Division of Health Service Regulation

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 ___	07/23/2018

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 and the Mecklenburg County Department of Social Services completed an initial survey on 07/23/18.	C 000		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (Resident #2) with orders for blood pressures. The findings are: Review of Resident #2's current FL2 dated 04/17/18 revealed: -Diagnoses included diastolic dysfunction without health failure, anxiety, and hypertension. -A physician order for blood pressure checks daily and as needed. Review of Resident #2's June 2018 electronic Medication Administration Record (eMAR) revealed: -There were no entries for blood pressures on the eMAR. -There were no blood pressures documented from 06/08/18-06/30/18.	C 249		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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C 249

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Review of Resident #2's June 2018 eMAR revealed:
-There were no entries for blood pressures on the eMAR
-There were no blood pressures documented from 06/08/18-06/30/18.

Review of Resident #2's record revealed there were no documented blood pressures since the resident's admission to the facility on 06/08/18.

Interview on Resident #2's responsible party on 07/23/18 at 2:35pm revealed:
-He did not know Resident #2 had an order for blood pressures daily and as needed.
-He was not sure if staff completed blood pressure checks daily and as needed for Resident #2.

Interview on with the Resident Care Coordinator (RCC)/medication aide (MA) on 07/23/18 at 2:50pm revealed:
-She worked as the RCC and an MA and worked 1st shift
-MAs and PCAs were responsible for completing blood pressure checks during first shift.
-Blood pressure checks were completed for Resident #2 when she allowed staff to complete checks.
-She checked Resident #2's blood pressure and recorded in a notebook, however it was misplaced.
-Without the notebook she could not recall when Resident #2's had refused blood pressure checks.
-The BP book was located on the the shelf next to the administrator's desk "I don't know what happened to it".
-The pharmacy had not placed the order for blood pressure checks on the eMAR.

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C 249	Continued From page 2 -There was not any reminders in place to ensure Resident #2's blood pressure had been checked daily. Interview with the Administrator on 07/23/18 at revealed: -He did not know Resident #2 had an order for blood pressure checks everyday. -He expected the RCC to make sure the blood pressure checks were completed daily and recorded in notebook. -He thought the staff recorded the blood pressure, but could not find the book for where it was recorded. -The blood pressure book was supposed to be on the shelf next to his desk, but he could not find the book. Interview with the nurse for Resident #2's physician on 07/23/18 at 5:49pm revealed: -Resident #2 had a history of falls and dizziness and felt blood pressure should be monitored. -She expected Resident #2's blood pressure to be checked daily and as needed. -If blood pressure was not checked daily, Resident #2 would be at risk for falling and dizziness.	C 249		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by:	C 311		

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Based on observations and interviews the facility failed to ensure two residents(#2 and #3) were treated with respect and dignity by staff related to residents privacy with the use of visual monitoring devices with visual and audio capabilities, allowing access for these devices to be located in the dining room, where other people viewed them who were not caregivers of the residents.

1. Review of Resident #2's FL2 dated 04/17/18 revealed diagnoses included weakness, anxiety, recurrent urinary tract infections, intermittent disorientation.

Observation of the monitoring devices on 07/23/18 at 9:15am revealed:
-An electronic monitoring device with visual and audio monitoring of Resident #2 sleeping in her bed.
-The monitoring device with audio was located on the counter between the living room and the kitchen.
-The monitoring device was faced towards the living room and could be accessed by anyone walking by.
-Resident #2 was observed on the electronic monitoring device lying in the bed, audio of movement was heard with clarity.

Interview with Resident Care Coordinator (RCC) on 07/23/18 at 2:05pm revealed:
-Monitoring device with video and audio were used by medication aides (MAs) while completing housekeeping tasks.
-Medication aides (MAs) used the monitoring device to listen and watch Resident #2 to prevent falls.
-The family of Resident #2 requested and purchased the monitoring device to help monitor the resident while she slept in her room to

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prevent falls.
-Care was not provided to Resident #2 while she was in the bed, care was always provided in the bathroom.
-She did not realize the monitoring devices affected Resident #2 resident right to privacy.

Interview with a 1st shift Personal Care Aide (PCA) on 7/23/18 at 2:30pm revealed:
-She knew Resident #2 had an audio and video monitoring device in Resident #2's bedroom.
-The audio and video monitor was kept on the cabinet in the dining room area. for anyone in the room to view it.
-She did not know if there was a contract agreement between the facility and Resident #2's responsible party (RP) allowing the use of the electronic monitoring device.
-The electronic monitoring device was used by staff to increase supervision of Resident #2 to prevent falls.

Telephone interview with Resident #2's RP on 07/23/18 at 2:35pm revealed:
-He recommended the monitoring device with video and audio capability.
-He felt that the monitoring device was needed so that staff could monitor Resident #2 when she was in her room to prevent falls throughout the day and at night.
-He had not signed a contract allowing the facility to monitor Resident #2 via video and audio monitoring.
-Resident #2's body was never exposed as care was not provided in the bed, but in the resident's bathroom away from the camera.

