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 _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARDIS OAKS	5151 SARDIS ROAD CHARLOTTE, NC 28270

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/23/24 through 09/27/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #DG8N11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/23/24 through 09/27/24. Event ID # DG8N11. The following intakes were investigated: NC00206200, NC00212073, NC00215457, NC00219743, NC00220261, NC00221500, NC00220562, NC00221879, NC00221896, NC00221918. Six of thirty-one complaint allegations resulted in deficiencies.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		10/25/24

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

Electronically Signed | 10/18/2024

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with a resident and staff, the facility failed to replace a nonfunctioning air conditioner unit in room 206. 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 206 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	F 584	On 9/24/24, the Maintenance Mechanic removed the faulty air conditioning unit in Room 206 and replaced it with a new unit. The Maintenance Mechanic tested the unit after installation, and it was working properly. On 9/25/24, the Maintenance team inspected 100% of the air conditioning units in every resident room to ensure proper functioning. A Maintenance Work Order Request Log will be placed at each nurse's station. Staff will fill out the log to make maintenance requests. The Maintenance	

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F 584	Continued From page 2 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 206 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 206 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 206 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 206, but that it did not come on and that the Resident said her room was hot. 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 206 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	F 584	Mechanic will check the log daily. When tasks are completed, the Maintenance Mechanic will initial the log. For emergent issues after hours, staff will call the on-call Maintenance Mechanic. By 10/25/24 all staff members will be in-serviced by the Nurse Educator or designee to educate them on the Maintenance Work Order Request Log process. Any staff members who do not receive the training by 10/25/24 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 10/25/24, the Plant Operations Supervisor will audit the Logs weekly for 12 weeks to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction date is 10/25/24.	

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F 584	Continued From page 3	F 584		

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 206. 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 206 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

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F 584	Continued From page 4 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.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: 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)	F 677	On 9/25/24, the assigned Nurse Aide cut and cleaned Resident #12's fingernails. On 9/25/24, each resident's fingernails	10/25/24

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F 677	Continued From page 5 (Resident #12). The findings included: Resident #12 was admitted to the facility on 12/23/20 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 8/14/2024 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.	F 677	were assessed for cleanliness and trimmed according to residents' preference. By 10/25/24 all nursing staff members will be in-serviced by the Nurse Educator or designee to educate them on the expectations for nail care. Any nursing staff members who do not receive the training by 10/25/24 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 10/25/24, the Nurse Supervisor or designee will audit the nails of five residents per week for 12 weeks to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction date is 10/25/24.	

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F 677	Continued From page 6	F 677		

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.

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

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F 677	Continued From page 7 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.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		10/25/24

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F 689	Continued From page 8 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 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 6/7/24 with diagnoses that included type 2 diabetes. The quarterly Minimum Data Set (MDS) dated 9/13/24 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	F 689	On 9/23/24, Unit Coordinator #1 picked up and properly disposed of the used insulin syringe from Resident #74's bedside table. On 9/23/24, the Director of Nursing re-educated Unit Coordinator #1 on the proper procedure for safe disposal of syringes and needles. On 9/25/24, a staff nurse conducted an inspection of every resident room to ensure no syringes or needles were left in the room. No issues were identified. By 10/25/24, all nurses will be in-serviced by the Nurse Educator or designee to educate them on the proper procedure for safe disposal of syringes and needles. Any nurse who does not receive the training by 10/25/24 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 10/25/24, the Nurse Supervisor or designee will inspect the rooms of five residents per week for 12 weeks to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 689	Continued From page 9 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.	F 689	Plan of Correction date is 10/25/24.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 693		10/25/24

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F 693	Continued From page 10 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: 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.	F 693	On 9/23/24, Unit Coordinator #1 contacted the third shift nurse (Nurse #1) to confirm when the tube feeding was hung. Unit Coordinator #1 then labeled and dated the tube feeding accordingly. On 9/23/24, the Director of Nursing and the Assistant Nurse Manager inspected 100% of the tube feedings that were hung to ensure proper labeling and dating. By 10/25/24 all nurses will be in-serviced by the Nurse Educator or designee to educate them on the proper procedure for labeling and dating tube feeding. Any nurses who do not receive the training by 10/25/24 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. This education will continue to be required annually and	

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F 693	Continued From page 11 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 9/13/24 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	F 693	during new hire orientation. Beginning 10/25/24, the Nurse Supervisor or designee will inspect 100% of the residents who receive tube feeding once per week for 12 weeks to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction date is 10/25/24.	

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F 693	Continued From page 12 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.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: 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 4/27/23 with acute chronic respiratory failure with hypoxia. A review of the quarterly Minimum Data Set (MDS) dated 5/20/24 indicated Resident #73 was coded for receiving oxygen.	F 695	On 10/8/24, the Central Supply Coordinator placed “Oxygen in Use” signage on the doors of Resident #73, Resident #52, Resident #15, and Resident #37. On 10/8/24, the Central Supply Coordinator placed “Oxygen in Use’ signage on the doors of all other residents with active oxygen orders. By 10/25/24, all resident rooms – regardless of oxygen usage – will have “Oxygen in Use” signage on the doors in an abundance of caution due to possible room changes. By 10/25/24 all nursing staff will be in-serviced by the Nurse Educator or	10/25/24

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F 695	Continued From page 13 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.	F 695	designee to educate them on the proper procedure for “Oxygen in Use” signage. Any nursing staff who do not receive the training by 10/25/24 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 10/25/24, the Nurse Supervisor or designee will inspect five rooms of residents with active oxygen orders once per week for 12 weeks to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction date is 10/25/24.	

