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
	NH0476	A. BUILDING: _____ B. WING _____	10/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR RD MORGANTON, NC 28655

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L 064	.2301(D) PATIENT ASSESSMENT AND CARE PLANNING 10A-13D.2301 (d) The facility shall review comprehensive assessments and plans of care no less frequently than once every 90 days and make necessary revisions to ensure accuracy. This Rule is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to provide comprehensive assessments and care plans for use of restraints for 7 of 7 sampled residents, (Resident's #2, #4, #6, #7, #11, #12 and #13). The findings included: 1. Resident #2 was admitted to the facility on 09/13/2011. Diagnoses included Alzheimer's dementia, osteoarthritis and right foot drop with use of brace. An observation of Resident #2 during tour of the facility on 10/07/2013 at 11:00 AM revealed Resident #2 being pushed down the hall by a family member in a wheelchair with a seat belt on. On 10/07/2013 at 11:05 AM in an interview Resident #2's family member revealed he had fallen about a year ago and the facility had put the seatbelt on. The family member further revealed there had been no more falls and Resident #2 did not try to get up anymore. The family member noted both Resident #2's hands were clenched and non-functioning and she confirmed he was unable to follow directions to release the belt. On 10/07/2013 at 11:20 AM interview with Nurse #1 revealed she had never seen Resident #2 try	L 064	1. Audits were conducted and the following actions taken for those residents directly affected by this alleged deficient practice: A. Comprehensive assessments have been completed on Residents #2, #4, #6, #7, #11, #12 and #13. B. Lap belts have been discontinued on Residents #4, #6, #7, #11, #12, and #13. Care plans for these residents were reviewed and updated as appropriate. C. Lap belt use continues on Resident #2 and the care plan was updated to reflect current lap belt use. 2. All residents were identified as having the potential to be affected by this alleged deficient practice. 3. The following measures were implemented to assure this alleged deficient practice does not recur: A. All nursing staff including both Unit Managers (UMs) were inserviced on: • the appropriate use of restraints • assessing residents for restraint usage prior to application • the importance of updating/revising resident care plans to reflect current status B. The facility has identified all residents currently using restraints. The charts of these residents have been audited to assure that 1) residents were properly assessed for restraint usage;	10/25/13 10/25/13 10/25/13 11/08/13 10/25/13

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Yost — TITLE: Ex Director/Nsg Hms Adm. — (X6) DATE: 10/25/13

Received DHSR NH Licensure Black Mountain WRO NOV 04 2013 by: PAM

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L 064	Continued From page 1 to get up. An observation on 10/07/2013 at noon of Resident #2 revealed him sitting at the dining room table to be served his lunch with the seat belt in place. A review of Resident #2's medical record revealed a Physician's order dated 09/07/2012 that read: "May have self release seatbelt (velcro) and Bed alarm to prevent unattended ambulation." Furt her review of Resident #2's medical record revealed no signed release, initial evaluation or ongoing assessments to determine if continued restraint use was necessary to treat the resident. Review of Resident #2's current care plan (documented as last updated 06/13/2012) documented no listing of the seatbelt with goals or interventions. Review of Resident #2's Resident Tracker/Careplan card (documented as last updated 08/07/2013 by UM #2) available to the direct care staff on how to meet the individual needs of the resident revealed no documentation that Resident #2 was wearing a seatbelt. On 10/08/2013 at 2:00 PM interview with Unit Manager #1 (UM #1) revealed she and Unit Manager #2 (UM#2) were responsible for initiating and updating the care plans and Tracker cards. UM #1 confirmed they both meet with families quarterly but UM #2 was the one trained to update the care plans on the computer system. On 10/09/2013 at 1:20 PM interview with Director of Nurses (DON) revealed she was unable to locate any restraint assessments, documentation on the Care Plan or the Tracker/Careplan card on Resident #2 for the self release seatbelt. On	L 064	2) their representatives were notified of the risks/benefits for restraint usage and a signed consent has been obtained from the resident/representative; 3) the physician orders are accurate and present in the residents' charts; and 4) the residents' care plans were reviewed and updated, and reflective of current status. 4. The following quality monitoring program has been implemented to assure the corrective actions are effective and sustained: Care plans will be reviewed by the Unit Managers on a quarterly basis and as conditions warrant with revisions and updates made as needed. The Director of Nursing will conduct random audits of the care plans for residents with restraint use on a weekly basis for two months. Trends and findings will be presented by the DON at the monthly Quality Assurance/Process Improvement meeting for a minimum of three months. 5. Completion date: 11/8/13	11/01/13 11/08/13

