STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-060161	A. BUILDING: _____ B. WING _____	07/22/2021

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SANCTUARY AT STONEHAVEN 3	6021 GLENRIDGE ROAD CHARLOTTE, NC 28211

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on July 22, 2021.	C 000		
C 257	10A NCAC 13G .0904(a)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the refrigerator was free of contamination related to expired foods for 3 of 3 sampled residents. Observation of the refrigerator in the kitchen on 07/22/21 at 9:43am revealed: -There were two sealed 4 oz cups of yogurt that expired on 03/27/21. -There was a sealed 6 oz cup of Greek yogurt that expired on 05/29/21. Observation of the lunch meal service on 07/22/21 at 1:04pm revealed: -One resident required her food to be pureed and received yogurt for dessert. -She was fed by a medication aide (MA). -The MA put the yogurt in front of the resident and peeled the foil seal off the yogurt, without looking at the expiration date, then stirred the yogurt with a spoon. -The expiration date on the yogurt was 03/27/21. Interview with the MA on 07/22/21 at 1:04pm	C 257		

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C 257	Continued From page 1 revealed that she did not know that yogurt was expired since she did not check the date. Observation of the MA on 07/22/21 at 1:05pm revealed: -She did not feed the resident the expired yogurt and disposed of it. -She picked up a cup of chocolate pudding and looked at the expiration date then fed it to the resident. Interview with the Supervisor in Charge (SIC) on 07/22/21 at 1:07pm revealed: -The yogurt was delivered by a grocery delivery service one week ago. -Food was normally delivered during second shift and they did not routinely check expiration dates before the food was put away. -The food in the facility was typically used within one week so she did not typically check expiration dates before giving it to residents. Interview with the Administrator on 07/22/21 at 3:00pm revealed: -The groceries were delivered to the facility by a grocery delivery service. -He expected the staff to reject expired products and check the expiration dates of food on a weekly basis.	C 257		
C 456	10A NCAC 13G .1301(d) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint;	C 456		

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C 456	Continued From page 2 (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order. (4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order. (5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record. (6) The restraint order shall be kept in the resident ' s record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the physician restraint assessment was complete which included the medical reason for restraints, alternatives to restraints, type of restraint to be used and the time period for the restraint to be used for 2 of 4 sampled residents with bed rails. The findings are:	C 456		

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C 456	Continued From page 3 1.Review of Resident #2's current FL2 revealed diagnoses of Alzheimer's dementia, apraxia and right knee osteoarthritis. Observation of Resident #2 on 07/22/21 at 9:10am revealed she was asleep in bed with one side rail up on the bed. Review of Resident #2's physician's order dated 09/29/20 revealed an order that the resident may use side rails for positioning in bed as needed and every hour monitoring while the side rails were in use. Review of Resident #2's progress notes revealed there was no documentation of restraint alternatives that were employed prior to using bed rails and no documentation of an assessment for restraints. Review of Resident #2's current Physician Restraint Order form dated 04/22/21 revealed: -The form included 5 assessment questions related to the reason for restraints, what type of restraints should be used and how long the restraints should be used. -The assessment questions on the form were not answered. -The form had a spot for a physician's signature and was signed by the Hospice Physician on 04/22/21. Review of Resident #2's Hospice progress notes from 04/22/21 to 07/22/21 did not reveal an assessment for restraints. Interview with Resident #2's family member on 07/22/21 at 1:35pm revealed he knew the facility had bed rails on her bed and did not remember the facility reassessing her need for restraints	C 456		

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C 456	Continued From page 4 since she moved in a year ago. Review of physician's orders revealed that Resident #2 had a 7 month interval between her initial restraint order, 09/29/20, and her current restraint order, 04/22/21. Telephone interview with the facility's contracted RN on 07/22/21 at 2:30pm revealed: -She was hired in March 2021. -She audited the resident records monthly to check the dates of restraint orders and restraint assessment forms. -She expected the physician to complete the restraint assessment questions quarterly and write a new restraint order quarterly. -When she was hired, Resident #2's restraint order and restraint assessment were 3 months overdue. -She instructed the SIC to have new Physician Restraint Order forms filled out in April 2021 but she did not check to see if the restraint assessment was completed. Review of email communication from the Adult Home Specialist (AHS) to the facility on 03/17/20 revealed: -The facility did not have documentation of assessments for residents requiring physical restraints when the AHS was in the facility. -The facility was required to have documentation available to review at the time of his visit. -He recommended to the facility to keep a tracking tool to ensure all necessary documentation was in the record and that it was updated within the required time frame. Based on record review and observation it was determined that Resident #2 was not interviewable.	C 456		

