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 _____	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT STONEHAVEN 3	6021 GLENRIDGE ROAD CHARLOTTE, NC 28211

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C 000	Initial Comments The Adult Care Licensure section and Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on August 14, 2025 through August 15, 2025. The complaint investigation was initiated by Mecklenburg County Department of Social Services on June 30, 2025.	C 000		
C 244	10A NCAC 13G .0901(c) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure immediate response and intervention by staff in accordance with the facility's policies and procedures for 1 of 1 sampled residents (Resident #1) who was observed by staff exhibiting and expressing signs of pain to her left side and who sustained an unwitnessed head injury where staff failed to seek any treatment, leading to the resident being in pain the next day. The Findings are: Review of the facility's Accident/Falls/Emergency and Fire Safety Policy revealed: -When an accident or an emergency occurs, staff should:	C 244		

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C 244	Continued From page 1 -Remove the resident from immediate danger, if possible. -Send for or call for help and evaluate the situation. -Call 911 or have someone call 911. -Assess the resident. -If injury apparent or possible, do not move resident. -Administer first aide as appropriate. -Call the resident's physician and responsible party. -Complete the Report of Accident and Incident Form. -If the accident or incident requires intervention greater than first aide, the Report of Accident and Incident Form should be sent to the local county Department of Social Services within 48 hours. -The Administrator/Supervisor in Charge (SIC) was to notify a resident's responsible person or contact person, as indicated on the Resident Register. -Any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness but staff and documented in the resident's file. -Any incident of the resident falling which does not result in injury requiring medical treatment of referral for emergency medical evaluations, with notifications to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file. Review or Resident #1's current FL2 dated 12/05/24 revealed: -Diagnoses included deep vein thrombosis (DVT) of the left lower extremity (blood clot), pelvic	C 244		

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fracture, subdural hematoma, multiple falls and dementia.
-She was intermittently disoriented.
-She was non-ambulatory.
-There was an order for apixaban (used to prevent and treat blood clots) 5mg, two tablets (10mg) by mouth, twice daily for 10 days and then one tablet by mouth twice daily for 25 days.

Review of Resident #1's Resident Register revealed and admission date of 09/09/24.

Review of Resident #1's hospital discharge summary dated 12/07/24 revealed:
-Resident #1 was admitted to the hospital due to acute DVT of the left lower extremity.
-There was an order for apixaban 5mg, two tablets (10mg) by mouth, twice daily for 10 days and then one tablet by mouth twice daily for 25 days.

Review of Resident #1's Accident and Incident Report dated 12/08/24 at 1:30pm revealed:
-Resident #1 returned to the facility on 12/07/24 from the local acute care hospital during the night.
-Resident was in pain to her left lower extremity.
-Her recent hospital admission was due to a blood clot.
-Resident #1's family member and staff stated the resident was unable to ambulate and pain was intolerable.
-Resident #1 was sent back to the local acute care hospital.
-Resident #1's family member notified the facility on 12/09/24 that the resident's hip was fractured.

Review of Resident #1's Emergency Medical Service (EMS) report dated 12/08/24 revealed:
-EMS was dispatched on 12/08/24 at 3:41 pm

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due to a residents fall from bed with an onset date of 12/07/24 at 10:00pm documented.
-Resident #1 was sitting in a recliner chair under the care of her family member and facility staff.
-Staff stated the resident had been released from the hospital on 12/07/24 due to a blood clot to her leg and had been prescribed apixaban (used to prevent and treat blood clots).
-Staff stated the resident fell trying to get out of bed on 12/07/24 and hit the left side of her face on the bed railing and was caught mid fall by the staff.

Review of Resident #1's Orthopedic Provider's hospital note dated 12/20/24 revealed:
-Resident #1's admission diagnoses included healing left pelvic fractures (10/30/24), mildly displaced/angulated fracture of the left femoral neck, which was favored as acute and abrasion to her left forehead.
-Resident #1 underwent a left total hip arthroplasty on 12/09/24 and was discharged to a short-term rehab facility on 12/26/24.

Review of Resident #1's staff charting note dated 12/08/24 at 11:00am revealed:
-On 12/07/24, Resident #1 came back from the hospital at 9:00pm via ambulance transport.
-Resident #1 asked to go to the bathroom and could not stand.
-The SIC placed Resident #1 in a wheelchair and took her to the bathroom.
-While Resident #1 was in the bathroom, the MA went to check on another resident.
-The SIC returned to Resident #1's room where the resident was stuck between the bed post and the nightstand.
-Resident #1 had a skin tear above her left eye that was bleeding.
-The SIC contacted the Resident Care