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L 064	Continued From page 2 further interview the DON revealed she had only been at the facility a few months and when she had taken the position of DON she had assessed the residents and determined there were no restraints in place but had not documented the information. The DON confirmed she expected Care Plans and Tracker/Careplan cards to be kept updated. On 10/09/2013 at 1:30 PM interview with UM #1 confirmed she had been co-assigned the responsibility of the Care Plans and Tracker Care cards for 5 months and the belts/devices/restraints should have been documented and updated on Resident #2 on a quarterly basis. 2. Resident #4 was admitted to the facility on 10/10/2011. Diagnoses included weakness, senile dementia, adult failure to thrive, osteoporosis and chronic obstructive pulmonary disease. An observation of Resident #4 on 10/07/2013 at 11:20 AM revealed Resident #4 sitting in the dining room waiting for lunch with her seatbelt hanging down behind her. On 10/07/2013 at 11:25 AM interview with Unit Manager #1 (UM #1) revealed Resident #4 preferred to stay in bed a lot but was fully capable of removing her seatbelt and often did. Resident #4 acknowledged: "Yes I can." A review of Resident #4's Medical Administration Record (MAR) revealed an order dated 02/26/2010 that read: "Bed pad alarm and seatbelt with alarm to prevent unassisted ambulation."	L 064		

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L 064	Continued From page 3 Further review of Resident #4's medical record revealed no signed release, initial evaluation or ongoing assessments to determine if continued restraint use was necessary to treat the resident. Review of Resident #4's current care plan (documented as last updated 09/01/2013) documented no listing of the seatbelt with goals or interventions. Review of Resident #4's Resident Tracker/Careplan card (documented as last updated 06/12/2013 by UM #2) available to the direct care staff on how to meet the individual needs of the resident revealed no documentation that Resident #4 was wearing a seatbelt. On 10/08/2013 at 2:00 PM interview with Unit Manager #1 (UM #1) revealed she and Unit Manager #2 (UM#2) were responsible for initiating and updating the care plans and Tracker cards. UM #1 confirmed they both meet with families quarterly but UM #2 was the one trained to update the care plans on the computer system. On 10/09/2013 at 1:20 PM interview with Director of Nurses (DON) revealed she was unable to locate any restraint assessments, documentation on the Care Plan or the Tracker/Careplan card on Resident #4 for the self release seatbelt. On further interview the DON revealed she had only been at the facility a few months and when she had taken the position of DON she had assessed the residents and determined there were no restraints in place but had not documented the information. The DON confirmed she expected Care Plans and Tracker/Careplan cards to be kept updated. On 10/09/2013 at 1:30 PM interview with UM #1 confirmed she had been co-assigned the responsibility of the Care Plans and Tracker Care cards for 5 months and the	L 064		

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L 064	Continued From page 4 belts/devices/restraints should have been documented and updated on Resident #4 on a quarterly basis. 3. Resident #6 was admitted to the facility on 01/24/2012. Diagnoses included rheumatoid arthritis in his feet, knees and hands, senile dementia and abnormal gait. On 10/08/2013 at 9:30 AM Resident #6 was observed dozing in his wheelchair in his room with velcro belt in place. An observation of Resident #6 on 10/08/2013 at 11:21 AM revealed Resident #6 sitting in the dining room waiting for lunch with his velcro seatbelt in place. In an interview on 10/08/2013 at 2:43 PM NA #4 revealed Resident #6 took his seat belt off continually. In an interview on 10/08/2013 at 3:00 PM Resident #6's family member revealed he had the velcro belt on for sometime but was able to unhook it and often did. A review of Resident #6's medical record revealed an order dated 09/10/2012 that read: "Bed alarm, chair alarm and self release seatbelt with velcro." Further review of Resident #6's medical record revealed no signed release, initial evaluation or ongoing assessments to determine if continued restraint use was necessary to treat the resident. Review of Resident #6's current care plan (documented as last updated 01/12/2013) documented no listing of the seatbelt with goals	L 064		

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L 064	Continued From page 5	L 064		

or interventions. Review of Resident #6's Resident Tracker/Careplan card (documented as last updated 09/25/2013 by UM #2) available to the direct care staff on how to meet the individual needs of the resident revealed no documentation that Resident #6 was wearing a seatbelt.

