STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345564	A. BUILDING ______ B. WING ______	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON TOWERS	**5100 SHARON ROAD CHARLOTTE, NC 28210**

(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 09/25/23 through 09/28/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #L51G11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 09/25/23 through 09/28/23. Event ID# L51G11.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		10/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/21/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 761	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a controlled substance in a permanently affixed compartment of the refrigerator in 1 of 1 facility medication room (Medicare Hall medication room). The findings included: On 9/26/23 at 3:13 PM an observation and interview were conducted with Nurse #2. The refrigerator in the Medicare Hall medication room was not locked and had a clear permanently affixed lock box that was locked and contained a 30 ml (milliliter) multi-dose bottle of Lorazepam/Intensol (a controlled substance) oral concentrate 2 mg (milligrams/ml). In another clear lock box that was locked, but not permanently affixed in the refrigerator, contained a 30 ml multi-dose bottle of Lorazepam/Intensol (a controlled substance) oral concentrate 2mg/ml and four 2 mg/ml vials of lorazepam for injection. Nurse #2 stated the unaffixed lock box was used for pyxis (automated medication dispensing system) removal. If a resident needed a stat dose of lorazepam, they would go to the pyxis and remove the key to open that lock box. She indicated she did not notice the lock box was not affixed because she had not retrieved any medications from it. During an interview with the Director of Nursing (DON) on 9/26/23 at 4:21 PM she revealed the unaffixed lock box in the Medicare Hall medication room refrigerator was for medications Pharmacy exchanged weekly. She explained the medications in the unaffixed box were for pyxis medication removal. The medications in that box	F 761	F761 It is the policy of this facility to store drugs and biologicals in accordance with State and Federal Laws. All drugs and biologicals in the facility are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Controlled drugs are stored and locked in separately locked, permanently affixed compartments. Affected Areas On 9/26/2023, the Administrator temporarily secured the narcotic exchange box to the mounted refrigerator shelves using zip ties. On 09/26/2023 the Administrator initiated a Control Sheet for licensed nurse signature each shift to ensure the placement of zip ties were secure at the beginning and end of each shift. On 10/03/23 the Facilities Director installed a full lock box that was mounted in the refrigerator and provides a separate locked compartment for the narcotic exchange medications. Other Areas There are no other medication fridges that require separate, locked compartments for narcotic exchange medications. Systemic Changes On 10/3/23, the Director of Nursing placed the key for the permanent affixed lock box placed on the Medicare Unit nurses' key	

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F 761	Continued From page 2 were for stat and one-time doses and the key to the box had to be retrieved from the pyxis. It was her understanding that because the medication room was locked and the box was locked, the box did not need to be affixed. She indicated that the medications that were in the unaffixed lock box were not in the affixed box because Pharmacy came weekly to exchange the unaffixed box. Pharmacy did not just exchange medications in the box, they exchanged the entire box. During an interview on 9/27/23 at 8:51 AM the Administrator revealed she had temporarily affixed the lock box in the Medicare Hall medication room refrigerator and had ordered a box to permanently affix in the refrigerator. She indicated she did not realize this was an issue.	F 761	ring. Attestation for key placement will be verified with each nurses' signature on the control sheet for each POA. On 10/03/2023, assigned planned of actions were reviewed and updated as necessary. This is to identify the only RN staff authorized to know the combination of the safe and those staff identified to complete the exchange utilizing the secured narcotic box key in conjunction with Nexsys controls. The facility pharmacy will continue with weekly delivery of controlled substance unless otherwise directed by the Director of Nursing. The pharmacy will count back all exchanged medications in containers upon arrival of each new cassette and lock box. Pharmacy will notify the Director of Nursing for any concern of suspected drug diversion with count back return. On 10/3/2023, 100% of licensed nurses were in-serviced regarding the process and procedure for the Nexsys pharmacy exchange and the importance of ensuring all drugs and biologicals are locked and secured per state and federal regulations. Quality Assurance/Monitoring The RN Supervisor will review the narcotic signature sheet weekly x four (4) weeks and then monthly for three (3) months to ensure the process for keeping drugs and biologicals locked and secured is being followed each shift. Any identified will be reported to the Director of Nursing for follow up.	

