

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049028	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 11/01/2017
NAME OF PROVIDER OR SUPPLIER AURORA OF STATESVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1902 ORA DRIVE STATESVILLE, NC 28625		
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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and compliant investigation on October 30-31, 2017 and November 1, 2017. The complaint investigations were initiated by the Iredell County Department of Social Services on September 5, 2017 and on October 20, 2017.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult 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; (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 ensure contact with the physician for clarification of orders for oxygen (O2) for 1 of 5 sampled residents (#4). The findings are: Review of Resident #4's current FL2 dated 7/18/17 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) -There was not an order for O2.	D 344		

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

TITLE

(X6) DATE

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D 344	Continued From page 1 Review of Resident #4's Resident Register revealed she was admitted to the facility on 6/1/09. Observation of Resident #4's room during the facility tour on 10/30/17 at 10:13 am revealed: -There was an O2 concentrator set up beside Resident #4's bed. -There was a portable O2 tank in the room. Review of Resident #4's Medication Administration Record (MAR) for August, September and October 2017 revealed no entry for O2. Review of the 6 month physician orders dated 2/9/17 revealed an order for O2 at 2 Liters per minute (L/min) at bedtime. Review of Resident #4's quarterly Pharmacy Medication Review for April 2017 revealed documentation that O2 was to be used as needed. Review of Resident #4's subsequent quarterly Pharmacy Medication Reviews revealed no documentation regarding O2. Interview with Resident #4 on 11/1/17 at 8:29 am revealed: -She used O2 at night time and as needed during the day. -She turned her O2 concentrator on and put her O2 on when needed, without assistance from staff. -She used her O2 when she got short of breath. -She had been using O2 for a long time because she had COPD. -Her doctor had not told her to stop using O2.	D 344		

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D 344	Continued From page 2 Interview with the Resident Care Director (RCD) on 11/1/17 at 2:50 am revealed: -She had been employed as the RCD for about 3 weeks. -The facility did not have Treatment Administration Records (TARs) -Resident #4's O2 should have been listed on the MARs. -The pharmacy was responsible for entering current orders onto the MAR. -Orders were faxed to the pharmacy by facility staff. -Resident #4's current FL2 dated 7/18/17 was faxed to the pharmacy. -The O2 must have been discontinued because it was not on Resident #4's current FL-2 dated 7/18/17 which was signed by the physician. -She did not know why Resident #4 still used O2 if it was discontinued. -There was no order to discontinue Resident #4's O2 other than the signed FL-2 omitting the O2. -She did not know why O2 was left off of Resident #4's most current FL-2. -The RCD was responsible for reviewing the FL-2 and checked it against physician orders for accuracy. -The pharmacy was responsible for updating the MAR after the RCD sent over the FL-2 or any new orders. Interview with the Administrator on 11/1/17 at 3:12 pm revealed: -She was not aware O2 was not listed on Resident #4's MAR. -The pharmacy was responsible for entering current orders onto the MAR. -Orders were faxed to the pharmacy by facility staff. -All medication and treatment orders were	D 344			

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D 344	Continued From page 3 entered on the MAR. -Resident #4's O2 should have been listed on the MAR if she had an order for it. -If Resident #4 did not have an order for O2, then it should not have been in her room. - "I haven't seen her use the O2." -The RCD was responsible for completing a monthly audit for O2. -The RCD was responsible for reconciling the MAR with the current orders. -The RCD was responsible for clarifying orders with the physician's office. -The RCD was responsible for completing a monthly O2 audit for residents who had orders for O2. -The last O2 audit for Resident #4 was in September 2017 and did not indicate that Resident #4's O2 had been discontinued. Interview with a Medication Aide (MA) on 11/1/17 at 3:21 pm revealed: -Resident #4 used O2 as needed. -The O2 had not been discontinued to her knowledge. -There was not an entry on the MAR to document O2 use. -She knew that O2 was not on the MAR. -She did not know why O2 was not on the MAR. -She had not that O2 was not listed on the MAR. Interview with a second MA on 11/1/17 at 3:25 pm revealed: -Resident #4 used 2L of O2, but she did not know what the ordered frequency was. -Resident #4 used her O2 when she needed it. -She knew that O2 was not on the MAR. -O2 should have been on Resident #4's MAR. -O2 had not been discontinued to her knowledge. -She had not told anyone that O2 was not listed on the MAR.	D 344		

