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
	HAL049028	A. BUILDING: _____ B. WING _____	R-C 11/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA OF STATESVILLE	1902 ORA DRIVE STATESVILLE, NC 28625

(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
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	D344 Med Aides trained on claifications of physcians orders for O2. Resident Care Director and Special Care Coordinator will do audit of all residents using O2. Resident Care Director and Special Care Coordinator will monitor all O2 orders monthly.	12/15/17

reviewed and accepted 12/15/17

H Ray Preston

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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 Med Aides trained on medication administration, ordering of medications and documentation. Resident Care Director and Special Care Coordinator will audit all residents with IM injections. Resident #4 B12 levels checked and orders clarified by physcian. Facility has Registerd Nurse on staff who will be administering IM injections not covered by home health every 3rd Wednesday of the month. Resident Care Director and Special Care Coordinator to monitor all IM injections monthly.	12/15/17
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 Med Aides trained on medication administration, ordering and documentation. Resident Care Director and Speial Care Coordinator completed audit of MARs for any ommissions.	12/15/17
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	Resident Care Director and Special Care Coordinator to monitor weekly for one month and then monthly going forward.	

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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049028	A. BUILDING: _____ B. WING _____	R-C 11/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA OF STATESVILLE	1902 ORA DRIVE STATESVILLE, NC 28625

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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	D 482 All staff trained on Restraint and Alternative Policy. New Policy put in place. All residents accessed for least restrictive restraint alternative. Resident Care Director and Special Care Coordinator to monitor monthly. Registered Nurse to re access quarterly.	12/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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		

Staff Meeting
Topic: Clarification of Orders, Medication Ordering,
Administration and Documentation

Date 11-29-17

Print Name	**Signature**
Vivian Hobbs	Vivian Hobbs
Shannon Eckard	Shannon Eckard
Erica Glaspy	Erica Glaspy
Shelitha Johnson	Shelitha Johnson
Shanita Rucker	
Michelle Martinez	Michelle Martinez
Kristen Stevenson	Kristen Stevenson
Michelle Peet	Michelle Peet
Cindy Rehmeyer	Cindy Rehmeyer
Angel Anderson	Angel Anderson

MAR REVIEW

Expectation:

Resident Care Coordinator, and Special Care Coordinator will check all resident MAR's from the current month to the upcoming month at the end of each month. The Care Coordinators will trace any changes in All residents MAR back to the original order, (in resident's chart) to insure accuracy in order transcription.

Resident care coordinators will also be checking for;

1.) medication omissions to be reported to Primary Care Physician
2.) PRN narcotics not being used (to be D/C'd)
3.) Monitoring of O2
4.) Monitoring of Restraints and Alternative.
5.) Monitoring of IM injections

** Please document all Medication errors, make physician aware, make Resident Care Director aware, make appropriate staff members aware of error, and make staff member aware of what action to be taken to avoid med errors.

Resident Care Director to insure MAR checks are completed accurately, and timely.

Resident Care Coordinator — 11/22/17

Special Care Coordinator — 11/22/17

Administrator — 11-22-17

Aurora of Statesville

1902 Ora Drive
Statesville, NC 28625
Phone (704) 878-6376 Fax (704) 878-0879

To: _____ Fax #: _____

Resident: _____ Date of Birth: _____

Order Request/Clarification:

_____

_____

_____

_____

Thank You!
Signature: _____ Date: _____

Physician's Order:

_____

_____

_____

_____

Physician's Signature: _____ Date: _____

Physician Printed Name: _____

(All orders will be refilled for one year unless otherwise specified. CIII – CV will be filled for six months, or five refills, which ever comes first. CII medications require a written prescription every time they are dispensed, and cannot be refilled.)

Please fax back to 704-878-0879. If you have any questions, please call 704-878-6376.

Faxed to MD	Faxed to Pharmacy	Noted on MAR	48 hour Verification
Date:	Date:	Date:	Date:
Initials	Initials	Initials	Initials

Alternative Physical Restraint Policy

POLICY

Alternative Physical Alternative restraints will only be used for the safety of the resident with the written permission of the attending physician and Responsible Party. Residents will be restrained with the least restrictive alternative physical or mechanical device as determined by the Resident Care Director, Administrator and attending physician. If the alternative restraint is applied at a time when the attending physician is unavailable, the physician will be consulted at the first available opportunity.

