DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/17/2013
FORM APPROVED
OMB NO. 0938-0391

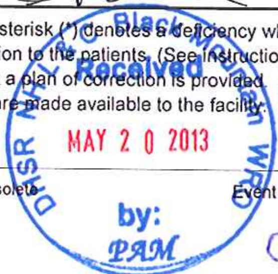
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING ______ B. WING ______	03/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER ST MARSHVILLE, NC 28103

(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) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide a dignified dining experience for 2 of 16 residents (Resident # 110 and #89) eating in the Recreational dining room, by not providing a meal tray to the residents while other residents were at the table eating for 2 of 2 meals observed. The findings are: 1. Resident #110 was admitted to the facility in November 2011 with diagnoses of Dementia with behavioral disturbance. A quarterly minimum data set (MDS) assessment dated 01/15/13 indicated Resident #110 with cognitive impairment and requiring extensive assistance with meals. A dinner meal observation on 03/24/13 from 5:14 PM until 5:40 PM revealed six residents sitting at two connected horseshoe shaped tables in the recreational dining room. Resident #110 was observed sitting in her wheelchair at the table with five residents and nurse aide (NA) #6 sitting on the inside of the horseshoe tables. At 5:14 PM the dining cart arrived to the recreational dining room. At 5:16 PM meal trays were served to all other residents at the horseshoe tables except for Resident #110 and Resident #89. At 5:17 PM	F 241	This plan of correction will serve as the facility's allegation of compliance with requirements of 42 CFR, Part 483, Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to HCFA 2567 for the 03-28-13 survey and does not constitute an agreement or admission of Autumn Care of Marshville of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as it's allegation of compliance with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 03-28-13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: May 17 2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



Original Signature Date: 4-19-13

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F 241	Continued From page 1 Resident #110 removed a cup of sweet tea from the tray of the resident seated to the right of her. A staff member immediately removed the cup from Resident #110's hands and placed it on top of the dining cart. At 5:18 PM Resident #110 removed a cup of water from the tray of the resident to the right of her and removed the lid from the water cup. At 5:20 PM a NA observed Resident #110 with the uncovered cup of water and removed the cup from Resident #110 and placed it on the dining cart. At 5:23 PM Resident #110 removed a cup of fruit from the tray of the resident seated to the right of her and a NA took the cup of fruit from the resident and placed it back on the tray. At 5:25 PM Resident #110 still did not have a meal tray and was observed looking around the table while other residents were eating or being assisted with the meal. At 5:26 PM Resident # 110 pulled closer to the table and continued to look around the table. At 5:27 PM a staff member entered the recreational dining room and placed a meal tray in front of Resident # 110. At 5:28 PM Resident #110's tray was set up. Resident # 110 waited 14 minutes for her meal. Interview with NA #7 on 03/24/13 at 6:15 PM revealed all the residents in the dining room routinely ate in that dining area and the meal trays should have been on the cart. NA # 7 added she was not sure why the tray was not on the cart for Resident #110. Interview with NA #6 on 03/24/13 at 6:20 PM revealed she was unsure whether Resident #110's tray was sent to the hall or the main dining room. NA #6 explained the tray tickets usually got "mixed up" and it was not intentional for trays to	F 241	**The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.** For the residents affected, the facility will designate a dining location to ensure their trays arrive, are set-up, and available to eat when others are available. The facility has always allowed confused residents to eat in any location of their choice in order to minimize agitation for improved food intake. For similar residents having a potential to be affected, the registered dietician will audit meals to ensure other residents that eat at multiple locations are assigned an area to ensure a timely delivery of their trays. Once completed, a list of residents in the recreational area, which was the area of concern for the surveyor, will be created and checked prior to the tray cart leaving the serving	4/18/13

