

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155600	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/15/2012
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NAME OF PROVIDER OR SUPPLIER  MULBERRY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058
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F0000	<p>This visit was for the Investigation of Complaint IN00103421.</p> <p>Complaint IN00103421 - Substantiated. Federal/state deficiencies related to the allegation are cited at F250 and F325.</p> <p>Survey dates: February 14 and 15, 2012</p> <p>Facility number: 000470 Provider number: 155600 AIM number: 100289210</p> <p>Survey team: Donna M. Smith, RN, TC Tammy Alley, RN (February 15, 2012)</p> <p>Census bed type: SNF: 20 SNF/NF: 106 Residential: 4 Total: 130</p> <p>Census payor type: Medicare: 18 Medicaid: 71 Other: 41 Total: 130</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings</p>	F0000	Mulberry Health & Retirement Community respectfully request to have a desk review in lieu of an on sight follow up survey.	

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

TITLE

(X6) DATE

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.

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	cited in accordance with 410 IAC 16.2.  Quality review 2/22/12 by Suzanne Williams, RN				

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to attempt and/or identify possible behavior interventions/reasons for a resident observed by staff hiding and throwing away food from her meals for 1 of 1 resident reviewed with behaviors in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 2/14/12 at 11:20 a.m. The resident's diagnoses included, but were not limited to, hypertension, cerebrovascular accident, right hemiplegia, glucose tolerance, gastrointestinal bleed, and diabetic mellitus - diet controlled. The resident's annual minimum data set (MDS) assessment, dated 10/27/11, indicated the resident was moderately cognitively impaired. The resident ate independently with set up only.</p> <p>The Speech therapy notes indicated the following:</p> <p>On 10/17/11, the Speech Therapist</p>	F0250	<p><b>F250</b> No action can be taken for the resident identified in the survey as they have already been discharged from the facility. All residents hiding or throwing away food have the potential to be affected. Social Service Director will evaluate all residents to determine if any other resident is at risk for hiding or throwing away food. For any resident indentified at risk for hiding or throwing food away a care plan will be developed to address interventions and possible risks. Nursing staff will document behavior when it occurs on facility behavioral monitoring log. Social Service Director will monitor at least monthly for any adverse affects. Social Service Director will make recommendations accordingly. Licensed Nursing staff will be in serviced on facility behavior policy and supportive documentation. Social Service Director will utilize a CQI tool to audit behaviors to ensure proper documentation and interventions are occurring. The CQI tool will be used once weekly for eight weeks then quarterly for six months to assure consistent and ongoing compliance as well as prompt identification and</p>	03/15/2012			

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	<p>indicated an evaluation request was received for Resident #B due to nursing had reported the resident was having difficulty swallowing, including swallowing the smallest pills. She also had had a recent weight loss. Staff had reported the resident would put her food in her wheelchair side bag and take it back to her room where she would throw it away when no one was looking.</p> <p>On 10/18/11, this Speech Therapist did see Resident #B hide her food, and this may have been due to her difficulty in initially swallowing or may be a contribution.</p> <p>The Nurse's Notes indicated the following:</p> <p>On 7/25/11 at 10:00 a.m., the resident was found hoarding most of breakfast from the dining room and wrapped in her napkins. She stopped at the housekeeping cart in the hallway and proceeded to throw it away. The resident indicated she wasn't hungry and educated she did not need to take it from the table as need to know her intake.</p> <p>On 8/08/11 at 6:45 p.m., the resident was observed to place wrapped items in the basket of the E-Z stand. Three-fourths of manicotti from supper was observed</p>		<p>resolution to noncompliance. A compliance threshold of 100% has been established by the governing CQI committee to ensure a measurable system is in place not only to ensure ongoing compliance but also to affectively identify areas of noncompliance and barriers to achieving compliance on an ongoing basis. If compliance threshold is not achieved with in the first 60 days then the monitoring period will be extended to a level found appropriate by the CQI committee. Date of compliance March 15, 2012</p>		