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D 344	Continued From page 4 -The RCD was responsible for reviewing the MAR for accuracy. Telephone interview with a nursing assistant (NA) at Resident #4's physician's office on 11/01/17 at 3:49 pm revealed: -Resident #4 was last seen in the physician's office on 8/21/17. -Resident #4 had been on O2 at 2L at bedtime for years, but the NA could not confirm the original order date for the O2. -There was not an order to discontinue O2. -She did not know why the O2 was not listed on the FL-2 signed by the physician on 7/18/17. -No one from the facility had called to clarify the order for O2. -She was unable to provide the date of the most current order. Review of documents provided by the RCD on 11/1/17 revealed she had received clarification from Resident #4's physician to continue O2 at 2L at bedtime and as needed.	D 344			
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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.	D 358			

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D 358	Continued From page 5 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to assure medication was administered as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (Resident #4). The findings are: Review of the Resident #4's current FL-2 dated 7/18/17 revealed: -Diagnoses included diabetes mellitus, hyperlipidemia, hypothyroidism, gastroesophageal reflux disorder, osteoarthritis, acute renal failure, and anxiety. -There was a physician's order for cyanocobalamin (B-12) 1,000 mcg/ml, inject 1 ml subcutaneously each month. (Cyanocobalamin is a vitamin supplement). Review of Resident #4's electronic Medication Administration Record (eMAR) for August 2017 revealed: -An entry for cyanocobalamin 1,000 mcg/ML to be administered 1 time each month. -Documentation cyanocobalamin was administered on 8/17/17 and signed off by a Medication Aide (MA). -There was no designated date or time for cyanocobalamin to be administered. Review of Resident #4's MAR for September 2017 revealed: -An entry for cyanocobalamin 1,000 mcg/ML to be administered 1 time each month.	D 358			

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D 358	Continued From page 6 -Documentation cyanocobalamin was administered by the home health nurse on 9/15/17. -There was no designated date or time for cyanocobalamin to be administered. Review of Resident #4's MAR for October 2017 revealed: -An entry for cyanocobalamin 1,000 mcg/ML to be administered 1 time each month. -Documentation cyanocobalamin was administered on 10/14/17 and signed off by a MA. -There was no designated date or time for cyanocobalamin to be administered. Observation of medications on hand for administration for Resident #4 on 11/01/17 at 9:29 am revealed there was no cyanocobalamin on the medication cart. Interview with the Medication Aide (MA) on 11/01/17 at 9:29 am revealed: -Resident #4 received cyanocobalamin injections once a month. -The home health nurse administered the cyanocobalamin injection to Resident #4 in the facility or she went to the doctor's office to get the injection. Interview with the Resident Care Director (RCD) on 11/01/17 at 9:37 am revealed: -The home health nurse administered cyanocobalamin injections to Resident #4 once a month. - She was not sure how the pharmacy knew to send the cyanocobalamin, but it was usually on the cart prior to when it needed to be administered. -There was not a certain day of the month when the cyanocobalamin was to be administered.	D 358		