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F 241	Continued From page 2 end up on the hall or in the main dining room. Review of Resident # 110's meal ticket indicated dining location was Recreational 1. On 03/27/13 a continuous observation of the lunch meal was made from 12:18 PM until 12:38 PM. At 12:18 PM the dining cart arrived in the recreational dining room. Resident # 110 was observed to be seated at two connected horseshoe shaped tables with five other residents. Resident #110 was seated with no other residents within close proximity. At 12:22 PM all residents in the recreational dining room were served their meal trays except for Resident #110. During the observation Resident #110 closed and opened her eyes looking around the table at the other residents as they were eating and being assisted with their meal. Resident #110 continued this behavior until her meal tray was delivered to her. At 12:35 PM a NA entered the recreational dining room and placed a tray in front of Resident #110 and set it up for the resident. Resident #110 sat in front of her tray with her hands folded and not eating until encouraged by staff. The resident waited 17 minutes for her meal tray to be served. Interview with NA #8 on 03/27/13 at 12:37 PM revealed the tray tickets indicated the residents dining location. NA #8 added Resident #110 regularly ate in the recreational dining room therefore her meal ticket indicated recreational 1. She further added when she became aware Resident # 110 did not have a tray she went to the kitchen to retrieve the tray but the tray had not been made and she had to wait for the kitchen staff to make a tray for Resident #110.	F 241	line. This will ensure residents that eat at multiple locations will have a tray at the same dining area for every meal. The facility will still allow residents to choose locations to eat. To ensure on-going compliance, the registered dietician on staff will audit 5 meals a week for 2 weeks and then 3 meals a week for 2 weeks and then PRN for 2 weeks. The results of these audits will be informally discussed in the management meeting in order to adjust the Plan of Correction if needed to maintain substantial compliance. In addition, these results will be discussed in our next Quality Assurance Committee. If the audits need to continue beyond the meeting date, they will be discussed at the following Quality Assurance Meeting or until the administrator is satisfied the facility remains in	

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F 241	Continued From page 3	F 241	substantial compliance with this regulation.	

On 03/27/13 at 5:28 PM an interview was conducted with the dietary manager (DM), registered dietician (RD) and director of nursing (DON).

The DM explained meal tray tickets were printed from the computer with an assigned dining location. The meal tickets were then positioned in stacks according to dining location. The dietary aides would then prepare all of the trays according to the tickets in the stacks and place the trays on the meal carts.

The DON explained any NA could change a residents dining location by removing the residents meal ticket from one stack and placing it in another stack. The DON added this would cause the tray to be placed on a different meal cart, and delivered to another location. She stated this was a typically practice of the NAs when a resident wanted to eat in their room instead of the dining room. The DON added the NA who changed the residents dining location by rearranging the meal ticket on the tray line was not always the NA assigned to the dining room area. The DON further added she recalled during the dinner meal on 03/24/13 the NAs were asking for Resident #110 ' s tray and went to the hall to retrieve the meal tray.

The RD stated she was notified on 03/27/13 that the meal ticket for Resident #110 could not be located and therefore her tray had not been made. The RD added she printed a new meal ticket and the tray was made immediately. The RD added this had not happened before and she did not know what had happened to the original

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F 241	Continued From page 4 meal ticket. During an interview with the DON on 03/27/13 at 5:55 PM, the DON stated in regards to dignity ideally the facility would like the residents to have their meals at the same time as the other residents at their table but the facility cannot anticipate the mood of the residents and if the residents will go to another dining location. The DON further added in regards to Resident #110 this was not the most desirable situation. 2. Resident #89 was admitted to the facility in August 2010 with diagnoses of Senile Dementia and Dementia with behavioral disturbance. A quarterly minimum data set (MDS) assessment dated 12/30/12 indicated Resident #89 with cognitive impairment and requiring supervision with meals. During an observation of the dinner meal on 03/24/13 from 5:14 PM until 5:40 PM, Resident #89 was noted to be seated at a horseshoe table with five other residents and nurse aide (NA) #6 sitting on the inside of the horseshoe table. At 5:14 PM the dining cart arrived to the recreational dining room. At 5:16 PM meal trays were served to all other residents at the horseshoe tables except for Resident #89 and Resident #110. At 5:33 PM Resident #89 was observed playing with a baby doll, the other residents at the horseshoe table were eating or being assisted with their meal. At 5:36 PM a NA entered the recreational dining room with Resident #89's tray and set up her meal tray. Resident # 89's meal ticket indicated recreational 1 as the dining location. Resident #89 waited 22 minutes for her meal tray to be served.	F 241		

