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MACGREGOR DOWNS HEALTH AND REHABILITATION	2910 MACGREGOR DOWNS ROAD GREENVILLE, NC 27834

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E 000	Initial Comments An unannounced Recertification survey was conducted on 10/27/19 through 10/31/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #DELI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/27/19 through 10/31/19. Event ID# DELI11. 20 of the 20 complaint allegations were not substantiated.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		11/25/19

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

Electronically Signed | 11/15/2019

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F 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff, Nurse Practitioner and physician interviews and record review, the facility failed to report a change of condition to the physician for 1 of 1 resident (Resident # 152) reviewed for discharge. Findings included: A review of Resident #152 labs revealed a prothrombin time (measures the number of seconds it takes for the blood to clot) dated	F 580	Please accept this Plan of Correction as MacGregor Downs Health and Rehabilitation's Center's credible allegation of compliance for the alleged deficiency cited. Submission and implementation of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of correction is submitted to meet requirements established by Federal and State laws , which requires an acceptable	

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F 580	Continued From page 2 9/17/2019 with the result of 12.5 (normal range is 11 to 13.5 seconds). Resident #152 was admitted to the facility on 9/23/2019 with diagnoses which included atrial fibrillation, after care following joint replacement surgery and chronic obstructive pulmonary disease. A review of a Minimum Data Set (MDS) dated 10/08/2019 revealed Resident #152 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toilet use, and bathing. She was able perform personal hygiene care with supervision and ate independently. Physician orders dated 9/23/2019 revealed orders for Lovenox solution inject 30 milliliter (ml) subcutaneously one time a day for deep vein thrombosis prevention for 37 days and on 10/1/2019 Asprin 81 mg one time a day related to unspecified atrial fibrillation. Nurse #5's progress note dated 10/7/2019 late entry for 10/6/2019 stated at approximately 11:00 pm she was notified by the Nurse Aide (NA) #8 that Resident #152 had a skin tear. The wound was cleansed with normal saline and a bandage was applied. Nurse #5's progress note revealed at 2:00 am, she returned to Resident #152's room because the skin tear had started bleeding again. Nurse #6 assisted Nurse #5 to apply a pressure dressing which controlled the bleeding at that time. The progress note further read Nurse #5 indicated to Nurse #6 that Resident #152 was on Lovenox and the on call provider had been called.	F 580	Plan of Correction as a condition of continued certification. Resident #152 was assessed by Nursing Staff at 9:30 a.m on 10/7/19, and informed Nurse Practitioner. The Nurse Practitioner instructed the Nursing Department to transport the resident to the ED for evaluation. Resident returned the same day, with sutures. resident was monitored , and returned to the Hospital on 10/8/19 per Physician order. The resident did not return. On 10/9/2019, The Director of Nursing(DON) and Assistant Director of Nursing (ADON) reviewed all incident and accident reports for the previous 30 days to assure Physician notifications were conducted. All Licensed Nursing Staff were re-educated on the prompt notification of the Physician when there is a acute change of condition to a resident. This education began on 10/9/19, and will be completed by 11/25/19. The DON, ADON, Assistant Administrator, and 4 Unit Managers will audit 24 hour reports, Nurses Notes,and SBARS to determine if acute changes of conditions were reported promptly to the Physician. The Nursing Documentation audits will be conducted 5 times per week for 4 weeks, with results reported to the Administrator and to the QAPI Committee. The audits will continue for 2 times per week for 4	

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F 580	Continued From page 3 During a telephone interview with Nurse #5 on 10/30/2019 4:49 pm, she stated she was called in the room by an NA #8 because Resident #152 had a skin tear. Nurse #5 stated the skin tear was dressed and it did not seem to be a serious injury. Nurse #5 stated at 2:00 am the blood seeped through the dressing, but it was not a significant amount of blood on the dressing. Nurse #5 also stated she decided to wait until morning to inform the family and the Nurse Practitioner (NP) about the skin tear. She also stated she was unaware of the time the physician or the representative was notified. Nurse #5 further stated the day shift NA #7 came to the nursing station and reported Resident #152's dressing had blood on it. Nurse #5 was unable to go to Resident #152's room at that moment, so the resident was seen by the Assistant Director of Nursing (ADON). A telephone interview with Nurse #6 on 10/30/2019 at 5:10 pm revealed that she was not Resident #152's primary nurse on 10/7/2019 but assisted Nurse #5 with the resident's skin tear. Nurse #6 stated she went to the resident's room and assisted with placing a pressure dressing on the left arm and the bleeding was under control when she left the room. Nurse #6 further stated at 2:00 am she was called again to assist Nurse #5 to reinforce Resident #152 dressing. Nurse # 6 stated there was a moderate amount of bleeding through the dressing. Nurse #6 further stated she did not see the wound because the bottom layer of the dressing was not removed. She also stated 2:00 am was the last interaction with Resident #152 until after 7:00 am when she assisted with the dressing change by placing ice on Resident #152's arm. Nurse #6 indicated that she was under the impression that the physician had been	F 580	additional weeks, with results reported to the Administrator and to the QAPI Committee. The audits will continue monthly, and reported to the Administrator and QAPI Committee, until the QAPI Committee deems it is no longer necessary.	