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F 761	Continued From page 3	F 761	Results of the audits will be reported to the QA Committee. Date of Completion 10/18/2023	
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 staff interviews, the facility failed to discard spoiled food stored in the lower-level refrigerator, failed to discard expired food items stored for use in the lower-level dry goods storage room and in the rehabilitation hall nourishment refrigerator. This practice had the potential to affect food served to residents.	F 812	F812 It is the policy of this facility to meet all Food Safety Requirements in regards to Food Procurement, Storage, Preparation, Serving, and Sanitation Guidelines; to store, prepare, distribute and serve food in accordance with professional standards for food service safety.	10/18/23

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F 812 Continued From page 4

The findings included:

1. An observation on 9/25/23 at 11:20 AM with the Culinary Director revealed the following:

-The refrigerator located in the lower-level kitchen storage revealed had 4 green peppers covered in white/ grayish fuzzy substance and wilted brownish iceberg lettuce.

-The dry storage room in the lower level kitchen revealed a) 20 8 ounce (oz) jars of sushi pickled ginger with a "best buy" date of 11/7/2021; b) 26 4oz cans of curry paste with a "best buy" date of 6/2022; c) 20 4oz cans of curry paste with a "best buy" date of 2/2022; d) baking flour "use by" date of 4/9/23; e) caramel paste "best buy" date of 7/4/2022; f) candy sprinkles "use by" date of 3/21/23; g) hazel nut paste "best buy" date of 7/20/22; h) chocolate shavings "best buy" date of 4/2023.

During a follow-up observation of the refrigerator and dry storage room, an interview on 9/26/23 at 2:45 PM the Culinary Director revealed the expired green peppers and expired items in the dry storage room, listed above, were discarded on 9/25/23. He further revealed he expected all dietary staff to check and discard expired foods.

2. An observation on 9/27/23 at 10:30 AM revealed a 4 oz container of yogurt (expired 9/21/23) in the nourishment refrigerator on the rehabilitation hall.

During an interview on 9/27/23 at 10:35 AM the Certified Dietary Manager (CDM) indicated the assigned Dietary Supervisor was responsible for

F 812

Affected Areas
On 09/25/2023, the Culinary Director immediately disposed of all items that were expired or outdated in the kitchen and the Certified Dietary Manager removed the expired yogurt in the nourishment refrigerator.

Other Areas
On 09/26/2023 the Culinary Director and Certified Dietary Manager assessed all other food storage areas and refrigerators and all identified outdated/expired items were discarded.

Systemic Changes
On 10/03/2023, the Director of Culinary implemented a checklist and Standard Operating Procedure to addresses elimination of the possibility of expired items utilizing a standardized multi-faceted Inventory Control plan. This includes any item that has not been ordered in the last six (6) months will automatically not be included on the order guide.
Par levels were established to ensure proper stock level of the items are within utilization range. All team members will be assigned specific roles. Team Members designated as the daily receiver will be visibly and legibly mark, with a black marker, the receiving date on all freezer boxed items and all dry goods packaging (to include cans and jugs) to be visual identifiers for proper rotation.
The Executive Chef will conduct weekly checks to ensure the storage areas are

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F 812	Continued From page 5 checking for expired foods before restocking the nourishment refrigerators. She further indicated that she expected the nourishment refrigerators to be checked for expired food items on a daily basis. An interview with the Administrator on 9/28/23 at 2:45 PM indicated she was not aware of the expired foods and that she expected the dietary department to discard expired foods daily.	F 812	properly organized, swept, consolidated, and have legible dates. The checklist will be verified weekly by the Director of Culinary Services and the monthly checklist will be stored in the Inspection Binder in the Director of Culinary' s office. Any items that are discarded during this process will be logged on the checklist and the appropriate food vendor will be notified. In other food services areas such as the main kitchen, bistro kitchen, and skilled nursing kitchens, where portion controlled items are used, current rounding logs will be maintained by the Dietary Supervisor. These logs are stored in the Certified Dietary Manager's office (in the Skilled nursing Area) and will be reviewed daily. The Executive Chef will monitor findings of new ordering and storage procedures, make adjustments, and report findings to the Culinary Director on a weekly basis. On 10/16/2023 the checklist and process was received and approved by the Administrator. On 10/17/2023 the Culinary Director provided the 100% training of dietary staff and will continue to work with assigned receivers throughout the rest of the year to ensure proper training and compliance. Quality Assurance/Monitoring The Culinary Director will audit expired item logs daily for two (2) weeks; weekly for four (4) weeks and monthly for three (3) months.	