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D 358	Continued From page 7 Telephone interview with a pharmacy representative on 7/01/17 at 10:42 am revealed: -Cyanocobalamin was not a cycle filled medication. -Cyanocobalamin had to be reordered by the facility before it was sent to the facility. -Cyanocobalamin was last sent out to the facility on 8/10/17 and there had been no other orders since then. -Cyanocobalamin was sent to the facility in a vial containing 1 dose per order. A second interview with the RCD on 11/01/17 at 10:55 am revealed: -The MA was responsible for reordering medications. -The pharmacy sent a receipt to the facility when medication was ordered or reordered. -A notification appeared on the Resident #4's electronic MAR that it was time to give Resident #4 her injection. -There was no scheduled date each month to order or give Resident #4 her cyanocobalamin injection. -The home health nurse was in the building every other day and would give the cyanocobalamin injection when it was in the facility. -The MA would give the cyanocobalamin to the home health nurse to administer. -The MA would document that the cyanocobalamin was administered. -She had reordered the cyanocobalamin in August 2017. -The RCD had documented that the cyanocobalamin was administered in August 2017. -The RCD had not witnessed a home health nurse administer cyanocobalamin in August 2017. -The RCD did not know why she had documented	D 358		

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D 358	Continued From page 8 that cyanocobalamin was administered in August 2017. Review of the pharmacy reorder requests form revealed: -Cyanocobalamin was reordered on 8/9/17. -There were no other reorder requests for cyanocobalamin since 8/9/17. Interview with Resident #4 on 11/01/17 at 11:07 am revealed: - "I used to get B-12 shots." - "I thought my doctor set that up, but I haven't gotten it in a few months." Interview with a second MA on 11/01/17 at 11:10 am revealed: -She did not know who was responsible for ordering cyanocobalamin for Resident #4. -She had never ordered cyanocobalamin for Resident #4. - "The home health nurse must administer the cyanocobalamin injection to Resident #4." Telephone interview with a home health provider for the facility on 11/01/17 at 11:23 am revealed: -Resident #4 was opened for home health services on 9/04/17 and was discharged on 9/27/17. -Resident #4 received physical therapy, but never received any injections through home health. Interview with the Administrator on 11/01/17 at 11:25 am revealed: -Facility staff did not administer cyanocobalamin injections. -The home health nurse administered cyanocobalamin injections to Resident #4. -The RCD was responsible for reordering cyanocobalamin.	D 358			

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D 358	Continued From page 9 -She was not aware if the cyanocobalamin was a cycle filled medication or if it had to be reordered. -She did not know why the medication had not been reordered. Interview with a second home health provider for the facility on 11/01/17 at 11:49 am revealed Resident #4 was not in their system for services and had never been opened for services with them. A second interview with the first shift MA on 11/01/17 at 1:47 pm revealed: -She found the vial of cyanocobalamin in the bottom drawer of the medication cart a few minutes ago. -The 1 ml vial of cyanocobalamin dated 8/10/17 had not been opened and had not been administered to Resident #4. -She did not know why it was documented on the MARs that cyanocobalamin had been administered to Resident #4 in August 2017. -She gave the cyanocobalamin to the home health nurse to administer to Resident #4 when the cyanocobalamin was in the facility. -When the home health nurse gave the cyanocobalamin injection, she would document that it was given on the electronic MAR by hitting the tab "given by home health nurse." -She did not observe the home health nurse administer the medication. -The home health nurse would document in the Home Health Documentation Log that the cyanocobalamin injection was given for Resident #4. -It was standard procedure for the home health nurse to document in the Home Health Documentation Log after services were provided to any resident in the facility.	D 358		

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D 358	Continued From page 10 Review of the Home Health Documentation Log on 11/01/17 revealed there was no documentation that cyanocobalamin injection was administered by a home health nurse for Resident #1. Telephone interview with a nursing assistant (NA) at Resident #4's physician's office on 11/01/17 at 3:49 pm revealed: -Resident #4 had not been into the physician's office to received cyanocobalamin injections. -Resident #4 did not have any scheduled appointments for cyanocobalamin injections. -Resident #4's last office visit was on 8/21/17. Review of Resident #4's record on 11/01/17 revealed: -There were no physician orders for vitamin B-12 labs. -There was no documentation of laboratory tests performed that measured vitamin B-12 levels.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration;	D 367		