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informed of the skin tear and the bleeding.

On 10/29/2019 at 10:45 am during an interview with NA #7, she indicated upon arrival on the unit around 7:00 am on 10/7/2019, Resident #152's call light was on and she went to answer the light. NA #7 stated she noticed blood was on the dressing so she went to the nursing station and informed Nurse #5 that there was a lot of blood on the pillow, towel and blanket. NA #7 further stated she was informed that Resident #152 was on a blood thinner and the Wound Nurse would assess it when she arrived at work. NA #7 also stated Nurse #5 could not go to the resident room at that time, so the ADON went to the resident's room to assess the dressing.

During an interview with the ADON on 10/30/2019 at 5:40 pm, she revealed upon entering the unit she went to Resident #152's room to assess the dressing. The ADON stated there was blood oozing from under the dressing and a large amount of blood was on the kerlix. The ADON further stated, she took the kerlix dressing off and got down to the dressing underneath it, put on 3 ABD (abdominal) pads, kerlix, elevated the resident's arm and put ice on the wound. The Wound Nurse then took over the wound care.

A Situation, Background, Assessment, Recommendation (SBAR) note dated 10/7/2019 written by the Director of Nursing (DON) revealed Resident #152 had a skin tear that was not responding to conservative management (pressure, ice, elevation) to stop the bleeding. The note also indicated Resident #152 was on Lovenox in the hospital and was started on Eliquis when the Lovenox was discontinued. The note further explained on 10/7/2019 at 7:30 am

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the kerlix dressing that had been applied by Nurse #5 and Nurse #6 was removed without removing the dermal seal dressing that covered the laceration. The skin tear was wrapped with three ABD pads, kerlix and a coban wrap was applied to maintain pressure. A towel was placed over Resident #152's left arm, ice applied and the arm was elevated on a sofa cushion. The note also stated the resident would be assessed by the wound nurse.

The Wound Nurse progress note dated 10/9/2019 for a follow up from 10/7/2019 revealed the Wound Nurse was asked to assess Resident #152's skin tear around 8:00 am on 10/7/2019. The nurse noted the skin tear had a kerlix and coban dressing that had soaked through with blood. The skin tear was cleansed with normal saline, steri-strips applied, ABD pads applied, rewrapped with two kerlix rolls and the arm was elevated on a pillow. The Wound Nurse rechecked the dressing one hour later and had to reinforce the dressing with another kerlix.

The Wound Nurse progress note dated 10/7/2019 revealed the resident skin tear was 7 centimeters by 1.4 centimeters (cm) and had bled through the dressing. The skin tear was cleansed, steri-strips applied with xeroform, ABD pads covered the wound and wrapped with kerlix. Resident #152's arm, was elevated and ice was applied. The note further indicated while the Wound Nurse was giving care the resident family member came in for a visit and was informed about the skin tear. The note also revealed the Nurse Practitioner (NP) went in Resident #152's room to assess the resident after the dressing was reinforced. Orders were received from the NP to send Resident #152 to the Emergency Department (ED) for

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evaluation and treatment.

The 10/7/2019 physician orders revealed to discontinue Lovenox solution, 10/7/2019 clean skin tear on left lower arm/wrist with normal saline, leave steri strips in place and cover with xeroform gauze and ABD pad, wrap with kerlix change daily and prn (as needed0 every day shift, 10/7/2019 send to Emergency department for excessive bleeding.

