She stated she expected the Kitchen Supervisor to conduct the initial daily rounds and address any storage concerns she found. She stated staff were educated on proper storage practices but may have been rushing and did not keep in mind the regulations. The Administrator stated in an interview on [DATE] at 1:32 PM that the dietary concerns identified were not the practice he expected for the dietary department. He stated that the dietary department should maintain working thermometers, and all opened foods should be properly sealed, labeled and dated. 3. A continuous observation of [NAME] #1 occurred on [DATE] from 9:46 AM until 10:26 AM. During this continuous observation, [NAME] #1 was observed without a hair or beard cover in place. [NAME] #1 was observed to wrap food for cold storage, sanitized the cook's prep table, washed dishes and placed foods in the warmer on the lunch tray line. [NAME] #1 stated during the observation I typically only wear a hair restraint and beard guard when I am cooking. A follow-up continuous observation occurred on [DATE] from 11:31 AM until 12:00 PM. The following concerns were observed regarding the use of a beard cover: - During this continuous observation, [NAME] #1 was observed conducting temperature monitoring of cold foods for the lunch meal tray line. He was observed with a beard cover that was positioned below his mustache and he stated, I have on a beard guard. - Dietary Aide (DA) #1 was observed mopping the floor while he wore a bead cover that was positioned below his mustache and he stated, I did not realize it fell down. An interview occurred on [DATE] at 12:31 PM with the Kitchen Supervisor. The Kitchen Supervisor stated it was her responsibility to monitor dietary staff for the use of hair and beard covers and that she told staff to raise their beard cover or to put on a hair restraint when she saw a concern. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Sardis Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 5151 Sardis Road Charlotte, NC 28270	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator stated in an interview on [DATE] at 1:32 PM that the dietary concerns identified were not the practice he expected for the dietary department. He stated that the dietary department should wear hair and beard restraints properly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Sardis Oaks		STREET ADDRESS, CITY, STATE, ZIP CODE 5151 Sardis Road Charlotte, NC 28270	
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40476 Based on observations, record reviews, and staff interviews, the facility failed to don required Personal Protective Equipment (PPE) before entering residents' room under transmission-based precautions for 1 of 3 residents reviewed for infection control (Resident #19). The findings included: 1. Review of the facility's policy for Enhanced Barrier Precautions (EBP) dated 09/01/2024 revealed the EBP will be implemented for the prevention of transmission of multidrug-resistant organisms. EBP employs gown and glove use during high resident care activities such as: Dressing Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device Care or use: central line, urinary catheter, feeding tube and tracheostomy, Wound Care: any skin opening requiring a dressing. On 09/25/24 at 9:42 AM an observation was made of Nurse Aide #3 entering Resident #19's room to provide a bed bath, change the residents brief and dress Resident #19 for the day. Resident #19 was under EBP for a feeding tube. The signage for EBP was posted on the door along with PPE. NA #1 was observed entering the room with towels, wash clothes, linens and a wash basin. Nurse Aide #3 was observed applying gloves and began washing Resident #19 from head to toe. NA #3 was observed with gloves on and changed them according to their handwashing policy and procedure but did not wear a gown while bathing, providing hygiene, changing Resident #19's brief or dressing the resident. An interview was conducted on 09/25/24 at 1:55 PM with NA #3. NA #3 was asked if Resident #19 was under any kind of precautions and replied yes, Enhanced Barrier Precaution's which meant she needed to wear a gown and gloves before entering the resident's room. NA#3 stated she had not put on a gown prior to giving the bed bath, changing the residents brief and assisting with dressing resident because a lot was going on that morning, and she had just forgotten to do so. NA #3 stated she always wore gloves and a gown when working with Resident #19 and knew to follow enhanced barrier precautions but today had forgotten the procedure. On 09/26/24 at 10:44 AM an interview was conducted with the Infection Preventionist. During the interview she stated for residents on EBP staff should be wearing a gown and gloves when performing any high contact resident activities such as dressing, bathing and changing the residents' brief. She stated NA #3 should have worn a gown while providing care and would need further education. On 09/25/24 at 10:59 AM during an interview with the Director of Nursing (DON) the DON explained that the Assistant Director of Nursing oversaw infection control and infection control education. The DON stated regardless all the staff knew to abide by the different types of precautions posted on the residents' door and to follow the assigned PPE. The DON stated all staff should be wearing a gown and gloves in the EBP rooms if they are providing direct hands on care such as bathing, dressing and changing the residents brief.		