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D 367	Continued From page 11 (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records (MARs) for 1 of 5 sampled residents (#1) related to documenting scheduled administration of depakote. The findings are: Review of Resident #1's current FL2 dated 06/03/17 revealed: -Diagnoses included dementia, acute kidney injury, diabetes and schizoaffective disorder. -An order for depakote 125 mg, (used for mood disorder) three times daily. Review of Resident #1's June 2017 eMAR revealed: -An electronic entry for depakote 125 mg, three times daily. -On 06/06/17, documentation Resident #1 refused the depakote 125 mg -On 06/09/17, a missed dose of depakote 125 mg, no documentation to support the reason. -On 06/11/17, another missed dose of depakote 125 mg, no documentation to support the reason. -On 06/15/17, a missed dose of depakote 125 mg, due to Resident #1 being asleep. -On 06/19/17 a missed dose of depakote 125 mg, no documentation to support the reason.	D 367		

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D 367	Continued From page 12 -On 06/26/17, a missed dose of depakote 125 mg, due to Resident #1 being asleep. -On 06/27/17, two doses of depakote 125 mg were missed, due to Resident #1 being in the hospital. -The depakote 125 mg was administered as ordered for the remainder of the month. Review of Resident #1's July 2017 eMAR revealed: -An electronic entry for depakote 125 mg, three times daily. -On 07/03/17, a missed dose of depakote 125 mg because Resident #1 was asleep. -On 07/04/17, a missed dose of depakote 125 mg due to Resident #1 being asleep. -On 07/04/17, another missed dose of depakote 125 mg, no documentation to support the reason. -On 07/09/14, two doses of depakote 125 mg were not administered due to Resident #1 being asleep. -On 07/09/14, a dose of depakote 125 mg was not administered due to Resident #1 not being in the facility. -On 07/31/17, two doses of depakote 125 were not administered, with no documentation to support the reason. -On 07/31/17, a dose of depakote 125 mg was not administered due to Resident #1 being in the hospital. -The depakote 125 mg was administered as ordered for the remainder of the month. Review of Resident #1's record revealed a subsequent physician's order dated 07/24/17 for depakote 500 mg, twice daily. Review of Resident #1's July eMAR revealed: -A electronic entry for depakote 500 mg, twice	D 367			

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D 367	Continued From page 13 daily, to begin on 07/25/17. -No documentation of administration of depakote 500 mg. Telephone interview on 10/31/17 at 11:40 am with a representative from the contracted pharmacy revealed: -The depakote 125 mg, three times daily, was cycle filled every two weeks since 05/18/17, with a total of 42 pills each time. -The order changed on 07/25/17 to depakote 500mg, twice daily, and 32 pills were sent to the facility on that date. -The pharmacy no longer had records of any depakote that had been returned from the facility, those records had been destroyed and were no longer available. Interview with a medication aide (MA) on 11/01/17 at 9:35 am revealed: -She worked at the facility as a MA when Resident #1 resided there. -She administered medications to Resident #1. -She was unable to recall exactly what medications were ordered for Resident #1 or if any medications were not administered as ordered. Interview on 11/01/17 at 10:30 with the Resident Care Director (RCD) revealed: -The facility sent new orders to the pharmacy. -The pharmacy entered the orders electronically and sent the medication to the facility. -She was unaware of the order change on July 25, 2017 to depakote 500 mg, twice daily for Resident #1. -She did not know how staff administered the medication during that time. Interview on 11/01/17 at 10:45 am with the	D 367		

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D 367	Continued From page 14 Administrator revealed: -The orders were sent to the pharmacy when received. -The pharmacy entered the orders electronically and sent the medication to the facility. -She was unaware if staff administered the depakote 500 mg as ordered on 07/25/17. Telephone interview on 10/31/17 at 11:55 am with Resident #1's primary care provider revealed: -Resident #1 was ordered depakote for a mood disorder. -The low dose of depakote is therapeutic for mood disorders. -He was not aware the facility did not administer the depakote 500 mg as ordered on 07/25/17.	D 367		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult 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	D 482		

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D 482	Continued From page 15 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 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 observations, interviews and record reviews, the facility failed to assure physical restraints were used only after an assessment and care planning process had been completed and consent had been obtained from the responsible party for 2 of 2 sampled residents (Resident #1 and Resident #2). The findings are:	D 482		