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F 241	Continued From page 5 Interview with NA #7 on 03/24/13 at 6:15 PM revealed all the residents in the dining room routinely ate in that dining area and the meal trays should have been on the cart. NA #7 added she was not sure why the tray was not on the cart for Resident #89. Interview with NA #6 on 03/24/13 at 6:20 PM revealed she was unsure whether Resident #89's tray was sent to the hall or the main dining room. NA #6 explained the tray tickets usually got "mixed up" and it was not intentional for trays to end up on the hall or in the main dining room. NA # 6 added she did not know if the meal tray came from the kitchen or from the hall. During an interview with the Director of Nursing (DON) on 03/27/13 at 5:55 PM, the DON stated in regards to dignity ideally the facility would like the residents to have their meals at the same time as the other residents at their table but the facility cannot anticipate the mood of the residents and if the residents will go to another dining location. The DON could not specify what happened to Resident #89's meal tray but did add Resident #89's wait was not the most desirable situation.	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 253	**The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.** For the residents found to be effected, Residents #9, #80, #87, and #105 received new bilateral arm rests during the	3/28/13

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F 253	Continued From page 6 interview the facility failed to provide a homelike environment by failing to maintain one Geri-chair and four wheelchairs without tears and cracks for 5 of 29 residents located on the 200 hall. (Resident #9, #87, #66, #105 and #80) The findings are: An observation was made on 03/25/13 at 7:45 AM of Resident # 9's wheelchair. Resident # 9's wheelchair was noted to be torn at the right armrest with the white padding exposed from the leather exterior and the left armrest with multiple cracks through which the white padding was exposed. An observation was made on 03/25/13 at 8:30 AM of Resident #87's wheelchair. Resident #87's wheelchair was noted to be torn at the left armrest with a nickel sized opened area which exposed the white padding from the leather exterior. An observation was made on 03/28/13 at 9:00 AM of Resident # 66's Geri-chair. Resident #66's Geri-chair was noted torn at the seams of the bilateral armrest and the white padding was exposed as well as a large tear approximately 6 inches across the top of the Geri-chair, above the resident's head which exposed a large portion of the white padding. An observation was made on 03/28/13 at 9:15 AM of Resident #105 and #80's wheelchairs. Resident #105 wheelchair was noted with multiple cracks and torn areas to the bilateral armrest. Resident # 80's wheelchair was observed with a torn area to the right armrest which exposed the	F 253	survey. In addition, it was noted Resident #66 had a Geri-chair in poor repair. This was identified the week before and one was ordered and received. In the meantime, another resident was ill and unable to transfer to a dialysis chair. Therefore, staff was required to utilize the chair in order to meet the needs of that resident while a second chair was ordered. The second chair was ordered prior to the survey and put in place 3/29/2013 for the noted resident. For similar residents that have the potential to be affected, staff were inserviced on April 18 to recognize any wheelchairs and Geri-chairs in poor repair. Upon recognition, they are to complete a maintenance request or notify any supervisor to ensure the need is communicated to maintenance. Upon receipt, maintenance will triage the work order with other tasks based upon the safety and well	3/29/13

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F 253	Continued From page 7 white padding. Observation with the Maintenance Director on 3/27/13 at 9:12 AM revealed maintenance work order forms located in a prominent location at the nurse's station. Interview with the Maintenance Director on 03/27/13 at 10:15 AM revealed he was responsible for the repair of torn wheelchairs and Geri-chairs. The Maintenance Director stated he relied mainly on the nursing staff to complete a work order or to verbalize concerns for repairs, however during his rounds if he noticed any concerns with wheelchairs or Geri-chairs he would repair them. Review of the maintenance work orders from December 2012 through March 2013 revealed no work orders for torn wheelchairs to be repaired. Follow-up interview with the Maintenance Director on 03/28/13 at 9:19 AM revealed he was unaware the wheelchairs were torn. He stated a Geri-chair had been ordered for Resident #66 and was in the building. He also added preventative wheelchair maintenance was being added to his monthly rounding. Observations on 03/28/13 at 12:30 PM of Resident #9, #87, #105 and #80 wheelchairs revealed all armrest were replaced. Interview with the Administrator on 03/28/13 at 2:45 PM revealed he was aware of Resident #66's Geri-chair but when her new chair had arrived it was given to another resident. The Administrator added he would be ordering	F 253	being of our residents. In addition, the administrator, director of nursing and staff development coordinator will be especially cognizant to inspect this aspect of wheelchairs and Geri-chairs during daily rounds to ensure compliance. To ensure ongoing compliance, the environmental director and/or his assistant will audit at least 10 wheelchairs/Geri-chairs 3 times a weeks for 2 weeks, and then 2 times a week for 2 weeks and then PRN for 2 weeks to ensure the measures taken to achieve and maintain substantial compliance are effective. The results of these audits will be informally discussed in the management meeting in order to adjust the Plan of Correction if needed to maintain substantial compliance. In addition, these results will be discussed in our next Quality Assurance Committee. If the	