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C 244	Continued From page 4 Coordinator (RCC) via video chat for the RCC to assess the resident's injury. -The RCC instructed the SIC to clean, bandage and place ice above Resident #1's left eye. -The RCC attempted to reach Resident #1's family member, "to no avail." -Resident #1's left leg was "more swollen." -The RCC came in the morning of 12/08/24 to evaluate Resident #1's eye bruises and preceded to help stand the resident up but "she was in too much pain." -The family member was there when the RCC stated the resident was going to be sent back out to the hospital around 1:00pm. Review of staff charting note dated 12/09/24 at 9:00am revealed resident #1's family member notified the facility the resident had a hip fracture. Review of a SIC's written statement dated 04/03/25 revealed: -She was on duty on 12/08/24 at 8:00am when the SIC came to access Resident #1. -Resident #1's family member was also present. -The SIC "washed her up and got her ready to go back to the hospital." -The ambulance took a long time to come, and the resident was sent to the hospital at 12:00pm. Review of a second SIC's written statement dated 04/07/25 revealed: -She arrived at the facility at 8:00am. -Resident #1 had a small skin tear above her left eye. -The SIC assigned to the facility, "cleaned her up in preparation to send her out to the hospital." -Resident #1's family member was present when the resident left for the hospital. Interview with a SIC on 08/14/25 at 4:20pm	C 244		

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C 244	Continued From page 5 revealed: -She worked on 12/07/24 when Resident #1 returned from the hospital and returned to work on 12/08/24 at 7:00am. -Resident #1 voiced she was in pain when EMS transferred her from the stretcher to her rollator. -Resident #1 had difficulty standing and voiced she was in pain while the SIC was putting on her pajamas. -Resident #1 had difficulty standing and voiced she had pain in her hip when the SIC helped resident onto the right side of her bed. -She thought the resident was hurting from her previous fall in October. -The SIC went to assist another resident when she heard Resident #1's bed alarm sound. -When she returned to the room around 10:00pm, Resident #1 was sitting on the left side of the bed, at the foot of the bed, leaning her head against the bed post and bleeding from above her left eye. -The SIC contacted the RCC via video chat who gave instructions on how to clean and dress Resident #1's injury. -Resident #1's eye was bleeding and the resident kept pulling off the band-aides. -She did not call Resident #1's Primary Care Provider (PCP) or her family member. -She did not know if the RCC called residents PCP and family member. -She assisted Resident #1 with transferring to her rollator, then rolled the resident to the right side of the bed, assisted her back into the bed while the resident complained of pain. -The RCC came in the following morning (12/08/24) around 9:10am, gave Resident #1 a shower and the resident kept stating, "it's hurting, it's hurting." -She was instructed to call 911 between 1:00pm-2:00pm by the RCC.	C 244		

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C 244	Continued From page 6 -The ambulance did not arrive until after 3:00pm. Telephone interview with a second SIC on 08/15/25 at 1:44pm revealed: -She came into work at 8:00am on 12/08/24. -She could tell the resident needed to go to the hospital because she seemed uncomfortable while sitting in a recliner. -She knew Resident #1 was uncomfortable, "just by how she was moving" and because the resident displayed facial grimacing. Interviews with the RCC on 08/14/25 at 10:00am and 2:00pm and on 08/15/25 at 1:22pm revealed: -She was called by the SIC on 12/07/24 around 10:00pm about Resident #1 having a fall. -The SIC contacted her via video chat to show her the resident's injury above her left eye. -She told the SIC how to clean and dress the resident's injury above her left eye. -The resident's eye was bleeding and the resident was crying when the SIC was trying to clean her injury. -She tried to reach the resident's family member. -She did not call the residents PCP. -She notified the Director of Operations the following morning of 12/08/24. -She arrived at the facility on 12/08/24 at 8:10am to assess the resident. -She gave the resident a shower around 8:20am because the resident had dried blood on her face and in her hair. -When she tried to stand Resident #1 up, the resident screamed. -She told Resident #1's family member who was at the facility that she was going to send the resident back to the hospital. -EMS was called sometime after breakfast but did not come so she called 911 again at 11:00am. -The SIC notified her on 12/07/24 that the	C 244		

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resident had complained of pain to her left hip ever since she was brought back to the facility by the ambulance.
-She did not tell the SIC to send her back to the hospital on 12/07/24 because the resident was "alert."
-The resident could not tell her or the SIC how she had injured herself.
-She knew she should have sent the resident to the hospital the night she hit her head.
-She notified the facility Registered Nurse (RN) on 12/08/24 that she was sending Resident #1 to the hospital due to her legs being swollen.
-She emailed the residents PCP on 12/08/24.

Telephone interview with Resident 1's PCP on 08/15/25 at 10:42am revealed:
-She was notified of Resident #1's 12/07/24 incident on 12/08/24.
-The resident should have been sent to the hospital immediately due to the amount of pain she was in, especially if there were no pain medications ordered.

Interview with the Administrator on 08/15/25 at 9:10am and 2:24pm revealed:
-He was notified of Resident #1's 12/07/24 incident on 12/08/24.
-Staff should be notifying the Director of Operations and the facility RN of any accident or incident.
-If a resident had an unwitnessed fall with head injury, staff should immediately notify 911 and the resident's responsible party.

Attempted telephone interview with another SIC on 08/15/25 at 11:02am was unsuccessful.

_____

The facility failed to immediately respond and provide care for Resident #1 after the resident

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C 244	Continued From page 8 voiced multiple complaints of pain with staff identifying the resident was in pain, an unwitnessed head injury with bleeding while the resident was taking a blood thinner, resulting in 911 not being contacted until over 17 hours later which revealed the resident had a fractured left hip. This failure placed the resident at substantial risk for harm and constitutes a Type A2 Violation. _____ The facility failed to provide an accepted plan of protection in accordance with G.S.131D-34 on for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2025.	C 244		