A telephone interview with the Wound Nurse 10/30/2019 at 6:00 pm revealed as soon as she arrived at work around 8:00 am, she was asked to assess Resident #152's arm and redress the arm if needed. The Wound Nurse stated she went in the room and changed the dressing and it was a bad skin tear. She stated the wound was cleansed and wrapped with extra gauzes. The Wound Nurse also revealed the wound was not bleeding profusely at that time. The Nurse further stated she came back to Resident #152's room and put another dressing on her arm so that steri-strips could be added to the skin tear. She also revealed the NP decided to send Resident #152 to the Emergency Department (ED). The Wound Nurse stated she reinforced the dressing before Resident #152 left the facility with three ABD pads to get the bleeding to stop. She also stated the ABD pads were used to make sure the skin tear did not bleed through as it did on the first dressing. The wound Nurse further stated the dressing was not dripping blood and she felt Resident #152 skin tear was looked at in a timely manner with the NP sending the resident to the hospital.

During an interview with the NP on 10/30/2019 at 12:45 pm, she revealed when she arrived at the

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facility and she usually got there around 9:30am, she was informed Resident #152 had a skin tear that continued to bleed. The NP stated, she gave an order to transport the resident to the ED for evaluation if the bleeding did not stop. The NP indicated she did not get a chance to see the skin tear because Resident #152 was in the process of being transported to the ED.

A review of the hospital progress notes dated 10/7/2019 indicated Resident #152 presented to the ED with a left wrist/ forearm laceration in a V shape that measured 7 cm by 6 cm which was bleeding from two sites. The note also indicated the bleeding appeared to be venous. Resident #152 received eleven sutures under local anesthesia and tolerated the procedure well. The ED discharge disposition was to return Resident #152 back to the facility and have her hemoglobin rechecked on 10/8/2019 and sutures removed in 7 days. Resident #152 vital signs upon entering the ED was temperature 98.9, pulse 103, respirations 18, blood pressure 110/60. The progress note indicated the resident was not in acute distress.

Resident # 152's hemoglobin labs results, that were completed while a resident at the facility, were on 9/25/2019 8.9, on 9/27/2019 8.6, on 9/28/2019 8.9, on 9/29/2019 9.4, on 9/30/2019 9.7, on 10/1/2019 8.7, on 10/4/2019 9.3, on 10/7/2019 7.6, and on 10/8/2019 6.7. The normal hemoglobin range for women is between 12.5 to 15.5 grams per deciliter.

An interview with the Director of Nursing (DON) 10/30/2019 at 4:40 pm, revealed the nurses did not call the on-call provider for Resident #152's skin tear during the night because the nurses felt

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the skin tear could be treated with conventional treatments. The DON further stated the facility does not usually call a physician or the representative for skin tears during the night. The DON also stated the plan was to inform the NP when she arrived at the facility that morning.

During an interview with Resident #152's primary physician on 10/30/2019 at 4:12 pm, the physician revealed that she only saw Resident #152 at the beginning of her admission. The Physician then stated the nurses would not have called her because the facility had an on-call provider for after hours. After reviewing the record during the interview, the physician stated someone should have been notified of the incident.

An interview with the DON on 10/30/2019 at 7:54 pm revealed in hindsight when the skin tear was noticed, the physician should have been notified.

The Administrator stated during an interview on 10/30/2019 at 8:13 pm, the staff should have complied with the facility's regulations to include the change of condition and anticoagulant therapy policies.

Progress note written by the Nurse Practitioner #2 dated 10/8/2019 revealed Resident #152 had injured her left hand on the table which required sutures for the lacerations. The note also indicated the resident's hand was noted to be edematous with bruising to the fingers and a dressing had been applied. A clinical addendum was added to the note which indicated Resident #152 was sent to the hospital for low hemoglobin due to a skin tear and the resident was on an anticoagulant. The addendum also revealed

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F 580	Continued From page 9 Resident #152 was transfused packed red blood cells. Resident #152 was discharged from the facility on 10/8/2019 and transferred to a facility of her choice.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment for the area of wounds for 1 of 35 resident assessments reviewed (Resident #29). Findings included: Resident #29 was admitted to the facility on 7/7/15 with diagnoses that included dementia and hypertension. A nursing progress note dated 7/24/19 revealed an ulcer on Resident #29's right lower leg. A physician's order dated 7/24/19 revealed an order to cover the ulcer on Resident #29's lower right leg with a protective dressing and change the dressing every three days. A nursing progress note dated 8/8/19 revealed no changes to ulcer on right lower leg. Resident #29's MDS assessment dated 8/7/19, a quarterly assessment, revealed she was assessed in Section M, as having no issues with	F 641	F 641D Facility failed to accurately code the Minimum Data Set for Resident # 29 in the area of Section M Skin Conditions. Resident # 29 MDS assessment with ARD of 8/7/2019 was modified on 11/13/2019 to reflect Section M was coded accurately. Director of Care Management conducted in-service education with Facility Administrator, Director of Nursing, and MDS Coordinators in relation to MDS accuracy and Coordination of assessment on 11/15/2019. Director of Care Management will review current residents with OBRA Admission, Annual, SCSA and Quarterly assessments completed and transmitted per Assessment History Report from 10/1/19 to 11/12/10 for accuracy of coding of Section M. Assessments with errors identified will be corrected as appropriate by the MDS Coordinator. Audit will be completed by 11/25/2019.	11/25/19