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	<p>wrapped in a napkin. When this writer attempted to speak to the resident about her "behavior," the resident shook her finger at her and said "No, No, Liar, Liar." One to one and redirections were unsuccessful.</p> <p>On 8/11/11 at 11:00 a.m., staff reported to nurse the resident had placed her breakfast cereal and toast and put in into the Hoyer lift pad. 1 to 1 education was completed to leave the food in the dining room.</p> <p>On 8/15/11 at 12:00 p.m., the resident was observed to put her left over food wrapped in a napkin into a pocket on the stand up lift. The resident was educated she did not have to eat 100 % of her meals and was not good to hide her food. The resident indicated she understood.</p> <p>On 11/11/11 at 1:30 p.m., a CNA witnessed the resident throwing away something in housekeeping's trash after lunch. The CNA discovered the resident had thrown away her lunch wrapped in a napkin.</p> <p>On 11/13/11 at 2:05 p.m., a CNA reported the resident had thrown her lunch wrapped in a napkin away in her room's trash. Writer indicated she would advise Social Services Director.</p>						

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	<p>On 11/28/11 at 8:45 p.m., Resident ate bites of supper but hiding the majority of the food in her napkins.</p> <p>On 11/30/11 at 9 p.m., the resident was observed to keep hiding her food in her napkin and then threw it away in her room so staff would not know she wasn't eating.</p> <p>The "SOCIAL SERVICE PROGRESS NOTES" indicated the following:</p> <p>On 8/12/11 the writer indicated she was notified this week the resident was hiding food in the Hoyer basket/sling on the unit. When this writer inquired, the resident indicated "too much, just too much." When the writer asked if she wanted smaller portions, the resident smiled and thanked this writer. Nursing and kitchen were notified.</p> <p>On 8/30/11 the resident continues to have episodes of hiding food although the food portions were made smaller. Nursing to continue to update Social Services.</p> <p>On 10/24/11 the resident asked why her diet was changed to pureed. The writer asked her if she was having problems swallowing or if she choked, and the resident stated "oh yes, and it was so scary." In addition, a note was added to</p>			

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	<p>include the resident was still having episodes of hiding food as reported by staff. Continue to encourage and educate resident on the importance of consumption.</p> <p>On 11/22/11 at 2:30 p.m., continue to observe and encourage resident to not take food back with her to throw away.</p> <p>The "BEHAVIOR MONITORING LOG" indicated the following:</p> <p>No information was indicated for July, August, September, November, or December, 2011.</p> <p>On 10/16/11 at 1:20 p.m., the behavior was indicated as "res (resident) goes to dining rm (room) but hides food to look like she has eaten then throws it away when we don't look she thinks." This behavior was indicated as lasting for 1 to 3 hours with the cause of the behavior as resident stated she had difficulty swallowing. The unsuccessful interventions were provide 1 to 1, reapproach, and converse with the resident. The successful intervention indicated was therapy was notified.</p> <p>The care plan, dated 11/01/11, indicated the problem was the resident exhibited episodes of refusal of food and would</p>				

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	<p>attempt to take back food to unit and miscellaneous areas from the main dining room. The approaches included, but were not limited to, educate resident if noted to take back food as it relates to her health/condition.</p> <p>On 2/14/12 at 4:00 p.m. during an interview, the Social Service Director indicated if a resident would be hiding food, initially she would address the behavior and determine if a solution was available. She indicated if the behavior would reoccur, she would address it in a care plan with identified interventions. She also indicated if a behavior was identified the information would be communicated on the behavior monitoring log which would then be reviewed as indicated for further interventions if needed.</p> <p>The "BEHAVIOR MANAGEMENT POLICY" was provided by the Social Service Director on 2/15/12 at 3:15 p.m. This current policy indicated the following:</p> <p>"PURPOSE</p> <p>Realizing the behavior is a form of communication, we will attempt to understand the resident while alleviating problems that adversely affect the</p>			

