STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060156	A. BUILDING: _____ B. WING _____	R 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT STONEHAVEN	6741 CISCAYNE PLACE CHARLOTTE, NC 28211

(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 10/10/19.	C 000		
C 326	10A NCAC 13G .1003(d) Medication Labels 10A NCAC 13G .1003 Medication Labels (d) Non-prescription medications shall have the manufacturer's label with the expiration date clearly visible, unless the container has been labeled by a pharmacist or a dispensing practitioner. Non-prescription medications in the original manufacturer's container shall be labeled with at least the resident's name and the name shall not obstruct any of the information on the container. Facility staff may label or write the resident's name on the container. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure non-prescription medications were labeled with the resident's name for 1 of 3 residents (#1). The findings are: Review of Resident #1's current FL2 dated 08/28/19 revealed diagnoses included Alzheimer's disease, hyperlipidemia, coronary artery disease, and anxiety. Review of Resident #1's physician's orders revealed: -There was an order dated 10/07/19 to apply a thin layer of barrier cream (used to treat irritated skin) to buttocks with each brief change and as needed to buttock, sacrum, and excoriated areas. -There was an order dated 10/07/19 to apply a thin layer of antifungal cream as needed to groin and under breasts for fungal rash.	C 326	➢ Plan of action were made by the Resident Care Coordinator to communicate clearly with Hospice and Pharmacy. Informed Hospice if they have new orders for the resident, they will also send us a copy of the order and notify us aside from sending or faxing it only to the Pharmacy. Hospice agreed that anything they provide or give to the resident during their visit, they will inform the facility staff right away. Made a call immediately to Pharmacy and requested labels for the creams. All unlabeled creams (Barrier and Antifungal cream) are now properly labeled with the resident's name and instructions ➢ Resident Care Coordinator had a meeting and started doing daily check with the Facility staff on how to properly check the label on the MAR. ➢ Requested for an order from Hospice to include a specific storage instruction for the creams ➢ Informed all the staff most especially the Supervisors-in-Charge to make sure and double check all medications including creams are stored safely and locked. All creams are now kept safe in a	10/31/2019

			All creams are now kept safe in a secure and locked place. After each use, informed the staff to properly return or put it back properly, not within residents reach	

Reviewed and accepted. SGR 12/02/2019

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C 326	Continued From page 1 Observations of Resident #1's medications available on the cart for administration on 10/10/19 at 1:25pm revealed there was no barrier cream or antifungal cream available for the resident. Observation of Resident #1's room 10/10/19 at 1:33pm revealed: -Resident #1 shared a bedroom and bathroom with one other resident. -Resident #1's bathroom consisted of two sinks in her bathroom. -Resident #1's side of the sink had (3) 4oz. containers of barrier cream that were on the counter, they were not labeled with the resident's name or instructions. -There were (2) 4oz. and (2) 2oz. containers of antifungal cream that were on the counter, they were not labeled with the resident's name or instructions. Interview with the Resident Care Coordinator (RCC)/medication aide (MA) on 10/10/19 at 1:29pm revealed: -Resident #1's creams were placed on her side of the bathroom counter. -She placed Resident #1's creams on the counter because it was more accessible. -The barrier and antifungal creams were brought into the facility by Hospice. -She did not know the creams needed to be labeled with the resident's name. -She would be responsible for labeling Resident #1's barrier and anti-fungal creams. Interview with the pharmacist at the contracted pharmacy on 10/10/19 at 2:19pm revealed: -The pharmacy received an order dated 10/07/19 for Resident #1's barrier and antifungal cream.	C 326		

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C 326	Continued From page 2 -The barrier and antifungal cream were not filled by the pharmacy. -Some of Resident #1's medications were not filled by Hospice. -Medications including creams were labeled with the resident's name and instructions. -The pharmacy could provide a label for medications if needed to include the residents name and instructions. -No one from the facility called to request labels for creams. Interview with the Administrator on 10/10/19 at 3:05pm revealed: -All medications were to be labeled with the resident's name and instructions. -The RCC was responsible for making sure all medications included a label with the name of the resident and instructions.	C 326		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the	C 342	➢ Clarify a discontinuation order with Hospice and requested for an updated and new order for Hydrocodone/Acetaminophen. ➢ Hospice sent/faxed an updated and new order for Hydrocodone to the Pharmacy and sent us a copy of the order too. Any changes about the order were both verified by the Resident Care Coordinator with Hospice and the Pharmacy on the same day. ➢ New order was immediately received by both The Pharmacy and the Facility.	10/31/2019