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F 812	Continued From page 6	F 812	The Dietary Supervisor will audit dry storage and kitchen refrigerators daily for two (2) weeks; weekly for four (4) weeks, and monthly for three (3) months. The Certified Dietary Manager will audit nourishment refrigerators daily for two (2) weeks; weekly for four (4) weeks; and monthly for three (3) months. Results of all audits will be reported to the QA Committee. Date of Completion 10/18/2023	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove loose garbage, food, and debris from around 1 of 1 trash receptacle located outdoors behind the kitchen. This practice had the potential to impact sanitary conditions and attract pests/rodents. The findings included: An observation (with the Director of Environmental Services) of the outdoor trash receptacle area on 9/26/23 at 3:15 PM revealed trash and food littered around the trash receptacle. During the observation, flies were swarming around the trash receptacle. The Director of Environmental Services indicated he	F 814	F814 It is the policy of this facility to meet all requirements in regards to the proper disposal and maintaining of all trash and refuse disposal. Affected Areas On 09/26/2023, the Director of Culinary Services had the ground area around the trash compactor and spent oil receptacle cleaned. Other Affected Areas There are no other areas on campus that contain trash compacters or spent oil receptacles.	10/26/23

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F 814

Continued From page 7

was filling in for the Maintenance Director who was out of the office and that the Maintenance Department was responsible for maintaining the trash receptacle and the trash removal company removed the receptacle once weekly, dumped the receptacle off-site then returned it to the facility within 2 hours. During the 2-hour period, maintenance usually removed littered trash and cleaned the area before the trash receptacle was returned. Maintenance may or may not know what time the receptacle was removed and returned, but the day of the week remained the same unless otherwise notified. He further indicated maintenance was responsible for cleaning the areas under and around the trash receptacle and the dietary department was responsible for cleaning the debris on and around the grease trap that was located next to the trash receptacle as needed. He expected trash and refuse to be maintained in the receptacle area on a weekly basis and as needed.

An interview with the Administrator on 9/28/23 at 2:00 PM indicated she was not aware there was an issue with garbage/ refuse cleanup and expected all garbage and refuse to be maintained by the Maintenance Department and/or dietary staff.

F 814

Systemic Changes
On 09/27/2023 the Facilities Director ordered Fly Bait from pest control vendor ECOLAB. Fly Bait will be placed in the trash compactor weekly on Saturdays.

On 09/27/2023 the Culinary Director initiated training to 100% of the Culinary and Environmental Services staff on proper procedures for trash bag tie offs, trash disposal, and the proper procedure for daily cleaning around the trash compactor and spent oil receptacle.

On 10/01/2023, the Director of Culinary Services updated the Utility Checklist and Manager Rounding Checklist to include the following items: 1. Daily inspection of the loading dock and trash compactor area; 2. Daily inspection of the spent oil receptacle and ensuring lid is closed with no build-up present.

On 10/01/2023, a recurring work order was implemented and is now part of the monthly cleaning schedule for Environmental Services to pressure wash the spent oil receptacle and the trash compactor.

Quality Assurance / Monitoring
The Culinary Director will monitor the area around the trash compactor and spent oil receptacle daily for two (2) weeks; weekly for four (4) weeks; and monthly for three (3) months to ensure for proper disposal of trash and refuse, and no incidents of flies.

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F 814	Continued From page 8	F 814	Results of the audits will be reported to the QA Committee. Date of Completion 10/26/2023	
F 880 SS=E	Infection Prevention & Control 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	F 880		10/25/23

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F 880	Continued From page 9 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 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 dining observations, staff interviews and record review, the facility failed to provide or assist 4 of 4 residents with hand hygiene before	F 880	F880 It is the policy of this facility to establish,	

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F 880

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meals during 2 of 2 dining observations (Resident #157, #207, #208, and #209).

The findings included:

The facility policy, entitled "Handwashing/Hand Hygiene", revised August 2019, recorded in part, this facility considers hand hygiene the primary means to prevent the spread of infections. Residents will be encouraged to practice hand hygiene. Use an alcohol-based hand rub or alternatively, soap and water for the following situations: before and after eating or handling food.

1a. A continuous observation of the lunch meal on the rehab unit occurred on 9/25/23 from 12:47 PM until 12:55 PM. Residents #207, #208 and #209 were assisted in their rooms by Nurse Aide (NA) #4 with meal set up for the lunch meal. Meal trays were removed from the meal cart, taken into each resident's room, placed on the overbed table, and set up for each resident, per their preference. Residents #207, #208 and #209 were not asked if hand hygiene had already been performed nor were the residents encouraged to perform or assisted with hand hygiene prior to eating their meal. Residents #207 and #208 both received curly fries and Resident #209 received a sandwich and potato chips, foods each resident ate with their hands.

