STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060-182	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT STONEHAVEN 6	3332 COTILLION AVE CHARLOTTE, NC 28210

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C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey and complaint investigation on August 7, 2025. The Mecklenburg County Department of Social Services initiated the complaint investigation on July 9, 2025.	C 000		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interview and record reviews, the facility failed to verify there were no substantiated findings on the Health Care Personnel Registry (HCPR) for 1 of 3 sampled staff (Staff B) prior to working in the facility. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 04/26/25 as a personal care aide (PCA). -There was a Health Care Personnel Registry (HCPR) check completed on 08/07/25 with no substantiated findings. -There was no HCPR check prior to 08/07/25. Observation of Staff B on 08/07/25 between 8:55am through 4:30pm revealed: -Staff B was seated at the dining room table	C 145		

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C 145	Continued From page 1 assisting a resident with eating her breakfast. -Staff B provided personal care and helped serve meals to the residents. Interview with Staff B on 08/07/25 at 4:19pm revealed: -She worked at the facility as a PCA. -She had worked at a sister facility and thought all her paperwork had been completed. Interview with the Personnel and Operations Manager on 08/07/25 at 4:26pm revealed: -The Supervisor In-Charge (SIC) was responsible for completing HCPR check for staff when new staff were hired. -She did not know Staff B did not have a completed HCPR check prior to 08/07/25. -She was aware that all employees were to have a completed HCPR check prior to providing care to residents. -She, the SICs and the facilities Registered Nurses (RN) completed personnel record audits monthly. -She did not know how Staff B's HCPR check had been missed. Interview with the Administrator on 08/07/25 at 5:00pm revealed: -He did not know Staff B did not have a completed HCPR check prior to 08/07/25. -The SIC or RNs were responsible for completing HCPR checks. -The RNs completed personnel record audits twice monthly.	C 145		
C 218	10A NCAC 13G .0704 (b) Resident Contract, Information on Facility 10A NCAC 13G .0704 Resident Contract,	C 218		

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C 218	Continued From page 2 Information On Facility, and Resident Register (b) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status; (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D- 4.8; and (6) resident's consent including a signature confirming the review and receipt of information contained in the form. The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf, at no charge. The facility may use a resident information form other than the Resident Register	C 218		

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C 218	Continued From page 3 as long as it contains same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Resident Register was signed and dated for 2 of 3 sampled residents (#2 and #3) when one was not signed and dated by the administrator or supervisor in charge (SIC) and responsible person (RP)(#3). The findings are: 1. Review of Resident #3's current FL2 dated 06/19/25 revealed: -Diagnoses included Alzheimer's disease, depression, anxiety, and Parkinson's disease. -Resident #2 was intermittently disoriented. Review of Resident #3's Resident Register revealed: -An admission date of 06/26/25. -It was not signed or dated by Resident #3's RP or the Administrator/SIC. Refer to interview with the Operations Director on 08/07/25 at 4:26 pm. Refer to interview with the Administrator on 08/07/25 at 5:00pm. 2. Review of Resident #2's current FL2 dated 06/10/25 revealed: -Diagnoses included dementia and	C 218		

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C 218	Continued From page 4 hyperlipidemia (high levels of fat particles in the blood). -Resident #3 was constantly disoriented. Review of Resident #2's Resident Register revealed: -An admission date of 06/27/25. -It was not signed or dated by Resident #3's RP. Refer to interview with the Operations Director on 08/07/25 at 4:26 pm. Refer to interview with the Administrator on 08/07/25 at 5:00pm. _____ Interview with the Operations Director on 08/07/25 at 4:26 pm revealed: -She was responsible for ensuring Resident Registers were completed and signed typically within 24 hours of admission. -She was on vacation when Residents #3 and #2 were admitted. -The SIC or Registered Nurses (RN) were responsible for completing the Resident Registers if she was unavailable. -She typically did not review newly admitted residents' Resident Registers. Interview with the Administrator on 08/07/25 at 5:00pm revealed: -He did not know Residents #3 and #2 did not have completed Resident Registers. -The Operations Director was responsible for completing Resident Registers unless she was unavailable. -The RNs were responsible for completing the Resident Register when the Operations Director was unavailable.	C 218		