On 10/08/2013 at 2:00 PM interview with Unit Manager #1 (UM #1) revealed she and Unit Manager #2 (UM#2) were responsible for initiating and updating the care plans and Tracker cards. UM #1 confirmed they both meet with families quarterly but UM #2 was the one trained to update the care plans on the computer system.

On 10/09/2013 at 1:20 PM interview with Director of Nurses (DON) revealed she was unable to locate any restraint assessments, documentation on the Care Plan or the Tracker/Careplan card on Resident #6 for the self release seatbelt. On further interview the DON revealed she had only been at the facility a few months and when she had taken the position of DON she had assessed the residents and determined there were no restraints in place but had not documented the information. The DON confirmed she expected Care Plans and Tracker/Careplan cards to be kept updated.

On 10/09/2013 at 1:30 PM interview with UM #1 confirmed she had been co-assigned the responsibility of the Care Plans and Tracker Care cards for 5 months and the belts/devices/restraints should have been documented and updated on Resident #6 on a quarterly basis.

4. Resident #7 was admitted to the facility on 09/14/2011. Diagnoses included Alzheimer's

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L 064	Continued From page 6 dementia, osteoporosis, debility and weakness. An observation of Resident #7 on 10/08/2013 at 9:25 AM revealed Resident #7 sitting in a gerichair in her room with an alarm click belt on. On 10/08/2013 at 9:27 AM interview with Nurse Aide #1 (NA #1), who was providing care to Resident #7, revealed she had not seen Resident #7 try to get up in ages and confirmed Resident #7 was unable to follow directions to release the alarm click belt. On 10/09/2013 at 10:10 AM interview with Nurse Aide #2 (NA #2), who was providing care to Resident #7, revealed she had never seen Resident #7 try to take off her belt and confirmed Resident #7 required total care, was transferred with a lift and unable to follow directions to release the alarm click belt. NA #2 added Resident #7 used to take her belt off but didn ' t do it anymore. A review of Resident #7's Medical Administration Record (MAR) revealed an order dated 11/16/2012 that read: "Seatbelt with alarm to prevent unattended ambulation." Further review of Resident #7's medical record revealed no signed release, initial evaluation or ongoing assessments to determine if continued restraint use was necessary to treat the resident. Review of Resident #7's care plan (doumented as last updated 08/06/2013) documented no listing of the alarm seatbelt with goals or interventions. Review of Resident #7's Resident Tracker/Careplan card (documented as last updated 08/07/2013) available to the direct care staff on how to meet the individual needs of the	L 064		

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L 064	Continued From page 7 resident revealed no documentation Resident #7 was wearing an alarm seatbelt. On 10/08/2013 at 2:00 PM interview with Unit Manager #1 (UM #1) revealed she and Unit Manager #2 (UM#2) were responsible for initiating and updating the care plans and Tracker cards. UM #1 confirmed they both meet with families quarterly but UM #2 was the one trained to update the care plans on the computer system. On 10/09/2013 at 1:20 PM interview with Director of Nurses (DON) revealed she was unable to locate any restraint assessments, documentation on the Care Plan or the Tracker/Careplan card on Resident #7 for the alarm seatbelt. On further interview the DON revealed she had only been at the facility a few months and when she had taken the position of DON she had assessed the residents and determined there were no restraints in place but had not documented the information. The DON confirmed she expected Care Plans and Tracker/Careplan cards to be kept updated. On 10/09/2013 at 1:30 PM interview with UM #1 confirmed she had been co-assigned the responsibility of the Care Plans and Tracker Care cards for 5 months and the belts/devices/restraints should have been documented and updated on Resident #7 on a quarterly basis. 5. Resident #11 was admitted to the facility on 03/27/2012. Diagnoses included debility, Alzheimer's dementia and osteoporosis. An observation of Resident #11 on 10/08/2013 at 10:55 AM revealed Resident #11 sitting in a wheelchair with a click seatbelt in place on her	L 064		

