STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345331	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sardis Oaks	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 19 residents reviewed for accuracy of assessments (Resident #4).The findings included:Resident #4 was admitted to the facility on [DATE] with diagnoses which included history of a stroke and dysphagia (the inability to swallow). A physician progress note dated 1/23/2025 indicated Resident #4 underwent replacement of her percutaneous endoscopic gastrostomy tube (PEG, a flexible feeding tube inserted through the abdominal wall directly into the stomach) on that date.Resident #4 had a physician's order dated 8/1/2025 for a specialized nutritional supplement, 237 milliliters (ml), three time daily bolus via PEG if consumed 50% or less of meal. A review of the Medication Administration Record (MAR) indicated Resident #4 had received the specialized nutritional supplement, 237 ml bolus tube feeding via the PEG on 10/9/2025, 10/10/2025, 10/11/2025 and 10/12/2025.A review of a Registered Dietician (RD) progress note dated 10/14/2025 at 4:14 PM revealed Resident #4 continued to receive the specialized nutritional supplement, 237 ml bolus tube feeding via the PEG if ate 50% or less of a meal. Resident #4 had refused some of the bolus tube feeding on occasion. A quarterly MDS assessment dated [DATE] indicated Resident #4 was moderately cognitively impaired. The quarterly MDS did not indicate a feeding tube had been used, and the proportion of total calories and average fluid intake by tube feeding was not included.An interview on 12/17/2025 at 11:30 AM with the MDS Coordinator indicated the RD was responsible for coding the Swallowing/Nutritional Status section of the MDS. The MDS Coordinator stated that the quarterly MDS dated [DATE] for Resident #4 should have been coded for the feeding tube, the proportion of total calories Resident #4 received through tube feeding and the average fluid intake per day by tube feeding.An interview on 12/17/2025 at 11:40 AM with the Registered Dietician (RD) indicated she had not coded Resident #4's quarterly MDS dated [DATE] correctly. The RD stated she should have coded the quarterly MDS to reflect Resident #4 had a feeding tube and coded the portion reflecting the proportion of total calories received through tube feeding and also the average fluid intake per day by tube feeding. The RD stated it was a mistake and she missed completing the section. An interview on 12/18/2025 at 3:48 PM with the Director of Nursing indicated the MDS should be completed accurately.An interview on 12/18/2025 at 3:50 PM with the Administrator indicated the MDS should be coded correctly.

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening Resident Review (PASRR) evaluation for a resident with a new diagnosis of a serious mental illness for 1 of 3 residents reviewed for PASRR (Resident #45).The findings included:Review of the medical record revealed a Level I PASRR was completed for Resident #45 on 9/02/22 prior to admission to the facility.Resident #45 was admitted to the facility on [DATE] with diagnoses including lymphedema and cellulitis and open wound of left lower extremity. A review of the electronic medical record (EMR) revealed there was no evidence that a Level II PASRR evaluation request was submitted for Resident #45.The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #45 was cognitively intact, exhibited no behaviors during the assessment period and was coded for receiving antidepressant and anticonvulsant medications. Resident #45's list of active diagnoses included major depressive disorder and paranoid personality disorder. A psychiatry note dated 12/09/25 revealed Resident #45's active diagnoses included paranoid personality disorder, generalized anxiety disorder and major depressive disorder and his current medications included duloxetine 30 mg by mouth at bedtime and depakote sprinkles 125 mg by mouth twice a day. Resident #45 was noted to be in stable condition, and no new orders were received. During an interview with the Social Worker (SW) on 12/18/25 at 10:55 AM she stated when a resident was admitted to the facility the PASRR evaluation request was submitted and completed by the hospital prior to admission. She indicated if a resident received a new diagnosis of a serious mental illness after admission to the facility, she was notified by nursing and submitted a request for a Level II PASRR evaluation when needed. The SW revealed Resident #45 was diagnosed with a new mental illness after admission to the facility but a request for a Level II PASRR evaluation was not submitted due to an oversight on her part.An interview conducted with the Director of Nursing (DON) on 12/18/25 at 10:35 AM revealed when a resident received a new diagnosis of a serious mental illness the SW was notified by nursing, received the psychiatric visit note via email and then was responsible for submitting the request for a Level II PASRR evaluation. The DON indicated the SW should have submitted a request for a Level II PASRR evaluation for Resident #45 however it must have been overlooked.An interview was conducted with the Administrator on 12/18/25 at 3:40 PM. He stated when a resident received a new mental health diagnosis that met the criteria for a Level II PASRR evaluation then a request for the Level II evaluation should be submitted.