The use of alternative restraints for discipline or staff convenience is prohibited.

To insure compliance with this policy, in-service training will be provided to all staff caring for residents with medical symptoms that warrant alternative restraints. Training will include the use of alternative restraints rather than physical alternative restraints and the care of the resident who is physically restrained with an alternative restraint. Training and competency validation on alternative restraints will be provided during staff orientation and as needed.

PROCEDURE

- A decision to utilize an alternative restraint for a resident will be based on the Resident's Assessment for Restraint Alternative and the Fall Prevention Program Resident Cumulative Report.
- A written order for alternative restraint use will be obtained from the attending physician. If the order is obtained from an on-call physician, the attending physician will be contacted within seven days to obtain the order. If the resident changes physicians, the new physician will update and sign the existing alternative restraint order. Alternate restraint orders will be reviewed and renewed with any change of condition or quarterly. Alternate restraint orders will be maintained with the current FL2 in the resident chart.

- In an emergency situation, the Administrator, Resident Care Director or SIC will make the determination if it is necessary to use an alternative restraint for resident safety, the type of alternate restraint to be used and the time to elapse between release and Range of Motion exercises until the physician is notified. Contact must be made within 24 hours.
- The Administrator, Resident Care Director or SIC will contact the resident's responsible party to discuss the use of the alternative restraint including potential negative outcomes. The resident's Responsible Party involved in the alternative restraint decision will be required to date and sign a statement to the effect that they have been informed of the above and their desire for or desire not to use alternative restraints. Contact will be documented in the resident record. **This contact and discussion will be made prior to the physician writing the alternative restraint order.** Should the Responsible Party be reachable only by phone, a witness to the conversation between the SIC and Responsible Party will document the conversation and add the information to the resident record. Attempts to reach the Responsible Party and/or another contact listed in the resident's record will be no less than 3 and will be documented in the resident record.
- Except in emergency situations, assessment and care planning will be conducted prior to the use of an alternative restraint. Assessment and care planning will be completed through a team process. The team will consist of, but not be limited to the Resident Care Director, the SIC, the LHPS nurse, if available, and the resident's Responsible Party. If the Resident Responsible Party is not present, there must be documented evidence that the Resident Responsible party was notified and declined the invitation to participate.
- All residents using any type of restraint are to be observed by staff every 15 minutes.
- All residents using any type of restraint will be released at a minimum of every two hours for a minimum of 15 minutes. During this 15 minutes, resident will be toileted, snacks offered, fluids offered and given the opportunity to walk if feasible.
- The LHPS Nurse will assess the resident quarterly for restraint reduction or restraint alternatives. This assessment will be documented on a quarterly review form or documented in the resident record.

- Restraint orders will include:
    - Type of restraint to be used. **See list of allowable alternative restraint devices.**
    - Medical need for the restraint
    - Period of time the restraint is to be used

ACCEPTABLE ALTERNATIVE RESTRAINTS:

Lap Pillows (Buddies)
Pommel Cushion
Geri Chair
Wedge Cushion
Anti-Slide mat
Chair Alarms (cushion or clip)
Bed Pressure Alarms (pad or clip)
Reclining Chair

ASSESSMENT FOR RESTRAINT ALTERNATIVE

Resident Name: _____

Date: _____

History of Falling: Refer to the Fall Prevention Notebook Number of Falls _____Past Week _____ 30 Days _____ 60 Days

Mental Status: _____ Oriented _____Confused _____ Dementia Diagnosis

_____ Intermittant Confusion _____ Independent/Continent _____Independent/Incontinent

Alternative Restraints in Use

	WHERE USED	FREQUENCY/DURATION
_____ Lap Cushion (Buddy)	_____	_____
_____Pommel Cushion	_____	_____
_____ Geri Chair	_____	_____
_____Wedge Cushion	_____	_____
_____Anti-Slide Mat	_____	_____
_____ Alarm Cushions, Chair or Bed	_____	_____
_____Alarm Clips, Chair or Bed	_____	_____