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2. Resident #52 admitted to the facility on 1/11/24. 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%.

A significant change Minimum Data Set (MDS) assessment dated 8/29/24 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

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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 8/29/24. 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 9/4/24 indicated that Resident #15's cognition was intact, and he received supplemental oxygen therapy.

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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.

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

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F 695	Continued From page 17	F 695		

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.

4. Resident #37 was admitted to the facility on 11/4/22 with diagnoses that included chronic obstructive pulmonary disease.

A review of the quarterly Minimum Data Set (MDS) dated 6/19/24 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

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F 695	Continued From page 18 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.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: 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	F 812	On 9/26/24, Dietary Aide #2 was verbally re-educated on proper hand hygiene procedures (Dietary Aide #2 is no longer an employee of the facility). On 9/23/24, the sausage patties,	10/25/24

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F 812	Continued From page 19 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 9/26/24 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 9/26/24 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 9/26/24 at 12:31 PM that dietary staff were provided an in-service in July 2024 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 7/12/24 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."	F 812	meatballs, cookie dough, carrots, and hamburger patties that were either unsealed, open to air and/or not labeled/dated, or were expired, were disposed of. On 9/23/24, a thermometer was placed in the reach-in refrigerator. On 9/23/24, Cook #1 was instructed by the Kitchen Supervisor to put on a hair net and beard restraints. On 9/26/24, Cook #1 and Dietary Aide #1 were re-educated by the Kitchen Supervisor to raise their beard guards to cover their mustaches appropriately. By 10/25/24 all dietary staff will be in-serviced by the Kitchen Supervisor, the Kitchen Manager, or the Corporate Support Dietary Manager to educate them on proper hand hygiene, properly sealing, labeling, and dating food items, proper disposal requirements for expired items, proper requirements and usage of thermometers in coolers and freezer, and proper usage of hair net and beard restraints. Any dietary staff who do not receive the training by 10/25/24 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 10/25/24, the Kitchen Supervisor, Kitchen Manager or Lead Cook will complete a new log that	

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F 812	Continued From page 20 The Administrator stated in an interview on 9/26/24 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 9/23/24 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. - 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 9/11/24. - 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	F 812	documents daily compliance with hand hygiene, properly sealing, labeling, and dating food items, proper disposal requirements for expired items, proper requirements and usage of thermometers in coolers and freezer, and proper usage of hair net and beard restraints. This daily compliance log will be shared with the Administrator weekly for 12 weeks. Beginning 10/25/24, the Kitchen Supervisor, the Kitchen Manager, or the Corporate Support Dietary Manager will observe the tray line and audit for hand hygiene compliance five meals per week for 12 weeks to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Beginning 10/25/24, the Kitchen Supervisor, the Kitchen Manager, or the Corporate Support Dietary Manager will conduct five inspections per week of all food storage areas (both cold and dry) for 12 weeks to ensure food is properly sealed, labeled, and dated, and that no items are expired. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 812	Continued From page 21 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 9/26/24 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 9/23/24, but these storage concerns were missed. An interview with the Corporate Support Dietary Manager occurred on 9/26/24 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 9/26/24 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 Cook #1 occurred on 9/23/24 from 9:46 AM until 10:26 AM. During this continuous observation, Cook #1 was	F 812	Beginning 10/25/24, the Kitchen Supervisor, the Kitchen Manager, or the Corporate Support Dietary Manager will audit all coolers and freezers five times per week for 12 weeks to ensure thermometers are in place and in working order. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Beginning 10/25/24, the Kitchen Supervisor, the Kitchen Manager, or the Corporate Support Dietary Manager will conduct five observations per week for 12 weeks to ensure proper usage of hair nets and beard restraints. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction date is 10/25/24.	

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F 812	Continued From page 22 observed without a hair or beard cover in place. Cook #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. Cook #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 9/26/24 from 11:31 AM until 12:00 PM. The following concerns were observed regarding the use of a beard cover: - During this continuous observation, Cook #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 9/26/24 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. The Administrator stated in an interview on 9/26/24 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.	F 812		
F 880 SS=D	Infection Prevention & Control	F 880		10/25/24

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	345331	A. BUILDING _____ B. WING _____	C 09/27/2024

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F 880	Continued From page 23 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 24 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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:	F 880	On 9/25/24, the Director of Nursing re-educated Nurse Aide #3 of proper usage of PPE when caring for residents on Enhanced Barrier Precautions. To identify other residents who have the potential to be affected by the deficient practice, an audit will be conducted by 10/25/24 to ensure that all residents who meet the criteria for Enhanced Barrier	

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F 880	Continued From page 25 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	F 880	Precautions have appropriate signage in place. By 10/25/24, all nursing staff will be in-serviced by the Infection Preventionist or designee to educate them on the proper usage of PPE when caring for residents on Enhanced Barrier Precautions. Any nursing staff who do not receive the training by 10/25/24 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. By 10/25/24, additional PPE caddies will be affixed to the walls along each hallway (not to obstruct handrail usage) to provide easier access and further visual reminders that will promote compliance of PPE usage. Beginning 10/25/24, the Infection Preventionist or designee will observe five care interactions per week for 12 weeks involving residents on Enhanced Barrier Precautions to ensure compliance with PPE usage. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction date is 10/25/24.	

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F 880	Continued From page 26	F 880		

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.