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C 456	Continued From page 5 Refer to the telephone interview with the Hospice RN on 07/22/21 at 11:34am. Refer to the interview with the Supervisor in Charge (SIC) on 07/22/21 at 2:20pm. Refer to the telephone interview with the AHS on 07/22/21 at 11:13am. Refer to the interview with the Administrator on 07/22/21 at 3:00pm. 2. Review of Resident #4 current FL2 dated 04/22/21 revealed: -Diagnoses of dementia, generalized weakness and difficulty walking. -Resident was non-ambulatory and required a wheelchair. Observation of Resident #4 on 07/22/21 at 9:12am revealed she was awake in a hospital bed that was positioned at a 60 degree angle and had half side rails up on both sides of the bed. Review of Resident #4's physician's order dated 04/09/21 revealed a hospital bed with full side rails and staff were to visually check on her every hour while she was in bed. Observation of Resident #4 on 07/22/21 at 11:35am revealed: -She was awake and had scooted to the bottom of the bed. -Her legs were hanging off the bed and the blanket was wrapped around her waist. -Staff came in to check on her during the observation. Review of Resident #4's progress notes revealed	C 456		

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there was no documentation of restraint alternatives that were tried prior to using bed rails and no documentation of an assessment for restraints.

Review of Resident #4's current Physician Restraint Order form dated 04/22/21 revealed:
-The form included 5 assessment questions related to the reason for restraints, what type of restraints should be used and how long the restraints should be used.
-The assessment questions on the form were not answered.
-The form had a spot for a physician's signature and was signed by the Hospice Physician on 04/22/21.

Review of Resident #4's Consent for Physical Restraint Use form revealed the form was not signed or dated.

Telephone interview with the facility's contracted RN on 07/22/21 at 2:30pm revealed:
-She was hired in March 2021.
-She audited the resident records monthly to check the dates of restraint orders and restraint assessment forms.
-She expected the physician to complete the restraint assessment questions quarterly and write a new restraint order quarterly.
-She instructed the SIC to have new Physician Restraint Order forms filled out in April 2021 but she did not check to see if the restraint assessment was completed.

Review of email communication from the Adult Home Specialist (AHS) to the facility on 03/17/20 revealed:
-The facility did not have documentation of assessments for residents requiring physical

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restraints when the AHS was in the facility.
-The facility was required to have documentation available to review at the time of his visit.
-He recommended keeping a tracking tool to ensure all necessary documentation was in the record and that it was updated in the required time frame.

Attempted telephone interview with Resident #4's responsible party on 07/22/21 at 2:04pm was unsuccessful.

Based on record review and observation it was determined that Resident #4 was not interviewable.

Refer to the telephone interview with the Hospice RN on 07/22/21 at 11:34am.

Refer to the interview with the Supervisor in Charge (SIC) on 07/22/21 at 2:20pm.

Refer to the telephone interview with the AHS on 07/22/21 at 11:13am.

Refer to the interview with the Administrator on 07/22/21 at 3:00pm.

_____

Telephone interview with the Hospice RN on 07/22/21 at 11:34am revealed:
-She and the Hospice Physician assessed residents as a team.
-The bed rails were ordered to increase residents' mobility in bed and to keep the residents from falling out of bed.
-She did not provide quarterly restraint assessments.
-Bed rails were the only restraint that Hospice approved.
-The facility required that the resident was

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monitored hourly while restrained.
-She discussed restraint use with residents' family members when the initial orders were written.

Interview with the Supervisor in Charge (SIC) on 07/22/21 at 2:20pm revealed:
-She was trained, sometime in the last 4 months, by the facility's RN on how to use physical restraints.
-The facility was required to have a physician's order and signed family consent to use restraints on a resident.
-She was not trained on how to fill out the Physician Restraint Order form.
-She did not think the assessment questions on the Physician Restraint Order form needed to be answered if the facility had a physician's order for restraints.
-It was her responsibility to get the Physician Restraint Order form signed by the physician.
-She did not know a new form needed to be signed every 3 months.

Telephone interview with the Adult Home Specialist (AHS) on 07/22/21 at 11:13am revealed:
-He knew the facility used restraints.
-He sent a detailed email to the Resident Care Coordinator (RCC) on 03/17/21 detailing what documentation was required in the resident's record if restraints were being used.
-He expected the facility to have a signed responsible party consent for restraints and the physician's assessment for restraints.
-He also expected the physician's assessment for restraints to be updated every 3 months.

Interview with the Administrator on 07/22/21 at 3:00pm revealed:

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C 456	Continued From page 9 -The facility was required to have family consent, a new physician's order for restraints every 3 months and the resident had to be checked on every hour by staff to use restraints. -The SIC was responsible for ensuring the Physician Restraint Order form and Consent for Physical Restraint Use form was completed.	C 456		