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D 482	Continued From page 16 1. Review of Resident #1's current FL2 dated 06/03/17 revealed diagnoses included dementia, acute kidney injury, diabetes and schizoaffective disorder. Review of Resident #1's record revealed: -A physician's order dated 06/10/17 to obtain a lap buddy restraint, but with no information regarding length of time between releases. -No documentation of an assessment for the least restrictive device and alternatives to restraints was available for review. -No documentation of a consent for the application of a restraint from Resident #1's Power of Attorney (POA) was available for review. -There was no documentation of alternatives used prior to the use of the lap buddy restraint. Review of an undated Fall Assessment Tool labeled with Resident #1's name revealed a score of 27, indicating she was a "High Risk" for falls. Review of the Licensed Health Professional Support evaluation form dated 06/14/17 revealed: -The form had been signed by a Registered Nurse. -Documentation of a lap buddy as a restraint. (A lap buddy restraint is a cushion inserted across the lap and secured between the side rails of a wheelchair.) Review of Resident #1's Personal Care Physician Authorization and Care Plan signed by the primary care physician on 05/17/17 revealed: -The resident was assessed to require 30 minute checks due to fall risk. -The resident was assessed to require extensive assistance with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring.	D 482		

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D 482	Continued From page 17 Review of the June and July 2017 Personal Care Record (August was not in the record) revealed: -There was no documentation to reflect the restraint had been released for any time periods. -Facility staff had initialed "30 minute checks due to fall risk". -Facility staff had initialed every day for June 2017, except for June 23, when staff documented "Resident in Hospital". -Facility staff had initialed every day for July 2017, except for July, 29, July 30, July 31, when staff documented "Resident Hospital". Interview on 11/01/17 at 9:00 am with the Resident Care Director (RCD) revealed: -The facility had not obtained an assessment on Resident #1 prior to the application of the lap buddy restraint. -The facility had not obtained a consent from Resident #1's POA prior to the application of the lap buddy restraint. -"We didn't know we needed that until yesterday" (in reference to the assessment and consent for Resident #1). Interview on 11/01/17 at 9:35 am with the Administrator revealed: -Resident #1's lap buddy was a restraint. -The facility had not completed an assessment or obtained consent from Resident #1's POA prior to the application of the lap buddy restraint. -The facility staff were not aware of the need for an assessment or a consent prior to the use of a lap buddy restraint until yesterday. -The facility now has a restraint policy concerning the need for an assessment and consent, along with the order from the physician, prior to the application of a restraint. -The facility staff would follow the policy on all restraints in the future.	D 482		

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D 482	Continued From page 18 Telephone interview on 10/31/17 at 11:55 am with Resident #1's primary care physician revealed: -Resident #2 was very sick when she was admitted to the facility. -The lap buddy restraint was ordered to keep Resident #1 "from leaning forward and sliding out of wheelchair". -The lap buddy restraint was for the safety of Resident #1. -The facility staff did everything "humanly possible to care for her". 2. Review of Resident #2's current FL2 dated 09/16/17 revealed diagnoses included dementia, hypertension, anxiety, and depression. Review of Resident #2's record revealed: -A physician's order dated 01/29/16 to obtain a lap buddy restraint with no information regarding length of time between releases. (A lap buddy restraint is a cushion inserted(applied) across the lap and inserted and secured between the side rails of a wheelchair.) -There was no documentation of an assessment for least restrictive device and alternatives to restraints was available for review. There was no documentation of a consent for the application of a restraint from Resident #2's Power of Attorney (POA) was available for review. -There was no documentation of alternatives used prior to the use of the lap buddy restraint. Observations of Resident #2 at various times from 10/30/17 to 11/01/17 revealed: -On 10/31/17 at 12:10 pm, Resident #2 was sitting in wheelchair, in the dining room of the Special Care Unit (SCU), with lap buddy restraint in place. -On 11/01/17 at 7:50 am, Resident #2 was observed sitting in wheelchair, with lap buddy	D 482		