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F 253	Continued From page 8 another Geri-chair.	F 253	audits need to continue beyond the meeting date, they will be discussed at the following Quality Assurance Meeting or until the administrator is satisfied the facility remains in substantial compliance with this regulation.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.** For the resident affected, a new MDS was scheduled with an ARD of 4/18/2013 which will accurately reflect the condition of her teeth. For similar residents having a potential to be affected, the MDS Nurses will assess all residents that have had at least a quarterly MDS completed since March 15, 2013 to date to ensure the dental assessments are accurate. Any similar concerns will be properly noted in the next assessment.	4/19/13

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F 272	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to conduct a comprehensive assessment for missing teeth and mouth pain for 1 of 21 sampled residents (Resident #61). The findings are: Resident #61 was readmitted to the facility on 09/27/12 with diagnoses which included diabetes type 2 and recent below the knee amputation. Review of Resident #61's significant change Minimum Data Set (MDS) dated 10/04/12 revealed intact cognition and no oral or dental problems. Observation of Resident #61 on 03/25/13 at 9:15 AM revealed an approximately ¼ inch gap between 2 front teeth. The two front teeth were gray and black. No bottom teeth were visible. Interview with Resident #61 on 03/25/13 at 11:19 AM revealed mouth pain occurred at times while eating due to missing teeth. Resident #61 explained a tooth broke while eating a cookie before admission but a future dental appointment was on "hold" until after the surgery on her leg and rehabilitation. Observation of Resident #61 during the lunch meal on 03/27/13 at 12:50 PM revealed no difficulty with meal consumption.	F 272	To ensure on-going compliance, the director of nursing or second MDS nurse will randomly audit 2 of the most recently completed MDS's and visually inspect the resident's mouth to ensure the accuracy of the assessment. These audits will be conducted for 3 weeks. If concerns are noted, the audit period will be extended at the discretion of the administrator. The results of these audits will be informally discussed in the management meeting in order to adjust the Plan of Correction if needed to maintain substantial compliance. In addition, these results will be discussed in our next Quality Assurance Committee. If the audits need to continue beyond the meeting date, they will be discussed at the following Quality Assurance Meeting or until the administrator is satisfied the facility remains in substantial compliance with this regulation.	

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F 272	Continued From page 10 Interview with Nurse #1 on 03/28/13 at 9:17 AM revealed she was not aware of Resident #61's missing teeth or mouth pain during eating. Nurse #1 explained it would be up to Resident #61 to request assistance with dental needs. A second interview with Resident #61 on 03/28/13 at 10:07 AM revealed several bottom teeth remained in addition to several on the upper portion of the mouth. Resident #61 explained she intended to make a dental or oral surgeon appointment within the next month. Resident #61 reported she did not inform staff of the need for extractions and dentures. Interview with MDS Nurse #1 on 03/28/13 at 11:43 AM revealed no assessment was conducted related to Resident #61's dental needs upon admission or during routine assessments. The MDS Nurse #1 explained she did not examine Resident #61's mouth or interview the Resident and completed the oral assessment of the MDS. Interview with the Director of Nursing on 03/28/13 at 12:48 PM revealed she expected nursing staff to conduct a full assessment of residents' oral and dental status.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the	F 274	**A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not**	