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L 064	Continued From page 8 way to have a shower. On 10/08/2013 at 12:15 PM interview with Resident # 11, in the presence of UM #1 during observation of medication pass, revealed Resident #11 to state she could remove her seatbelt whenever she wanted to and at that time Resident #11 demonstrated she was able to unhook her seatbelt. A review of Resident #11's Medical Administration Record (MAR) revealed an order dated 10/03/2012 that read: "Bed & floor alarm, seatbelt with alarm to prevent unattended ambulation." Further review of Resident #11's medical record revealed no signed release, initial evaluation or ongoing assessments to determine if continued restraint use was necessary to treat the resident. On 10/08/2013 at 2:00 PM interview with Unit Manager #1 (UM #1) revealed she and Unit Manager #2 (UM#2) were responsible for initiating and updating the care plans and Tracker cards. UM #1 confirmed they both meet with families quarterly but UM #2 was the one trained to update the care plans on the computer system. On 10/09/2013 at 1:20 PM interview with Director of Nurses (DON) revealed she was unable to locate any restraint assessments on Resident #11 for the wheelchair seatbelt with alarm. On further interview the DON revealed she had only been at the facility a few months and when she had taken the position of DON she had assessed the residents and determined there were no restraints in place but had not documented the information. The DON confirmed she expected Care Plans and Tracker/Careplan cards to be	L 064		

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L 064	Continued From page 9 kept updated. 6. Resident #12 was admitted to the facility on 09/26/2008. Diagnoses included osteoarthritis, Alzheimer's and muscle weakness. On 10/08/2013 at 9:20 AM Resident # 12 was observed dozing in her wheelchair in front of the nurse's desk with a click seatbelt in place. An observation of Resident #12 on 10/09/2013 at 11:10 AM revealed Resident #12 sitting in front of the nurse's desk with her click seatbelt in place. In an interview on 10/08/2013 at 11:11 AM Resident #12, identified as interviewable by the staff, demonstrated she was able to release her seatbelt but struggled to reconnect the belt. In an interview on 10/08/2013 at 11:15 AM Nurse #2 revealed Resident #12 had no problem releasing her seatbelt. A review of Resident #12's medical record and Medical Administration Record (MAR) revealed no physicians order documented for the seatbelt. Further review of Resident #12's medical record revealed no signed release, initial evaluation or ongoing assessments to determine if continued restraint use was necessary to treat the resident. Review of Resident #12's current care plan (documented as last updated 05/21/2013) documented no listing of the seatbelt with goals or interventions. Review of Resident #12 ' s Resident Tracker/Careplan card (updated 08/2013) available to the direct care staff on how to meet the individual needs of the resident revealed no documentation that Resident #12 was wearing a seatbelt.	L 064		

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L 064	Continued From page 10 On 10/08/2013 at 2:00 PM interview with Unit Manager #1 (UM #1) revealed she and Unit Manager #2 (UM#2) were responsible for initiating and updating the care plans and Tracker cards. UM #1 confirmed they both meet with families quarterly but UM #2 was the one trained to update the care plans on the computer system. On 10/09/2013 at 1:20 PM interview with Director of Nurses (DON) revealed she was unable to locate any physician order for the seatbelt, restraint assessments, documentation on the Care Plan or any on the Tracker/Careplan card on Resident #12 for the seatbelt. On further interview the DON revealed she had only been at the facility a few months and when she had taken the position of DON she had assessed the residents and determined there were no restraints in place but had not documented the information. The DON confirmed she expected Care Plans and Tracker/Careplan cards to be kept updated. On 10/09/2013 at 1:30 PM interview with UM #1 confirmed she had been co-assigned the responsibility of the Care Plans and Tracker Care cards for 5 months and the belts/devices/restraints should have been documented and updated on Resident #12 on a quarterly basis. 7. Resident #13 was admitted to the facility on 06/24/2011. Diagnoses included Alzheimer's. On 10/08/2013 at 11:40 AM Resident # 13 was sitting in the dining room waiting for lunch with her velcro seatbelt hanging loosely behind her chair. In an interview on 10/08/2013 at 11:42 AM NA #3	L 064		

