

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL060156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/14/2021
NAME OF PROVIDER OR SUPPLIER THE SANCTUARY AT STONEHAVEN		STREET ADDRESS, CITY, STATE, ZIP CODE 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 survey on April 14, 2021.	C 000		
C 176	10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. If the only staff person on site has been deemed physically incapable of performing these procedures by a licensed physician, that person is exempt from the training. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure at least one staff who had completed a course on cardiopulmonary resuscitation (CPR) and choking management within the last 24 months was always on the premises for 1 of 3 sampled staff (Staff A). The findings are: 1. Review of Staff A's personnel records revealed: -Staff A was hired on 06/14/20. -Staff A completed a course in Adult and Child	C 176	1. Staff A – After a review of staff A file by the state representative it was brought to our attention that the referenced staff was out of compliance with her CPR. Staff in mentioned CPR was expired as of Feb 28 th , 2021. It was the manager responsibility to keep track of making sure all staff follow all Training. And to ensure that all up to date training is in the staff file. Resolution- 1. Manager spoke with the staff in mention to ensure that she received a current copy of her CPR certification card. Current copy of CPR card has been placed into the staff file. 2. Manager has come up with a tracking system to ensure that herself and RCC's are able to follow and stay on track with all employees certification/training renewals. They will check this tracking system at the end of each month to make sure that they are aware of what is to be completed the following month and make sure the current month requirements have been meet.	4/17/2021

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEFORM

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EL0811

If continuation sheet 1 of 6

Karen M. Polce

Received and Acknowledged

06/14/21

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE SANCTUARY AT STONEHAVEN

**6741 CISCAYNE PLACE
CHARLOTTE, NC 28211**

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C 176	Continued From page 1 CPR on 06/28/19 with an expiration date of February 28, 2021. -There was no documentation Staff A completed CPR recertification training after February 2021. Interview with Staff A on 04/14/21 at 3:02pm revealed: -She typically worked at the sister facility for the 4:00pm-8:00pm shift. -When staffing was short she covered shifts at other houses and worked the 3:00pm-11:00pm shift. -During the 3:00pm-11:00pm shift, she was the only staff in the facility from 8:00pm to 11:00pm -She thought that she took a CPR class in December 2020 but was not certain. -Staff A did not keep a record of her trainings at home and stated that her most recent CPR certificate was in her staff binder. Observation of the facility's staffing schedule from 03/29/21 through 04/13/21 revealed: -Staff A worked 12 of 14 possible third shift assignments from 03/29/21 through 04/13/21. -There were no additional staff assigned to those shifts. Interview with the Manager of the facility on 04/14/21 at 3:10pm revealed: -She was responsible for the oversight of the facility and two sister communities. -She had been training two Resident Care Coordinators (RCC) for two of the communities. -When the RCCs were fully trained, they would be responsible for the day to day operations in their community, including the personnel files and the resident records. -At this time she was trying to audit the resident records and personnel files for accuracy. -Staff on second shift worked 8:00pm-11:00pm	C 176		

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STATE FORM

6800

EL0811

If continuation sheet 2 of 6

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C 176	Continued From page 2 alone, and staff on third shift also worked alone from 11:00pm-7:00am. -All staff were required to have a current CPR certification and a copy should be retained in their personnel file. -Staff A worked on second and third shift. -She did not know Staff A's CPR certification had expired on 02/28/21. Interview with the Administrator on 04/14/21 at 3:45pm revealed: -The Manager was responsible for ensuring the personnel files were accurate and had the necessary documentation for each employee. -The Manager was responsible for ensuring staff had completed the required training and had current CPR certification. -He did not know Staff A did not have a current CPR certification.	C 176		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents	C 330	After the completion of state review, this rule has been stated to not have been met by the state representative. Staff and Manager spoke with Pharmacy concerning the order at the time the order was made and the Pharmacy did not carry Turmeric at the time of the order. The wife of the resident in question was to look online to find Turmeric at a cheaper price than quoted by the pharmacy.	4/14/2021

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C 330	Continued From page 3 (Resident #1) related to a medication for inflammation. The findings are: Review of Resident #1's current FL2 dated 03/16/21 revealed: -Diagnoses included Alzheimer dementia, expressive language impairment and unsteady gait. -There was an order for a Turmeric capsule 400mg twice daily, used to decrease inflammation. Review of Resident #1's March 2021 electronic medication administration record (eMAR), from 03/16/21 through 03/31/21 revealed: -There was an entry for a Turmeric capsule 400mg twice daily, to be administered at 8:00am and 8:00pm. -There was no documentation the Turmeric capsules were administered for 30 of 30 possible opportunities from 03/16/21 through 03/31/21. Review of Resident #1's April 2021 eMAR from 04/01/21 through 04/14/21 revealed: -There was an entry for a Turmeric capsule 400mg twice daily, to be administered at 8:00am and 8:00pm. -There was no documentation the Turmeric capsules were administered for 30 of 30 possible opportunities from 04/01/21 through 04/14/21. Observation of Resident #1's medications on hand 04/14/21 at 2:50pm revealed Turmeric 400mg capsules were not available for administration. Interview with a representative from the facility's contracted pharmacy on 04/21/21 at 11:30am	C 330	State representative explained to the manager and staff in the facility that a family may request to find the medication. However, they must have the medication within 24hrs or have it discontinued until the family is able to get it into the facility. The manager called the Dr. office and had the order discontinued right away. Manager also called the family to explain that they would have to have the order discontinued until she could bring it into the facility. At which time, the wife of the resident in question decided to go without the medication all together. Manager has made all staff aware of the rule. Manager and RCC will be sure to track when a new order has been written and given to the pharmacy to ensure that the medication is in the facility in a timely manner. If medication is not available it should be discontinued or substituted by the doctor order.	

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C 330	Continued From page 4 revealed: -There was a current order dated 03/16/21 for Turmeric capsule 400mg twice daily. -The Turmeric was not filled by the pharmacy. -Resident #1's family was to provide the Turmeric capsules. Interview with medication aide (MA) on 04/14/21 at 2:55pm revealed: -She administered medications to the residents. -She had never administered Turmeric capsules to Resident #1. -The facility was waiting for the family to bring in the Turmeric capsules. -She did not document why the medication was not administered, she just did not initial that she had administered the medication. -The Manager of the facility was aware. Interview with the Resident Care Coordinator (RCC) on 04/14/21 at 2:15pm revealed: -She was recently hired as the RCC of the facility, and was still in training. -It would be her responsibility to audit the medication carts and eMARS when she was fully trained. -She did not know Resident #1 had Turmeric capsules twice a day as a signed physician order and they were not available for administration. Interview with the Manager on 04/14/21 at 2:30pm revealed: -Resident #1's family member was going to bring the Turmeric capsules to the facility for the staff to administer. -The family member was searching online for pricing and was unsure if she wanted to purchase the Turmeric capsules due to their cost. -The facility staff had been awaiting her decision. -She did not know they would have to order the	C 330			

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C 330	Continued From page 5 Turmeric capsules through the pharmacy or request an order from the PCP to discontinue the Turmeric capsules. -She did not know they could not wait for the family member to decide on purchasing the Turmeric capsules. Interview with the Administrator on 04/14/21 at 3:10pm revealed: -He expected the RCC and the Manager to review the eMARS and perform cart audits weekly to ensure medications for the residents were in the facility as ordered. -Family members who want to provide medications need to bring them to the facility staff within 24 hours. -If a medication was not available for administration, it should be ordered from the pharmacy or followed up with the physician. -It was the responsibility of the RCC or Manager to follow up with the physician.	C 330		