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(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) COMPLETION DATE
F 274	Continued From page 11 resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to conduct a comprehensive assessment after a significant change in urine incontinency, dependence with transfers, toilet use and assistance with eating with behavior changes for 1 of 3 sampled residents who required a significant change assessment (Resident #142). The findings are: Resident #142 was readmitted to the facility on 12/20/12 with diagnoses which included dementia with behaviors, delusional disorder and secondary Parkinsonism. Review of Resident #142's admission Minimum Data Set (MDS) dated 12/27/12 revealed an assessment of severely impaired cognition with wandering behavior. The admission MDS assessed Resident #142 required the limited assistance of one person with transfers and toilet use. The MDS assessed Resident #142 was occasionally incontinent of urine. Resident #142 ate independently after set up of meals. Review of Resident #142's quarterly MDS dated	F 274	**normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)** For the resident found to have been affected, a new quarterly assessment was scheduled for an ARD of 4/18/2013 to reflect a current assessment of the resident. For residents having the potential of being affected, the MDS nurses will review a report available from our electronic medical record that compares the areas assessed on the MDS. They will compare the current and previous MDS to ensure two or more areas have not changed. If a change is noted, a significant change MDS will be coded as defined in the RAI Manual. To ensure ongoing compliance, the MDS nurse that did not	4/19/13

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	345268	A. BUILDING ______ B. WING ______	03/28/2013

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F 274	Continued From page 12 02/17/13 revealed severely impaired cognition with the behaviors of wandering with physical behavioral symptoms directed towards others. The MDS assessed Resident #142 required the extensive assistance of two persons with transfers and toilet use. The MDS indicated Resident #142 was frequently incontinent of urine and required limited assistance of one person with eating. Observation on 03/27/13 at 8:19 AM revealed Nurse Aide (NA) #1 fed Resident #142 the breakfast meal. Resident ate the meal with eyes closed and did not attempt to initiate utensil use. Observation on 03/27/13 at 9:38 AM revealed Nurse #1 and Nurse #4 transferred Resident #142 to the bed. Interview with Nurse #4 on 03/27/13 at 1:36 PM revealed Resident #142 required the assistance of one or two persons with transfer and was incontinent of urine. Observation on 03/28/13 at 7:50 AM revealed NA #1 assisted Resident #142 to the toilet. Resident #142 walked with a shuffling gait. Interview on 03/28/13 at 8:15 AM with NA #1 revealed Resident #142 either required 1 or 2 persons with transfers. NA #1 explained Resident #142 used briefs and was frequently incontinent of urine. NA #1 reported she would approach Resident #142 at a later time should care be resisted. NA #1 explained Resident #142 required total assistance with eating. Interview with MDS Nurse #1 on 03/28/13 at	F 274	complete the assessment will audit a minimum of 4 new MDS's weekly for 2 weeks and then 2 MDS's for 2 weeks and then PRN for 2 weeks. These audits can be extended at the discretion of the administrator to ensure compliance. The results of these audits will be informally discussed daily in the management meeting in order to adjust the Plan of Correction if needed to maintain substantial compliance. In addition, these results will be discussed in our next Quality Assurance Committee. If the audits need to continue beyond the meeting date, they will be discussed at the following Quality Assurance Meeting or until the administrator is satisfied the facility remains in substantial compliance with this regulation.	

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F 274	Continued From page 13 10:58 AM revealed a significant change assessment should have been conducted for Resident #142 due to the increased dependency with transfers, toilet use, increased assistance with eating, increase in frequency of incontinent episodes and behavioral changes.	F 274		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and medical record review, the facility failed to provide set-up assistance and adaptive equipment to 1 of 3 sampled residents who required limited staff assistance with eating to maintain independence. (Resident #63) The findings are: Resident #63 was admitted to the facility on 09/27/11. Diagnoses included diabetes mellitus, glaucoma, cataracts and general pain. A quarterly minimum data set dated 02/14/13 assessed Resident #63 with impaired cognition and requiring staff to set-up his meals while eating. Review of the Resident's care plan and care guide dated 02/20/13 (posted inside his closet) revealed he required staff to assist him with tray set-up.	F 311	**A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a) (1) of this section.** For Resident #63, an occupational therapy screen, based on medical appropriateness, was completed on 4/15/2013 to determine the need for "built up" utensils. The assessment revealed the adaptive equipment not necessary to maintain or improve his ability to eat. However, the resident stated he preferred the use of it sometimes. As a result, the facility will have adaptive equipment available upon request from the resident during meals.	4/18/13