1b. A continuous observation of the lunch meal on the rehab unit occurred on 9/26/23 from 12:20 PM until 12:45 PM. Residents #157, and #207 were assisted in their rooms by NA #1 with meal set up for the lunch meal. Resident #209 was assisted in her room by NA #2 with meal set up

F 880

implement, and monitor a comprehensive infection prevention and control program that includes hand hygiene as a primary means to prevent the spread of infections.

Affected Residents
Residents #157, #207, #208, and #209 are receiving hand hygiene before and after meals.

Other Residents
All other residents who require assistance with handwashing are receiving hand hygiene before and after all meals. On 9/26/2023, the Infection Control Preventionist assessed all areas throughout the unit to ensure an adequate stock of alcohol-based rub was available in the dining rooms, on medication carts, in nursing stations and medication prep rooms.

Systemic Changes
Individual handwashing toilettes will be placed on each resident's tray on meals by the Culinary department for use with resident handwashing before and after meals.
On 9/26/2023 a 100% nursing staff in-service was initiated by the RN Supervisor that included: proper handwashing techniques; expectation that handwashing be offered before and after all meals and that alcohol based rub should be used for residents between handwashing if hands are not visibly soiled.
On 09/26/2023, the Infection Preventionist initiated an 100% in-service of nursing

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SHARON TOWERS	5100 SHARON ROAD CHARLOTTE, NC 28210

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F 880	Continued From page 11 for the lunch meal. Meal trays were removed from the meal cart, taken into each resident's room, placed on the overbed table, and set up for each resident, per their preference. Residents #157, #207 and #209 were not asked if hand hygiene had already been performed nor were the residents encouraged to perform or assisted with hand hygiene prior to eating their meal. Residents #157, #207, and #209 received chocolate chips cookies, which they ate with their hands. An interview with NA #1 occurred on 9/27/23 at 9:25 AM. NA #1 stated that she was trained to assist residents before and after meals with hand hygiene. NA #1 stated Residents #157 and #207 both required assistance with hand hygiene, but that she did not offer them assistance. An interview with NA #2 occurred on 9/27/23 at 9:30 AM. NA #2 stated that she was trained to assist residents before and after meals with hand hygiene. NA #2 stated Resident #209 required more assistance at admission than she did currently, but that Resident #209 would currently at least need set up assistance. NA #2 stated she did not ask or encourage Resident #209 to perform hand hygiene before her meal. An interview with Nurse #1 for the rehab unit occurred on 09/27/23 at 10:46 AM. Nurse #1 stated that he was the nurse on the rehab unit, and he expected residents at a minimum were offered to use hand sanitizer prior to meals and if possible offered hand washing with soap and water, which was a better and more effective option. An interview with the Infection Control Preventionist (ICP), Staff Development	F 880	staff regarding the company Hand Washing Policy. All new hires will continue to be educated on the company handwashing policy and expectations during initial orientation and on floor training. Handwashing expectations was added to the agenda to discuss and review at the weekly health care meetings. Quality Assurance/Monitoring The RN Supervisor will observe five (5) residents daily for one week; weekly for four (4) weeks and monthly x two (2) months to ensure that hand hygiene is being offered to residents before and after all meals. Any issues identified will be reported to the Director of Nursing for necessary intervention. Results of the audit will be reported to the QA Committee. Date of Completion 10/25/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345564	A. BUILDING ______ B. WING ______	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON TOWERS	**5100 SHARON ROAD CHARLOTTE, NC 28210**

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F 880	Continued From page 12 Coordinator (SDC) occurred on 09/27/23 at 10:33 AM. The ICP/SDC stated all nursing staff received an in-service in April 2023 and June 2023 on hand hygiene which instructed staff to offer/assist residents with hand hygiene before and after meals. The ICP/SDC stated that if a resident was independent with their hygiene needs, staff were trained to encourage the resident to go to the bathroom to wash their hands before and after meals and if the resident was dependent on staff to meet their hygiene needs, staff should assist the resident by offering hand sanitizer, a soapy wash cloth or assist the resident to the bathroom to wash their hands. The ICP/SDC provided documentation of nursing staff in-services on infection control for review. A signature for NA #1 and NA #2 were both included in the documentation of infection control in-services. The Director of Nursing (DON) was interviewed on 09/27/23 at 11:35 AM. The DON stated that staff were expected to follow the facility's policy on hand hygiene and assist residents with hand hygiene with either hand sanitizer or hand washing with soap and water prior to and after meals. The Administrator stated in an interview on 9/28/23 at 11:00 AM that staff received an in-service related to hand hygiene which included education to assist residents with hand hygiene prior to meals. The Administrator stated that she expected staff to assist residents with hand hygiene before and after meals.	F 880		