Reason for Restraint Alternative Usage

_____Unsteady Gait _____Weakness _____Confusion

_____Deformity - including contractures _____Positioning

_____Disease Progression - Specify _____

ASSESSMENT FOR RESTRAINT ALTERNATIVE

Resident Name: _____ **Date:** _____

Mobility Status

_____ Independent Ambulation
_____ Ambulatory with assistance of 1 or 2
_____ Wheelchair bount/non ambulatory
_____ Self mobility in wheelchair
_____ Ambulator with Walker

Gait and Balance Assessment

_____Wide base of support
_____Loss of balance while standing
_____Balance problems when walking
_____ Balance problems from bed to chair/chair to standing
_____Decrease in muscular coordination
_____Lurching/swaying/slapping gait
_____Gait pattern changes through doorway
_____Unstable making turns
_____Use of assistive devices - specify _____
_____No gait disuurbance noted
_____Leaning
_____Ridgidity

Indicated for Restraint Alternative Trial _____YES _____NO

Narrative Assessment _____

_____

_____

_____

_____

Family/Responsible Party Communication

_____Family/RP agree to restraint alternative trial
_____Family/RP disagree to restraint alternative trial
_____Family/RP informed and consented to restraint alternative trial

Date Evaluated by _____Physical Therapy _____Occupational Therapy

Restraint Alternative Trial Initiated On _____ Date

Recommended time to elapse between release, Range of Motion and Reposition. _____

Follow Up Evaluation

Date _____
Date _____
Date _____
Date _____

Physician Alternative Restraint Order

The use of alternative physical restraints refers to the application of a physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily which restricts freedom of movement or normal access to one's body and includes:

Lap Pillows (Buddies)
Pommel Cushion
Geri Chair
Wedge Cushion
Anti-Slide mat
Chair Alarms (cushion or clip)
Bed Pressure Alarms (pad or clip)
Reclining Chair

Alternative physical restraints are to be used for safety purposes only. The facility prohibits the use of alternative physical restraints for convenience of the staff . Approved use of alternative physical restraints may include but are not limited to: confusion in regards to safety, risk of falls and risk of abusive or injurious behaviors to self or others.

Resident name:_____

Medical reason for alternative restraint use: _____

_____

_____

Type of Alternative Restraint to be used:_____

Time Period for use of alternative restraint: _____

Time intervals the alternative restraint must be:

Checked: _____

Loosened:_____

Removed: _____

Additional alternative restraint orders/remarks and/or alternative restraint to be used:

_____

_____.

_____ _____ Order of Expiration not to exceed 3 months.

Physician Signature Date

Resident/Responsible Party Consent for Physical Alternative Restraint

The use of alternative physical restraints refers to the application of a physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily which restricts freedom of movement or normal access to one's body and includes:

Lap Pillows (Buddies)
Pommel Cushion
Geri Chair
Wedge Cushion
Anti-Slide mat
Chair Alarms (cushion or clip)
Bed Pressure Alarms (pad or clip)
Reclining Chair

Potential Benefits

Prevention of falls which may result in injury.
Protection from accidents and injuries.
Medical treatment allowed to proceed without resident interference.
Protection of other residents from physical harm.
Increased feeling of safety and security.

Potential Risks

Accidental injury/death from alternative restraints.
Chronic Constipation
Incontinence
Pneumonia
Pressure Sores
Loss of muscle tone
Loss of balance
Reduced appatite
Loss of independent mobility
Increased agitation
Symptoms of depression, withdrawal
Contractures
Reduced social contact

I understand that this request can be changed at any time, in writing. My signature below indicates that I have been informed of and do understand the benefits, risks and alternatives to the alternative restraint as ordered by the physician. I understand that the list of Potential Benefits and Potential Risks is not all inclusive as there may be unforeseen benefits and risks associated to alternative restraint usage.

I _____, do/do not consent to the use of (name of alternative restraint)_____ as prescribed by the physician for (name of resident)_____ for (medical symptoms) _____.

_____ _____

Resident/Responsible Party Date

_____

Facility Witness to Signature