			➢ Updated order for Lorazepam done. Clarify and requested a new order, sent the new order to the Pharmacy immediately and is now currently on the eMAR ➢ Set up a training or refresher training to all staff most especially the MedAides on how to properly administer the medications, before shift ends, incoming and outgoing shift will do the medication counting and sign the narcotic book. ➢ Medtech on duty was informed to double check all the medications available in the medication cart and notify Supervisor or Resident Care Coordinator about missing medication, about to expire, need refills and discontinued order all the time. ➢ Informed staff to always follow the 6 rights of Medication administration. When in doubt, ask. ➢ **Change Medication Policy and Procedure:** **1. All doctors orders including hospice will have to be faxed to Sanctuary and Sanctuary will fax it to Pharmacy. This way we can assure that medication orders will not bypass the facility. If the facility is responsible for Medication orders implementation the facility must be handling orders.** **2. At the end of the month when we receive the Medication for the**	

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C 342	Continued From page 3 omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records (MAR) were accurate and complete for 1 of 3 sampled residents (Resident #1) related a medication used of pain and an anti-anxiety medication. The findings are: Review of Resident #1's current FL2 dated 08/28/19 revealed diagnoses included Alzheimer's disease, hyperlipidemia, coronary artery disease, and anxiety. a. Review of Resident #1's current FL2 dated 08/28/19 revealed a medication order for hydrocodone/acetaminophen 5/325mg (used to treat pain) one tablet every 6 hours as needed. Review of Resident #1's September 2019 electronic medication administration record (eMAR) revealed: -There was an entry for hydrocodone/acetaminophen 5/325mg one tablet every 6 hours to be administered as needed. -The entry indicated the order was discontinued on 09/23/19. -Hydrocodone/acetaminophen 5/325mg was not documented as administered from 09/01/19-09/30/19. Review of Resident #1's record revealed there	C 342	**following month the RCC should go through the medication card and see if there is a discontinued medication still in the cart by checking MedCart medications against EMAR.** **3. The independent pharmacy reviewer was requested to check the med cart for discontinued medication when performing quarterly reviews.**	

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C 342	Continued From page 4 was no discontinue order or order change for Resident #1's hydrocodone/acetaminophen 5/325mg. Reviewof Resident #1's October 2019 eMAR revealed there was no entry for hydrocodone acetaminophen 5/325mg. Observation of Resident #1's medications available for administration on 10/10/19 at 1:25pm revealed hydrocodone/acetaminophen 5/325mg was available for administration. Interview with the pharmacist at the contracted pharmacy on 10/10/19 at 2:19pm revealed: -The pharmacy received an order for hydrocodone/acetaminophen 5/325mg on 03/27/19 for Resident #1. -The order for hydrocodone/acetaminophen 5/325mg was valid for 6 months. -The pharmacy had not received an updated order therefore; the medication fell of eMAR. -The pharmacy had not received a discontinue order for hydrocodone/acetaminophen 5/325mg. -The facility had not notified that the order was not on the eMAR. -He would contact the physician for an updated order. Interview with the Resident Care Coordinator (RCC)/medication aide (MA) on 10/10/19 at 3:02pm revealed: -Resident #1 had a current order for hydrocodone/acetaminophen 5/325mg one tablet every 6 hours as needed. -She had not noticed the hydrocodone/acetaminophen was not on the eMAR. -She was responsible for checking the eMARs at the beginning of each month to ensure all	C 342		

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C 342	Continued From page 5 medications were accurate and printed on the eMAR. -She was the new RCC and October 2019 was her first month reviewing the eMARs for accuracy. Refer to interview with the Administrator on 10/10/19 at 3:05pm. b. Review of Resident #1's current FL2 dated 08/28/19 revealed there was no medication order for lorazepam 0.5mg (used to treat anxiety) one tablet every 8 hours as needed. Review of Resident #1's September 2019 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 0.5mg one tablet every 8 hours to be administered as needed. -The entry indicated the order was discontinued on 09/02/19. -Lorazepam 0.5mg was not documented as administered from 09/01/19-09/30/19. Review of Resident #1's record revealed there was no discontinue order or order change for Resident #1's lorazepam 0.5mg. Review of Resident #1's October 2019 eMAR revealed there was no entry for lorazepam 0.5mg. Observation of Resident #1's medications available for administration on 10/10/19 at 1:25pmg revealed lorazepam 0.5mg was available for administration. Interview with the pharmacist at the contracted pharmacy on 10/10/19 at 2:19pm revealed: -The pharmacy received an order for lorazepam	C 342		

