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 04/22/2022

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
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted from 4/20/22 through 4/22/22. One of the eight allegations investigated was substantiated. Intakes NC00186774 and NC00186251. Event ID# V45711.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		5/20/22

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

Electronically Signed | 05/13/2022

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F 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interviews, the facility failed to maintain a resident's dignity by delaying incontinence care for 1 of 3 residents (Resident #3) reviewed for dignity. The findings included: Resident #3 was admitted to the facility on 3/2/22. Review of the admission Minimum Data Set (MDS) dated 3/8/22 revealed Resident #3 was cognitively intact, required extensive assistance with toileting, frequently incontinent of bladder and occasionally incontinent of bowel. Rejection of care was not noted on the MDS. During an interview on 4/19/22 at 11:14 AM Resident #3 revealed that when she activated her call light to request assistance with toileting, she often had to wait up to two hours for help resulting in an incontinent episode. She further revealed she could get on the bedpan, but she wet herself because she had to wait too long and could not hold it. When Resident #3 was up in her wheelchair, she waited for long periods before staff could get her back to bed so she	F 550	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. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 4/20/22 at 11:11 AM, the Nurse Aide assigned to Resident #3's room provided incontinence care. Later that day on 4/20/22, the Director of Nursing spoke with Resident #3 to ensure resident's needs were met. Resident didn't express any further concerns or needs at that time. On 4/20/22, Administrator spoke with NA #1 about expectations for call bell response times and the process for	

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F 550	Continued From page 2	F 550		

could use the bedpan. Resident #3 sometimes soiled herself before staff arrived, she indicated she did not want to sit in a soiled brief.

A continuous observation and interview on 4/20/22 at 10:00 AM until 11:11 AM revealed Resident #3's call light was activated. At 10:00 AM Resident #3 stated she was upset, and she was soiled with urine and feces and needed to be changed. She explained this was the second time she put on her call light, and she had been waiting 30 minutes for assistance. At 10:05 NA #1 entered Resident #3's room with linen, turned off the call light and exited the room. At 10:30 AM Resident #3 stated NA #1 went to get a brief and she was still waiting for assistance. At 10:45 AM and 11:02 AM she had again activated her call light. At 11:11 AM NA #1 entered Resident #3's room and provided incontinent care.

On 4/20/22 at 11:11 AM an interview was conducted with NA #1. She stated she was aware that Resident #3 was waiting for care, and she was going to provide it now. NA#1 indicated she had a busy morning and she last provided incontinence care for Resident #3 at 7am or 8am. She normally provided incontinent care during rounds or as needed. NA #1 revealed she made rounds every 2-3 hrs. She further revealed if she saw a call light on, she answered it. If she was not available to answer the call light a responsible staff member at the nurse station would answer. The responsible staff member would come tell NA #1 what the resident needed.

An interview on 4/20/22 at 1:10 PM the Director of Nursing (DON) revealed when a resident activated their call light, it was answered either by staff on the hall or responsible staff at the nurse's

seeking help when additional assistance on her assignment is needed.

Address how the facility will identify other resident having the potential to be affected by the same deficient practice;

On 5/10/22, Nursing Administration team conducted interviews with alert and oriented residents on the assignment for NA #1. No issues of delay in call bell response were reported.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;
The week of 5/9/22, the Nursing Administration team began educating Nurses and Nursing Assistants on call bell response expectations, time management, and prioritization of care. Any staff members who do not receive the training by 5/20/22 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift at the facility upon their return. This education is included in the new hire orientation.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Beginning the week of 5/16/22, the Director of Nursing or designee will conduct 5 call bell response time audits each week. Audits will consist of rounding with alert and oriented residents facility-wide and – with their permission – triggering their call bell to assess the

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F 550	Continued From page 3 station. If answered at the nurse's station the responsible staff would find out the resident's needs and notify the appropriate staff member. She further revealed when a resident activated their call light, they should not have to wait more than 30 minutes for assistance. The DON stated that she was not aware that Resident #3 had concerns regarding how long she had to wait for toileting/incontinence care, she indicated this was unacceptable. Incontinence care should be provided every two hours and as needed. She indicated if a resident continued to activate their call light because they had not received assistance, the responsible staff that answered the call bell should let the responsible nurse know that care was needed. The nurse can provide the necessary care or delegate it to someone who can. During an interview on 4/22/22 at 10:51 AM the Administrator revealed call lights should be answered much sooner than an hour, long waits for care were not acceptable. The facility strived to provide care in under 10 - 15 minutes. He further revealed the responsible staff at the nurse's station answering call lights should determine what the resident needed and the alert appropriate staff. If there was a delay in response, the individual should have gone to the resident to determine if they could provide assistance. If they were unable provide what the resident needed, they should have found staff that was able to provide care. If all staff were busy, the individual should have alerted nursing leadership for assistance.	F 550	timeliness of response. 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 the week of 5/16/22, the Director of Nursing or designee will conduct weekly interviews with 5 alert and oriented residents facility-wide to assess the timeliness of call bell response. 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. Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State. POC Completion Date: 5/20/22	