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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sardis Oaks	**5151 Sardis Road , Charlotte, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/15/2025 through 12/18/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DDED6-H1.	E0000		01/07/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/15/2025 through 12/18/2025. Event ID# 1DDED6-H1. The following intakes were investigated 808748, 808747, 808739, and 808738. 8 of the 8 complaint allegations did not result in deficiency.	F0000		01/07/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F641 MDS coding for Resident #4 was corrected on 12/17/25 to reflect presence of a PEG tube. MDS was re-submitted on 12/17/25 and accepted. To identify other residents having the potential to be affected by this same deficient practice, we will audit the most current MDS submitted for 100% of residents who have a PEG tube in place to verify accuracy of coding. To ensure the deficient practice will not recur, the Director of Nursing in-serviced the Registered Dietician on 1/13/26 for accurate coding of the Swallowing/Nutrition Status section of the MDS.	01/15/2026

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 reverse for further 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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F0641 SS = D	Continued from page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: 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 2/20/2021 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 10/14/2025 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	F0641	Continued from page 1 Beginning Monday, 1/19/26, the MDS Director or Designee will monitor the accuracy of the Swallowing/Nutrition Status section of 100% of residents who have a PEG tube in place. 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 1/15/26.	

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F0641 SS = D	Continued from page 2 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 10/14/2025 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 10/14/2025 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.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F0644	F644 On 12/18/25, Resident #45's Preadmission Screening and Resident Review (PASRR) was submitted by the Social Worker for further Level II screening for the resident's new diagnosis of major depressive disorder and paranoid personality disorder. Beginning 1/13/26, the Medical Records Coordinator audited 100% of residents with a new diagnosis of major depressive disorder and paranoid personality disorder on the problem list. All residents who had these new diagnoses had a Level II PASRR screening submitted On 1/13/26, the Administrator provided education to Social Workers who submit PASRRs on submitting further Level II screening requests related to residents' diagnosis of major depressive disorder, paranoid personality disorder, and all other new serious mental illness diagnoses that have also had a significant change in condition. Any Social Workers who do not receive the training by 1/15/26 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be	01/22/2026

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F0644 SS = D	Continued from page 3 This REQUIREMENT is NOT MET as evidenced by: 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 9/25/22 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 10/08/25 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	F0644	Continued from page 3 included with new hire orientation. Beginning 1/14/26, the Social Workers will continue to submit Level II screening requests for any residents with a new diagnosis of a serious mental illness disorder and that has had a significant change in condition. Beginning Monday, 1/19/26, the Administrator or Designee will review five residents with problem lists containing any serious mental illness disorder and a significant change in condition each week for 12 weeks to ensure submission for further Level II review. 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 1/22/26.	

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F0644 SS = D	Continued from page 4 (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.	F0644		
F0693 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 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 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:	F0693	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F693 On 1/13/26, the facility Infection Preventionist observed Nurse #1 providing gastric tube care with Resident #79 for compliance with Lippincott gastric tube care procedures. No issues were identified. Beginning 1/7/26, the Facility Educator conducted in-services with nurses on following infection control standards and procedures during gastric tube care. Any nurses who do not receive the training by 1/15/26 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire Orientation. Beginning 1/13/26, the facility Infection Preventionist provided clinical observations of nurses providing gastric tube care to ensure compliance with Lippincott gastric tube care procedures. Any staff members who do not receive the training by 1/15/26 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Beginning 1/13/26, the Facility Educator implemented the Lippincott gastric tube care procedures checklist to ensure nursing compliance with management of the tube feeding syringe.	01/15/2026

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F0693 SS = D	Continued from page 5 Resident #79 was admitted to the facility on 7/29/2025 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 11/5/2025 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.	F0693	Continued from page 5 Beginning 1/19/26, the facility Infection Preventionist or Designee will conduct weekly gastric tube care observations with 2 observations 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 1/15/26.	
F0694 SS = D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff	F0694	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F694 On 1/13/26, the facility Infection Preventionist observed Nurse #1 providing proper disinfection of the intravenous medication port. No issues were identified.	01/15/2026

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F0694 SS = D	Continued from page 6 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.	F0694	Continued from page 6 Beginning 12/17/25, the Facility Educator conducted in-services with nurses on providing proper disinfection of the intravenous medication port. Any nurses who do not receive the training by 1/15/26 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire Orientation. Beginning 1/13/26, the facility Infection Preventionist provided clinical observations of nurses providing proper disinfection of the intravenous medication port. Any staff members who do not receive the training by 1/15/26 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Beginning 1/13/26, the Facility Educator implemented the Lippincott intravenous solution preparation checklist to ensure nursing compliance. Beginning 1/19/26, the facility Infection Preventionist or Designee will conduct weekly observations of proper disinfection of the intravenous medication port with 2 observations 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 1/15/26.	