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F 641	Continued From page 10 her skin. During an interview on 10/30/19 at 2:53 PM MDS Nurse #1 stated Resident #29's MDS assessment should have reflected the ulcer on her right lower leg. She continued the nurse who completed the assessment was no longer with the facility. During an interview with the Director of Nursing on 10/30/19 at 4:36 PM she indicated Resident #29's MDS assessment should have reflected the ulcer on her right lower leg.	F 641	The Director of Care Management is responsible for oversight and monitoring of 5 sample resident's weekly times four weeks and then 5 residents monthly for 2 months to review MDS accuracy of Section M. Results of the monitoring will be taken to QAPI and discussed by the QAPI Committee. The Director of Care management is responsible for implementation of this plan of care.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		11/25/19

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F 761	Continued From page 11 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to discard out of date medications from the medication cart for 2 of 3 medication carts reviewed. (Hall 1 Medication Cart and Hall 5 Medication Cart) Findings included: 1. Resident #4 was admitted to the facility on 5/20/15. His active diagnosis included other paralytic syndrome following unspecified cerebrovascular disease. Resident #4's orders revealed on 11/29/16 he was ordered Baclofen Tablet 10 milligrams 1 tablet by mouth as needed for muscle spasms three times a day as needed. During observation of the Hall 5 Medication Cart on 10/30/19 at 8:44 AM Resident #4's Baclofen 10 milligrams was observed to have a discard date of 11/28/18. During an interview on 10/30/19 at 8:44 AM Nurse #2 stated Resident #4's medication should have been discarded and not on the medication cart. During an interview on 10/30/19 at 10:22 AM the Director of Nursing stated outdated medications should not be on medication carts. 2. During observation of the Hall 1 Medication Cart on 10/30/19 at 8:26 AM Oxymetazoline Hydrochloride 0.05% nasal spray was observed	F 761	All expired meds identified were discarded immediately upon knowledge of expiration dates by Med Nurse assigned to cart and RN Supervisor. A audit was conducted on 10/30/19 for Resident #4, and it was determined he had not received any of the expired medication. The nasal spray identified was unopened, and discarded immediately. On 10/30/19, all med carts were inspected by the Assistant Administrator and Medication Nurses assigned to each cart, and any expired meds were discarded immediately. A monitoring tool was initiated on 11/15/2019 by the Assistant Administrator, to audit all medication carts with the medication nurse weekly for 4 weeks, then monthly for 3 months,with expired medications being discarded. Audit records and results will be reported to the Director of Nursing and Administrator.The Assistant Administrator and Director of Nurses will provide education to all Licensed Nurses on the importance of checking dates of medications and discard if expired, by 11/24/2019. The results of the monitoring will be discussed monthly at Quality Assurance Performance Improvement (QAPI) meeting for 4 months with any recommendations and continued	

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	345168	A. BUILDING _____ B. WING _____	C 10/31/2019

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F 761	Continued From page 12 on the cart with an expiration date of 9/19. During an interview on 10/30/19 at 8:26 AM Nurse #3 stated medications that were expire should not be on the cart. She concluded the nasal spray should have been discarded. During an interview on 10/30/19 at 10:22 AM the Director of Nursing stated outdated medications should not be on medication carts.	F 761	education. The Director of Nursing Services (DON)/Assistant Director of Nursing Services (ADOS) will be responsible for overall compliance. The QAPI Committee will determine if additional monitoring is required past the initial four months, which will be reflected in the QAPI minutes.	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide sippy cup, weighted fork, weighted spoon, and a nonslip pad under the plate for 1 of 4 residents reviewed for adaptive devices (Resident #69). Findings included: Resident #69 was admitted to the facility on 8/17/18 with diagnoses which included: dysphagia and hemiplegia. The care plan for Resident #69 was revised on 3/27/19 and included the risk of decreased or inadequate oral intake related to recent stroke and edentulous state. The care plan included an intervention to provide adaptive equipment which	F 810	Resident # 69 was evaluated by a Occupational Therapist on 10/29/19 to determine appropriate adaptive device, and received Occupational Therapy Services treatment until 11/8/2019. New recommendations were shared with the Dietary Department on 11/8/2019. The Meal Tray card was updated by the Dietary Department, and provided to the nursing department. All other residents who received adaptive equipment were screened by Therapy Staff to assure appropriate equipment was in place. An updated complete list of all residents needing adaptive devices was provided to Dietary Staff and Nursing	11/25/19