Interview with the administrator on 03/28/17 at 1:49 pm revealed:
-Resident #2's family requested that the

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electronic monitoring device be used to prevent falls.
-The facility utilized the audio and video monitoring device prevent Resident #2 from attempting to get out of bed without assistance.
-He did not have a specific contract agreement with Resident #2 RP allowing the use of an audio and video monitoring device.
-The RP for Resident #2 purchased the electronic monitoring device for her bedroom.
-MAs and PCA's assisted Resident #2 only in her private bathroom, which did not have electronic monitoring.
-He did not know the audio and video monitoring device impacted residents' right to privacy.

Based on observation and record review, it was determined Resident #2 was not interviewable.
2. Review of Resident #3's current FL-2 dated 06/05/18 revealed diagnoses included Alzheimer's Dementia, hypertension, coronary artery disease, gastroesophageal reflux disease, anxiety, hyperlipidemia.

Observation of the monitoring devices on 07/23/18 at 9:15am revealed:
-An electronic monitoring device with visual and audio monitoring of Resident #3 room asleep in her bed.
-The monitoring device with audio were located on the counter between the living room and the kitchen.
-The monitoring device was faced towards the living room and could be accessed by anyone walking by.
-Resident #3 was observed on the electronic monitoring device lying in the bed, audio of movement was heard with clarity.

Interview with Resident Care Coordinator (RCC)

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on 07/23/18 at 2:05pm revealed:
-A monitoring device with video and audio were used by medication aides (MAs) while completing housekeeping tasks in the common living areas of the home.
-MAs used the monitoring device to listen and watch Resident #3 to prevent falls.
-The family of Resident #3 requested and purchased the monitoring device to help monitor the resident while she was in her bedroom to prevent falls.
-Care was not provided to Resident #3 while she was in the bed, care was always provided in the bathroom.
-She did not realize the monitoring device affected Resident #3's right to privacy.

Interview with a 1st shift PCA on 7/23/18 at 2:30pm revealed:
-She knew Resident #3 had an audio and video monitoring device in her bedroom.
-The audio and video monitor was kept on the cabinet in the dining room area.
-She did not know if there was a contractual agreement between the facility and Resident #3's RP allowing the use of the electronic monitoring device.
-She stated the electronic monitoring device was used by staff to increase supervision of Resident #3 to prevent falls.

Interview with Resident #3's RP on 7/23/18 at 1:15pm revealed:
-Resident #3 had a history of falls prior to admission to the facility.
-He had discussed with the facility his preference for the facility to use an audio and video monitoring device in Resident #3's bedroom to monitor Resident #3 while she was in the bed.
-He had signed a contract with the facility allowing

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C 311	Continued From page 7 the facility to photograph Resident #3. -He did not know of a specific contract agreement allowing the facility to monitor Resident #3 with an audio and video monitoring device. -He wanted the audio and video monitoring device used for Resident #3 as a tool to reduce Resident #3's risk of falls from the bed. Interview with the Administrator on 03/28/17 at 1:49 pm revealed: - Resident #3 RP requested that the electronic monitoring device be used to prevent falls. -The facility utilized the audio and video monitoring device prevent Resident #3 from attempting to get out of bed without assistance. -He did not have a specific contract agreement with Resident #3 RP allowing the use of an audio and video monitoring device. -The RP for Resident #3 purchased the electronic monitoring device for her bedroom. -MAs and PCA's assisted Resident #3 only in her private bathroom, which did not have electronic monitoring. -He did not know the audio and video monitoring device impacted residents' right to privacy. Based on observation and record review, it was determined Resident #3 was not interviewable.	C 311		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;	C 315		

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C 315	Continued From page 8 (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify physician's orders for 1 of 3 sampled residents (Resident #2) related to order for timolol eye drops (used to treat glaucoma) which resulted in 14 missed doses. The findings are: Review of Resident #2's current FL2 dated 04/17/18 revealed: -Diagnoses included diastolic dysfunction without health failure, hypertension, and type 2 diabetes. -There was an order for timolol eye drops one drop in both eyes twice daily, wait 10 minutes prior to giving Lataprost eye drops. Review of Resident #2's Resident Register revealed she was admitted 06/08/18. Review of Resident #2's record revealed there was no order clarifying the strength or dosage of timolol to be administered. Review of Resident #2's June 2018 electronic medication administration record (eMAR) revealed: -An entry for timolol 0.5% drops, instill one drop in both eyes twice daily scheduled for administration at 8:00am and 8:00pm daily.	C 315		

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-There was no documentation of administration of timolol eye drops one drop in both eyes twice daily(BID), wait 10 minutes prior to giving Lataprost eye drops at 8:00am or 8:00pm from 06/08/18-06/21/18.

Observation of medications on hand on 07/23/18 at 2:05pm revealed timolol 0.5% drops were available for administration.

Interview with the Resident Care Coordinator (RCC) on 07/23/18 at 2:50pm revealed:
-She was responsible for receiving orders and ensured orders were reviewed and sent to the pharmacy.
-She did not notice that the order for Resident #2's timolol was not clear.
-The timolol was not on the eMAR from 06/08/18-06/21/18, so it was not administered.
-Physician orders and medications were supposed to be checked once per month, "if I have a weekend when I am not working".