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C 342	Continued From page 6 0.5mg on 03/06/19 for Resident #1. -The order for lorazepam 0.5mg was valid for 6 months. -The pharmacy had not received an updated order therefore; the medication fell of eMAR. -The pharmacy had not received a discontinue order for lorazepam 0.5mg. -The facility had not notified that the order was not on the eMAR. -He would contact the physician for an updated order. Interview with the Resident Care Coordinator (RCC)/medication aide (MA) on 10/10/19 at 3:02pm revealed: -Resident #1 had a current order for lorazepam 0.5mg to be administered every 8 hours as needed. -She had not noticed the lorazepam 0.5mg was not on the eMAR. -She was responsible for checking the eMARs at the beginning of each month to ensure all medications were accurate and printed on the eMAR. -She was the new RCC and October 2019 was her first month reviewing the eMARs for accuracy. Refer to interview with the Administrator on 10/10/19 at 3:05pm. Interview with the Administrator on 10/10/19 at 3:05pm revealed: -The RCC was responsible for reviewing the eMARs monthly and ensuring all medications were listed. -He expected all scheduled and as needed medications to be on the eMAR. -The current RCC was new to her positions and may have overlooked medications that were	C 342		

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C 342	Continued From page 7 missing from the eMAR. -The RCC was also responsible for checking the medications available on the medication cart with MAR to ensure no medications were missing from the eMAR. -The pharmacist who completed the pharmaceutical review should also catch medications missing from the eMAR and should notify the RCC of any changes that needed to be made.	C 342		
C 353	10A NCAC 13G .1006(b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure all non-prescription medications stored by the facility were maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. The findings are: Review of Resident #1's current FL2 dated 08/28/19 revealed diagnoses included Alzheimer's disease, hyperlipidemia, coronary artery disease and, and anxiety. Review of Resident #1's physician's orders	C 353	➢ Informed all the staff most especially the Supervisors-in-Charge to make sure and double check all medications including creams are stored safely and locked. All creams are now kept safe in a secure and locked place. After each use, informed the staff to properly return or put it back properly, not within residents reach.	10/31/2019

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C 353	Continued From page 8 revealed: -There was an order dated 10/07/19 to apply a thin layer of barrier cream (used to treat irritated skin) to buttocks with each brief change and as needed to buttock, sacrum, and excoriated areas. -There was an order dated 10/07/19 to apply a thin layer of antifungal cream as needed to groin and under breasts for fungal rash. Observations of Resident #1's medications available on the cart for administration on 10/10/19 at 1:25pm revealed there was no barrier cream or antifungal cream available for the resident. Observation of Resident #1's room 10/10/19 at 1:33pm revealed: -Resident #1 shared a bedroom and bathroom with one other resident who was diagnosed with memory impairment. -Resident #1's bathroom consisted of two sinks in her bathroom. -Resident #1's side of the sink had (3) 4oz. containers of barrier cream and (2) 4oz. and (2) 2oz. containers of antifungal cream that were on the counter. -The barrier cream nor the antifungal cream were maintained in a safe manner under locked security. Interview with the Resident Care Coordinator (RCC)/medication aide (MA) on 10/10/19 at 1:29pm revealed: -Resident #1's creams were placed on her side of the bathroom counter. -She placed Resident #1's creams on the counter as it was more accessible during care. -The barrier and antifungal creams were brought into the facility by Hospice. -Hospice staff used creams while in the building	C 353		

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C 353	Continued From page 9 and it was accessible to them. -She did not know the creams needed to be stored in a safe manner and locked. -She would be responsible for making sure medications were stored safely and locked. Interview with the Administrator on 10/10/19 at 3:05pm revealed: -All medications were to be stored safely and locked out of the reach of residents. -The RCC and all supervisors-in-Charge (SICs) were responsible for making sure all medications were stored safely and locked.	C 353		