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L 064	Continued From page 11 revealed the belt would not stay hooked and needed to be repaired. On 10/08/2013 at 11:45 AM Resident # 13 demonstrated she was able to release the velcro seatbelt when it was fastened. A review of Resident #13 ' s medical record and Medical Administration Record (MAR) revealed no physicians order documented for the velcro seatbelt. Further review of Resident #13's medical record revealed no signed release, initial evaluation or ongoing assessments to determine if continued restraint use was necessary to treat the resident. Review of Resident #13's current care plan (documented as last updated 08/14/2013) documented the wheelchair belt crossed out and initialed by UM #2. Review of Resident #13's Resident Tracker/Careplan card (undated) available to the direct care staff on how to meet the individual needs of the resident revealed no documentation that Resident #13 was wearing a seatbelt. On 10/08/2013 at 2:00 PM interview with Unit Manager #1 (UM #1) revealed she and Unit Manager #2 (UM#2) were responsible for initiating and updating the care plans and Tracker cards. UM #1 confirmed they both meet with families quarterly but UM #2 was the one trained to update the care plans on the computer system. On 10/09/2013 at 1:20 PM interview with Director of Nurses (DON) revealed she was unable to locate any physician order for the seatbelt, restraint assessments, current documentation on the Care Plan or any on the Tracker/Careplan card on Resident #13 for the seatbelt. On further	L 064		

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L 064	Continued From page 12 interview the DON revealed she had only been at the facility a few months and when she had taken the position of DON she had assessed the residents and determined there were no restraints in place but had not documented the information. The DON confirmed she expected Care Plans and Tracker/Careplan cards to be kept updated. On 10/09/2013 at 1:30 PM interview with UM #1 confirmed she had been co-assigned the responsibility of the Care Plans and Tracker Care cards for 5 months and the belts/devices/restraints should have been documented and updated on Resident #13 on a quarterly basis.	L 064		
L 078	.2305(C) QUALITY OF CARE 10A-13D.2305 (c) The facility shall not utilize any chemical or physical restraints for the purpose of discipline or convenience, and that are not required to treat the patient's medical condition. An evaluation shall be done to ensure that the least restrictive means of restraint have been initiated on patients requiring restraints. This Rule is not met as evidenced by: Based on observations, record review and staff interview, it was determined the facility failed to provide ongoing assessment for use of restraints and failed to assess for the least restrictive restraint or make attempts at reduction of restraints for 2 of 7 sampled residents, (Resident's #2 and #7).	L 078	1. Audits were conducted and the following actions taken for those residents directly affected by this alleged deficient practice: A. Comprehensive assessments have been completed on Residents #2, #4, #6, #7, #11, #12 and #13. B. Lap belts have been discontinued on Residents #4, #6, #7, #11, #12, and #13. Care plans for these residents were reviewed and updated as appropriate. C. Lap belt use continues on Resident #2 and the care plan was updated to reflect current lap belt use. 2. All residents currently utilizing any type of restraint or any device to restrain their mobility were identified as having the potential to be affected by this alleged deficient practice.	10/25/13 10/25/13 10/25/13

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	NH0476	A. BUILDING: _____ B. WING _____	10/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE RIDGE	500 LENOIR RD MORGANTON, NC 28655

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L 078	Continued From page 13 The findings included: 1. Resident #2 was admitted to the facility on 09/13/2011. Diagnoses included Alzheimer's dementia, osteoarthritis and right foot drop with use of brace. An observation of Resident #2 during tour of the facility on 10/07/2013 at 11:00 AM revealed Resident #2 being pushed down the hall by a family member in a wheelchair with a seat belt on. On 10/07/2013 at 11:05 AM in an interview Resident #2's family member revealed he had fallen about a year ago and the facility had put the seatbelt on. The family member further revealed there had been no more falls and Resident #2 did not try to get up anymore. The family member noted both Resident #2's hands were clenched and non-functioning and she confirmed he was unable to follow directions to release the belt. On 10/07/2013 at 11:20 AM interview with Nurse #1 revealed she had never seen Resident #2 try to get up. An observation on 10/07/2013 at noon of Resident #2 revealed him sitting at the dining room table to be served his lunch with the seat belt in place. A review of Resident #2's medical record revealed a Physician's order dated 09/07/2012 that read: "May have self release seatbelt (velcro) and Bed alarm to prevent unattended ambulation." Further review of Resident #2's medical record revealed no signed release, initial evaluation or	L 078	3. The following measures were implemented to assure this alleged deficient practice does not recur: A. All nursing staff including both Unit Managers (UMs) were inserviced on: • The importance of assessing residents for restraint usage prior to the restraint application and the need for on-going assessment. The restraining device will be applied to treat the resident's medical symptoms and will not be used for purposes of discipline or convenience. • Reviewing assessment with the attending physicians and obtaining the appropriate physician order • Informing the resident and their representative(s) of restraint • assessment information, discussing the risks/benefits of restraint usage and the signing of consent forms B. The facility has identified all residents currently using restraints. The charts of these residents have been audited to assure that 1) residents were properly assessed for restraint usage; 2) their representatives were notified of the risks/benefits for restraint usage and a signed consent has been obtained from the resident/representative; and 3) the physician orders are accurate and present in the residents' charts.	11/08/13 10/25/13