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F 810	Continued From page 13 included weighted utensils, sippy cup, nonslip pad, and divided plate. Observations of Resident #69 at 3 meals noted that adaptive equipment was not provided at the meals. These observations included: a. On 10/27/19 at 1:01 PM, Resident #69 was observed eating lunch in dining room #5. The tray card for Resident #69 noted a sippy cup, nonslip pad, weighted fork, weighted spoon, and divided plate should be provided with the meal. There were 2, 4-ounce cups with tea and water for the resident and no sippy cup. There was no nonslip pad under the resident's plate. Resident #69 did have a weighted fork, spoon, and divided plate. Resident #69 was observed to spill food and liquids on the table, clothing, and floor while feeding himself. b. On 10/28/19 at 9:08 AM, Resident #69 was observed eating breakfast in dining room #5. The tray card for Resident #69 noted a sippy cup, nonslip pad, weighted fork, weighted spoon, and divided plate should be provided with the meal. There were 3, 4-ounce cups with milk, water, and juice for the resident and no sippy cup. There was a nonslip pad under the resident's plate and he did have weighted utensils and divided plate. Resident #69 was observed with food and liquid spills on his clothing and the table. c. On 10/29/19 at 8:53 AM, Resident #69 was observed eating breakfast in dining room #5. The tray card for Resident #69 noted a sippy cup, nonslip pad, weighted fork, weighted spoon, and divided plated should be provided with the meal. There were 3, 4-ounce cups with milk, orange juice and water for the resident and no sippy cup. There was no nonslip pad under the resident's plate. There was a weighted fork and spoon on	F 810	Staff on 11/8/2019. A new system will be implemented by 11/25/19, to assure all residents receive the necessary adaptive devices. All necessary adaptive devices will be placed on a designated tray with each resident's meal by dietary staff. Dietary staff will then provide each tray to nursing staff, who serve the residents. Nursing Staff will review each tray card prior to delivery,to validate necessary equipment is provided for each resident. Education will be provided to all Dietary Staff and Nursing Staff prior to implementation. This system will be monitored by Nursing Leadership, Dietary Leadership, and Therapy Staff for accuracy. A monitoring tool will be utilized, which will validate the correct adaptive devices are listed on the tray card, and delivered to the resident. Each of the 6 dining rooms will be monitored two times per week for 4 weeks, and then 1 time per week for four weeks. Results will submitted to the Administrator and QAPI Committee,to determine compliance. The QAPI Committee will determine if additional monitoring is needed.	

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F 810	Continued From page 14	F 810		

the table and resident was observed using a regular spoon to eat cereal. Resident #69 was observed with milk and cereal on his clothing and the table.

On 10/29/19 at 8:59AM, an interview with Nurse Aide (NA) #1 revealed she was aware Resident #69 was supposed to have a nonslip pad, sippy cup, weighted utensils, and divided plate for each meal, but she had not provided the nonslip pad or sippy cup. She also revealed the NA was responsible for ensuring the residents had the adaptive equipment listed on the tray card and she had not done so due to her belief that Resident #69 did not need the sippy cup and she forgot to place the nonslip pad under his plate. NA #1 also stated this equipment was available for Resident #69's use and she had not provided it to the resident.

On 10/29/19 at 9:09 AM, an interview with Nurse #2 indicated he was aware Resident #69 was supposed to have adaptive equipment with each meal and was unaware the NA had not provided the equipment to the resident.

On 10/29/19 at 9:40 AM, an interview with the Rehabilitation Director revealed Resident #69 had been evaluated and ordered to have a divided plate, sippy cup, nonslip pad, weighted fork, weighted spoon and she did not know why the NA had not provided the adaptive equipment for the resident.

On 10/29/19 at 10:15 AM, an interview with the Director of Nursing (DON) indicated the NA should have read the tray card and provided the resident the adaptive equipment listed on the card. She also indicated she did not know why

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F 810	Continued From page 15 the NA had not provided the adaptive equipment to Resident #69. On 10/29/19 at 10:50 AM, an interview with the Administrator revealed that Resident #69 should have be provided his adaptive equipment and he did not know why the NA had not provided it to the resident.	F 810		