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C 246	Continued From page 5	C 246		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 2 of 2 sampled residents (#1 and #2) who had orders for physical therapy (PT) and occupational therapy (OT) for evaluation and treatment of gait, weakness and to prophylactically to prevent falls. The findings are: 1.Review or Resident #1's current FL dated 06/10/25 revealed: -Diagnoses included dementia with behavioral disturbance, dementia of the Alzheimer's type and abnormal gait. -Resident #1 was constantly disoriented. Review of Resident #1's Resident Register revealed an admission date of 06/12/25. Review of Resident #1's physician order dated 06/18/25 revealed there was an order for PT and OT to evaluate and treat for gait and weakness. Review of Resident #1's record revealed: -There was a fax confirmation sheet attached to the 06/18/25 PT and OT order. -There was no documentation that the resident had been evaluated by a home health agency. Review of the facility hot box charting form revealed there was no documentation that Resident #1 had an order/referral for a PT and	C 246		

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C 246	Continued From page 6 OT evaluation. Interview with Resident #1's Primary Care Provider (PCP) on 08/07/25 at 3:10pm revealed: -She was aware that Resident #1 had not been seen by PT and OT services. -She and the facility sent separate orders/referrals to the home health agency, via fax. -She did not know why Resident #1 had not been evaluated by the home health agency. -She ordered PT and OT to evaluate prophylactically to prevent falls. Interview with the facility Registered Nurse (RN) on 08/07/25 at 11:15am revealed: -She did not know Resident #1 had not been evaluated by PT and OT services. -She did not know if staff had made another attempt to fax residents PT and OT order, prior to the order being faxed on 08/07/25. Refer to interview with the Operations Director on 08/07/25 at 4:26pm. Refer to the interview with the Administrator on 08/07/25 at 5:00pm. 2. Review of Resident #2's current FL2 dated 06/10/25 revealed: -Diagnoses included dementia and hyperlipidemia. -Resident #2 was constantly disoriented. Review of Resident #2's Resident Register revealed an admission date of 06/27/25. Review of Resident #2's physician order dated 07/09/25 revealed there was an order for PT and OT evaluation.	C 246		

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C 246	Continued From page 7 Review of Resident #2's record on 08/07/25 revealed: -There was a fax confirmation sheet attached to the PT and OT order. -There was no documentation that the resident had been evaluated by a home health agency. Review of the facility hot box charting form revealed there was no documentation of that Resident #2 had an order/referral for a PT and OT evaluation. Interview with Resident #2's PCP on 08/07/25 at 3:10pm revealed: -She was aware that Resident #2 had not been seen by PT and OT services when she visited the facility on 08/06/25 (yesterday). -She and the facility sent separate orders/referrals to the home health agency, via fax. -She did not know why Resident #2 had not been evaluated by the home health agency. -She ordered PT and OT to evaluate prophylactically to prevent falls. Interview with the facility RN on 08/07/25 at 11:15am revealed: -She was aware that Resident #2 had not been seen by PT and OT services. -The Supervisors in Charge (SIC) were responsible for faxing therapy orders/referrals to home health agencies. Refer to interview with the Operations Director on 08/07/25 at 4:26pm. Refer to the interview with the Administrator on 08/07/25 at 5:00pm.	C 246		

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C 246	Continued From page 8 Interview with the Operations Director on 08/07/25 at 4:26pm revealed: -The SICs were responsible for faxing therapy orders to home health agencies. -Incomplete orders/referrals should be flagged in the residents' charts until completed. -New orders/referrals should have been placed on the facility hot box charting form for staff follow-up. -The facility RN completed resident record audits every month. -The residents PT and OT referrals, "were not completely followed through with." Interview with the Administrator on 08/07/25 at 5:00pm revealed: -He did not know Residents #1 and #2 had not been evaluated by therapy services. -The SIC and/or the RN were responsible for ensuring orders/referrals were made and completed. -The RN completed monthly resident record audits which included reviewing orders. -The RN should have follow-up with the PT and OT referrals.	C 246		