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D 482	Continued From page 19 restraint in place, waiting for food in the dining room area of the SCU. -On 11/01/17 at 8:20 am, Resident #2 was observed in the activity room of the SCU, sitting in a wheelchair with the lap buddy restraint in place. -On 11/01/17 at 8:45 am, Resident #2 was observed in the activity room of the SCU, sitting in a wheelchair with the lap buddy restraint removed; the resident was sitting quietly with hands grasped together watching the other residents. -On 11/01/17 at 12:00 pm, Resident #2 was observed sitting in a wheelchair, with lap buddy in place, waiting for food to be served in the dining room area of the SCU. Review of Resident #2's current and previous Licensed Health Professional Support (LHPS) evaluation forms, dated 08/10/17 and 05/08/17 revealed: -The forms had been signed by a Registered Nurse. -Documentation of a lap buddy as a restraint on both LHPS forms. Review of Resident #2's Personal Care Physician Authorization and Care Plan signed by the primary care physician on 09/16/17 revealed: -Documentation for staff to conduct one hour checks on Resident #2. -The resident was assessed with significant memory loss-must be directed. -The resident ambulated with a wheelchair. -The resident was totally dependent on staff for assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. -Documentation for a "lap buddy" restraint while in wheelchair. Based on record reviews, and observations on	D 482		

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D 482	Continued From page 20 10/31/17 and 11/01/17 at various times, it was determined Resident #2 was not interviewable. Interview on 11/01/17 at 8:40 am with the Memory Care Coordinator (MCC) revealed: -She had been in her current position for 3 weeks. -She was not aware if Resident #2 had an order for the lap buddy restraint, a current assessment for the least restrictive device, or a signed consent from the resident's POA. -The facility's Administrator would be responsible for assuring residents' restraint consents and assessments were obtained. Interview on 11/01/17 at 8:45 am with the Administrator revealed: -She had located Resident #2's original order dated 01/29/16 for the lap buddy restraint in the resident's thinned records. -She was not able to locate a signed consent for the lap buddy restraint from Resident #2's POA. -She was not able to locate documentation for quarterly reviews from Resident #2's physician's order for the lap buddy restraint since the original order dated 01/29/16. Interview on 11/01/17 at 9:00 am with the Resident Care Coordinator (RCC) revealed: -She had been in her current position for less than 4 weeks. -All orders, consents, and assessments for Resident #2's lap buddy restraint should be located in the resident's record, or the thinned record. -She was not able to locate Resident #2's POA's consent for the lap buddy restraint, or any assessment for least restrictive device and alternatives to restraints for review. -She was not able to locate documentation of	D 482			

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D 482	Continued From page 21 alternatives used prior to the use of the lap buddy. Telephone interview on 11/01/17 at 10:15 am with Resident #2's POA revealed: -The POA was aware Resident #2 had a lap buddy restraint in place since admitted to the facility. -She thought the facility may have sent her a consent for the lap buddy restraint, but she did not recall if she had signed the consent. -She did not recall being contacted by the facility to discuss a care plan for the use of the lap buddy since it was originally placed in January 2016. -She visited Resident #2 occasionally, but not every week. -She had not observed Resident #2 attempt to get out of his wheelchair in the last 3 months. -She did not believe Resident #2 would be able to remove the lap buddy if he decided to try to get up alone. Telephone interview on 11/01/17 at 3:00 pm with Resident #2's primary care physician revealed: -He was not Resident #2's primary care physician when the resident was admitted to the facility. -He was currently Resident #2's primary care physician as of approximately 6 to 8 months. -He was aware Resident #2 had a lap buddy restraint. -He had not written an order for Resident #2's lap buddy restraint. -Had he been not asked by facility staff to re-order the lap buddy or to assess the resident for the need for a lap buddy restraint. -He considered Resident #2's lap buddy a restraint and would start the process of quarterly order renewals, and assessments for the need of the lap buddy restraint.	D 482			