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F 311	Continued From page 14 Resident #63 was observed on 03/26/13 at 08:36 AM eating breakfast and using a regular fork. Further observation revealed an unopened carton of milk and an unopened container of apple juice. Review of his tray card revealed he was to receive a built up fork and spoon. Resident #63 did not drink his milk or apple juice and stated that he could not open them. An interview on 03/26/13 at 5:00 PM with nursing assistant (NA) #5 revealed that Resident #63 was independent with most of his activities of daily living including feeding himself, but he did require set-up help with his meals which was included in his closet care guide. On 03/27/13 at 08:23 AM, Resident #63 was observed to receive his breakfast meal in his room and received regular eating utensils. NA #2 brought the breakfast meal tray in, sat the meal tray on the over bed table in front of the Resident and left the room. NA #2 did not set up the meal tray or ask the Resident if assistance with set-up was needed. Resident #63 was observed to uncover his meal and using a fork without a firm grip, he poked small holes in his apple juice. The Resident drank his apple juice through the small holes. At 08:51 AM the Resident used his fork, again without a firm grip to open a small hole in his carton of milk and after multiple attempts he inserted a straw into the small hole in the milk carton. At 08:53 AM, the Resident removed his straw from his milk and made several attempts to insert the straw in his water with the lid on. The straw continued to bend as the Resident attempted to locate the hole in the lid of his water. Review of his tray card revealed he was to	F 311	It is the goal of the facility to support and encourage residents to maintain the highest level of independence possible. For residents having the potential of being affected, the staff was inserviced on April 18th on providing assistance with meal set-up. To ensure ongoing compliance, the registered dietician or staff development coordinator will audit at least 4 meals a week for 2 weeks and then 2 meals a week for 2 weeks and then PRN for two weeks. The audit will focus on residents requiring assistance with set-up and to ensure Resident #63 receives "built up" utensils if requested by the resident. If any concerns are noted, the respective staff member conducting the audit will immediately inservice the staff member(s) in order to achieve the highest level of assistance at all times.	

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F 311	Continued From page 15 receive built-up utensils, a fork and a spoon. During the observation, Resident #63 was asked if he had any difficulty setting up his breakfast meal or eating his food and he responded "My hands are in bad shape, I do the best I can."He further stated that it was hard to open everything like his milk for example and it was hard to grip the regular utensils. An interview on 03/27/13 at 1:40 PM with NA #2 revealed that Resident #63 should receive built-up eating utensils. NA #2 stated "He needs them, he gets them on his tray sometimes and sometimes he doesn't," NA #2 stated that he left it up to Resident #63 to let the NA know if he wanted the built-up eating utensils or not, but that the Resident ate better with the built-up utensils and that it was harder for the Resident to hold the regular utensils. NA #2 stated he realized the Resident did not receive the built-up utensils with his breakfast meal that morning (03/27/13) but did not inform the dietary department. An interview with dietary aide (DA) #1 on 03/27/13 at 1:49 PM revealed she knew Resident #63 used built-up utensils and stated he was the only Resident who currently received them. DA #1 stated Resident #63 should receive them with each meal, she thought she put them on his meal tray, but that she would try to pay more attention. An interview with the certified dietary manager (CDM) on 03/27/13 at 2:00 PM revealed that Resident #63 should receive built up eating utensils per his tray card. She further stated that the dietary department only had one pair of built up eating utensils and at times staff would have to locate them if the utensils were not returned.	F 311	The results of these audits will be informally discussed in the management meeting in order to adjust the Plan of Correction if needed to maintain substantial compliance. In addition, these results will be discussed in our next Quality Assurance Committee. If the audits need to continue beyond the meeting date, they will be discussed at the following Quality Assurance Meeting or until the administrator is satisfied the facility remains in substantial compliance with this regulation.	

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F 311	Continued From page 16 The CDM stated it was brought to her attention in the past that at times Resident #63 did not receive his built-up utensils and she would get an additional pair of utensils for the Resident. The rehab director was interviewed on 03/27/13 at 5:15 PM and stated that Resident #63 received occupational therapy in 2011 due to decreased range of motion in his bilateral upper extremities including his hands. Review of the occupational progress notes revealed built-up utensils were used with Resident #63, but the rehab director was unable to determine if a physician's order was written for the continued use. She stated that some times therapy requests for Residents to use adaptive equipment would be implemented based on a verbal request to the dietary department and not a written physician's order.	F 311		