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L 078	Continued From page 14 ongoing assessments to determine if continued restraint use was necessary to treat the resident. Review of Resident #2's care plan documented no listing of the seatbelt with goals or interventions. Review of Resident #2's Resident Tracker/Careplan card available to the direct care staff on how to meet the individual needs of the resident revealed no documentation that Resident #2 was wearing a seatbelt. An observation on 10/08/2013 at 9:27 AM revealed Resident #2 sitting up in his wheelchair in an activities session with seatbelt in place. An observation on 10/08/2013 at 11:30 AM of Resident #2 revealed him sitting at the dining room table to be served his lunch with the seat belt in place. An observation on 10/09/2013 at 11:40 AM of Resident #2 revealed him sitting at the dining room table to be served his lunch with the seat belt in place. On 10/09/2013 at 1:20 PM interview with Director of Nurses (DON) revealed she was unable to locate any documentation of an initial evaluation being done on Resident #2 for the self release seatbelt and noted the facility had no form available. In addition the DON confirmmed there was no documented ongoing assessments of least restrictive restraints or an initial signed release by the family for Resident #2. On further interview the DON revealed she had only been at the facility a few months and when she had taken the position of DON she had assessed the residents and determined there were no restraints in place but had not documented the information.	L 078	4. The following quality monitoring program has been implemented to assure the corrective actions are effective and sustained: The Unit Manager and/or Director of Nursing (DON) will conduct random audits of residents with restraint use weekly for two months. These audits will include visualization of the resident with a restraint, the restraint type, and verification that the documentation includes the assessment and current status written on the care plan. Care plans will be reviewed by the Unit Managers on a quarterly basis and as conditions warrant with revisions and updates made as needed. The DON will conduct random audits of the care plans for residents with restraint use weekly for two months. Trends and findings will be presented by the DON at the monthly Quality Assurance/Process Improvement meeting for a minimum of three months. 5. Completion date: 11/8/13	11/08/13

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L 078	Continued From page 15 2. Resident #7 was admitted to the facility on 09/14/2011. Diagnoses included Alzheimer's dementia, osteoporosis, debility and weakness. An observation of Resident #7 on 10/08/2013 at 9:25 AM revealed Resident #7 sitting in a gerichair in her room with an alarm click belt on. On 10/08/2013 at 9:27 AM interview with Nurse Aide #1 (NA #1), who was providing care to Resident #7, revealed she had not seen Resident #7 try to get up in ages and confirmed Resident #7 was unable to follow directions to release the alarm click belt. On 10/09/2013 at 10:10 AM interview with Nurse Aide #2 (NA #2), who was providing care to Resident #7, revealed she had never seen Resident #7 try to take off her belt and confirmed Resident #7 required total care, was transferred with a lift and unable to follow directions to release the alarm click belt. NA #2 added Resident #7 used to take her belt off but doesn't do it anymore. A review of Resident #7's Medical Administration Record (MAR) revealed an order dated 11/16/2012 that read: "Seatbelt with alarm to prevent unattended ambulation." Further review of Resident #7's medical record revealed no signed release, initial evaluation or ongoing assessments to determine if continued restraint use was necessary to treat the resident. Review of Resident #7's care plan documented no listing of the seatbelt with goals or interventions. Review of Resident #7's Resident Tracker/Careplan card available to the direct care staff on how to meet the individual needs of the	L 078		

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L 078	Continued From page 16 resident revealed no documentation Resident #7 was wearing a seatbelt. On 10/09/2013 at 1:20 PM interview with Director of Nurses (DON) revealed she was unable to locate any documentation of an initial evaluation being done on Resident #7 for the alarm seatbelt and noted the facility had no form available. In addition the DON confirmmed there was no documented ongoing assessments of least restrictive restraints or initial signed releases by the family for Resident #7. On further interview the DON revealed she had only been at the facility a few months and when she had taken the position of DON she had assessed the residents and determined there were no restraints in place but had not documented the information.	L 078		