Telephone interview with pharmacist at the contracted pharmacy on 07/23/18 at 3:19pm revealed:
-The order for timolol BID was received via the FL2 from the facility when Resident #2 was admitted 06/08/18.
-When the order was received it could not be processed as the strength and dosage were not listed.
-The timolol was not filled because the order was not clear, a clarification was needed from the doctor.
-Once the clarification was received, someone from the facility informed them that the prescription was not needed.
-The timolol was placed on the eMAR 06/20/18 because that's when the clarification was

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received.

Telephone interview with a pharmacist from another contracted pharmacy on 07/23/18 at 3:32pm revealed:
-The order for timolol was received on 04/08/18.
-There were 3 (15 milliliter) bottles of timolol was dispensed on 04/08/18.
-Each bottle of timolol should last 25 days.
-There were no other dispense dates.

Interview with the Administrator on 07/23/18 at 12:25 pm with the Administrator revealed:
-He did not know Resident #2 did not receive eye drops from 06/08/18-06/21/18.
-He was not sure what happened, "there were some issues with the eMAR system".
-The RCC was responsible for checking the medication order, eMAR, and medication available monthly.

Interview on 07/23/18 at 11:25 am with Resident #2's Responsible Party revealed;
-He picked up the medication from the contracted pharmacy and delivered it to the facility when Resident #2 was admitted.
-Resident #2 was prescribed the medication prior to being admitted to the facility.

Interview with Resident #2's Physician's nurse on 07/23/18 at 2:40pm revealed:
-Resident #2 was prescribed timolol eye drops by her Ophthalmologist.
-She did know the reason why Resident #2 was prescribed timolol eye drops.

Attempted telephone call with Resident #2's Ophthalmologist on 07/23/18 at 2:50pm was unsuccessful.

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C 315	Continued From page 11 Based on observation and record reviewed, it was determined Resident #2 was not interviewable.	C 315		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident	C 453		

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while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
Based on observation, interviews, and record reviews, the facility failed to ensure an assessment and care planning process, after alternatives had been tried and documented in in the resident's record, and used only with a written order for restraints from a physician for 1 of 1 sampled residents (Resident #2), who had a bed rails.

The findings are:

Observation on 07/23/18 at 08:54am during the initial tour revealed Resident #2 was lying in her bed with 1/2 length bed rails up on both side of her bed.

Review of Resident #2's current FL2 dated 04/17/18 revealed:
-Diagnoses included weakness, anxiety, and hypertension.
-Resident #2 was semi-ambulatory.
-There was no order for a restraint.

Review of Resident #2's Resident Register

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C 453	Continued From page 13 revealed an admission date of 06/08/18. Review of Resident #2's care plan dated 06/09/18 revealed: -Resident #2 needed extensive assistance with transfers and ambulation. -There was no documentation of an assessment for bed rails. Review of Resident #2's physician orders revealed there was no order, assessment or documentation of a care planning meeting for the use of bed rails. Review of a Licensed Health Professional Support (LHPS) evaluation for Resident #2 dated 06/09/18 revealed care of residents who physically restrained was not listed as a current task. Interview with Resident #2's Responsible Party (RP) on 07/23/18 at 2:35pm revealed: -He requested Resident #2 have bed rails on her bed to prevent her from getting out of bed and falling. -He purchased the bed rails and had them placed on the bed. -He had not signed a consent for Resident #2 to use bed rails because he did not know he had to complete a consent. -He had not attended or been notified of a care planning meeting for the use of bed rails. Interview with the Resident Care Coordinator (RCC) on 07/23/18 at 2:05pm: -Resident #2 had two falls since being admitted to the facility. -The bed rails were recommended by Resident #2's RP. -She had not obtained an order for the bed rails.	C 453		

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 ______	07/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 453	Continued From page 14 -The bed rails were used at night to prevent Resident #2 from getting out the bed and falling. -She was responsible for obtaining physician's order for restraints. -There had not been an assessment or care plan meeting completed for the bed rails. -Resident #2 was unable to lower bed rails on her own, "we always assist her". -She did not bed rails were a restraint and therefore did not complete an assessment. -There were no other alternative tried before bed rails were installed. -Resident #2 was checked every hour and monitor was used to observe resident's voice and movement. Interview with Resident #2's physician's nurse on 07/23/18 at 5:49pm revealed: -The physician did not know Resident #2 had bed rails on her bed. -The physician had not been contacted about an order for bed rails or attended a care planning meeting. -The physician thought bed rails could be used because Resident #2 was at risk for falls. -The bed rails could be used to "decrease falls". Interview on 07/10/18 at 8:55am with the Administrator revealed: -Resident #2 had bed rails because the family recommended they be placed on the bed. -He had a care plan meeting with the family and he completed the assessment but did not have documentation. -There was not an order for the bed rails, "it fell through the cracks and we did not get an order" -He knew an order was needed for restraints, "from now on it's going to be done". Based on observations, interviews, and record	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 453	Continued From page 15 reviews, it was determined Resident #2 was not interviewable.	C 453		