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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** Based on observation, record review and staff interviews, the facility failed to separate the tube feeding syringe components prior to storing it for use, which created the potential for bacterial growth, for 1 of 3 residents reviewed for tube feeding (Resident #79).Findings included:Resident #79 was admitted to the facility on [DATE] and had a gastric tube (flexible tube inserted in through the abdominal wall directly to the stomach) for medication, food, and water administration.The Minimum Data Set quarterly assessment dated [DATE] indicated Resident #79 had a severe cognitive deficit. Resident #79 was coded as having a feeding tube, receiving 51% or more of his total calories via tube feeding and more than 501cc (cubic centimeters) of fluid via tube feeding.On 12/17/2025 at 8:03 AM an observation revealed Nurse #1 administering medication via gastric tube using a 60 cc syringe. After use, Nurse #1 disassembled the syringe, rinsed the parts with tap water at the bathroom sink, reassembled the syringe without air drying, and placed it in a plastic bag. Visible water was noted inside the syringe and at the bottom of the bag.During an interview at 8:40 AM, Nurse #1 stated she routinely rinsed, reassembled, and stored the syringe in a plastic bag to dry, acknowledging awareness of water in the bag.On 12/18/2025 at 1:00 PM, the Director of Nursing (DON), also serving as Infection Preventionist, stated the facility's procedure required disassembling syringe parts, rinsing with warm water, air drying on a paper towel, and storing parts separately in a plastic bag. The DON confirmed stagnant water could promote bacterial growth.In a joint interview with the DON on 12/18/2025 at 3:24 PM, the Administrator stated the expectation was for syringe cleaning and storage to follow the DON's described procedure.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, record review, and staff interviews, the facility failed to clean normal saline solution bag connection port with alcohol prior to connecting antibiotic vial to the normal saline bag for mixing, which could introduce bacteria in the mixture. This was for 1 of 1 staff member observed for intravenous medication administration (Nurse #1).Findings included:On 12/17/2025 at 12:50 PM an observation revealed Nurse #1 preparing antibiotic intravenous bag for Resident #103. Nurse #1 gathered one (1) normal saline bag/100 ml (milliliters) and one (1) vial of Cefepime 2 grams powder antibiotic. Nurse #1 cleaned her hands and donned gloves. Next, Nurse #1 connected the antibiotic vial to the normal saline bag without cleaning the normal saline medication port with an alcohol swab. Nurse #1 then squeezed the normal saline in the antibiotic vial to mix with the antibiotic power. Nurse #1 mixed the antibiotic solution in the 100 ml normal saline bag to administer to Resident #103.An interview was conducted with Nurse #1 on 12/17/2025 at 1:20 PM. Nurse #1 stated the normal saline bag was sterile and the medication port did not require cleaning with alcohol prior to adding the antibiotic to normal saline for mixing. Nurse #1 confirmed the normal saline bag was not in a sterile package.On 12/18/2025 at 1:00 PM, the Director of Nursing (DON), also serving as the Infection Preventionist, stated the facility's procedure required medication ports to be cleaned with alcohol pad prior to connecting and mixing medications. The DON confirmed that medication ports were cleaned with an alcohol pad to prevent introduction of bacteria into the medication mixture.In a joint interview with the DON on 12/18/2025 at 3:24 PM, the Administrator stated the expectation was for medication ports to be cleaned prior to mixing medications to follow the DON's described procedure.