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	<p>well-being of the resident, other residents, staff, or visitors.</p> <p>POLICY</p> <p>The facility will provide or make referrals to provide appropriate interventions in establishing treatment for those residents identified as having problem behaviors. By definition a problem is one that does any of the following:</p> <p>1. Behaviors which constitute a source of distress for the resident or...</p> <p>PROCEDURE</p> <p>...6. Behavior monitoring logs will be placed in a location accessible for staff use.</p> <p>7. Staff will be trained to assure they understand the behavior program policy.</p> <p>8. Behavior summary / review sheets will be completed for residents being monitored. Data collected on the behavior monitoring logs will be analyzed to determine frequency, patters/ trends, factors and effectiveness of approaches being utilized.</p> <p>9. Recommendations for interventions, care plan updates, inpatient services and</p>						

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	<p>continued monitoring will be noted on the summary / review forms and communicated to the unit managers....."</p> <p>This federal tag relates to Complaint IN00103421.</p> <p>3.1-34(a)</p>				

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F0325 SS=G	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure a resident's decrease in consumption at meals and her subsequent significant weight loss of 38.5 pounds, or 23.9% of her body weight, in 30 days, was monitored and addressed accordingly, to implement possible interventions to avoid further weight loss, for 1 of 4 residents reviewed for weight loss in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 2/14/12 at 11:20 a.m. The resident's diagnoses included, but were not limited to, hypertension, cerebrovascular accident, right hemiplegia, glucose tolerance, gastrointestinal bleed, and diabetic mellitus - diet controlled. The resident's annual minimum data set (MDS) assessment, dated 10/27/11,</p>	F0325	<p><b>F325</b> No action can be taken for the resident identified as they have already been discharged from the facility. All residents have the potential to be affected. Nursing staff will weigh each resident of the facility to ensure an accurate weight is in place and determine if a fluctuation in weight has occurred since their last routine weight. Residents found to be at risk for weight loss will be weighed weekly until weight stabilizes. All other residents will be weighed monthly. For those at risk for weight loss a care plan will be developed to address interventions and possible risks. Dietician will monitor those on weekly weight and make recommendations accordingly. Facility has reviewed and revised its policy for Nutrition at Risk. Weekly Nutrition At Risk rounds will done by dietician, dietary manager, and nursing management. All residents found to be at risk for weight loss will be</p>	03/15/2012			

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	<p>indicated the resident was moderately cognitively impaired. The resident ate independently with set up only. The resident was discharged to the hospital on 12/3/11 with the complaint of possible GI (gastrointestinal) bleed with red, watery stools.</p> <p>A physician's order, dated 10/24/11, indicated "ST (Speech Therapy) Clarification: Rec. (Recommend) res. (resident) be NPO (nothing by mouth) status (c with a line over the c) (with) long-term alternative nutrition. However, son has declined PEG (feeding tube) tube and NPO. Res. to continue on mech. (mechanical) soft diet NCS (no concentrated sweets) and thin liquids as son will sign diet waiver and gave verbal agreement over phone. Informed nsg (nursing), DON (Director of Nursing), Social Services, and dietary mgr. (manager)."</p> <p>The resident's weights (in pounds [lbs.]) were indicated as follows: 7/4/11 - 160; 8/1/11 - 161; 9/2/11 - 160; 10/2/11 - 161; 10/30/11 - 122.5 with weekly weights initiated; 11/3/11 - 122 with a reweigh of 122.5; 11/8/11 - 119;</p>		<p>evaluated for effectiveness of interventions and need for new interventions. A CQI audit tool has been developed to monitor compliance with addressing weight loss according to facility policy. Nursing management will utilize the tool once weekly for the first eight weeks and quarterly for six months to ensure consistent and ongoing compliance as well as prompt identification and resolution to noncompliance. A compliance threshold of 100% has been established by the governing CQI committee to ensure a measurable system is in place not only to ensure ongoing compliance but also to affectively identify areas of noncompliance and barriers to achieving compliance on an ongoing basis. If compliance threshold is not achieved with in the first 60 days then the monitoring period will be extended to a level found appropriate by the CQI committee. Date of Compliance March 15, 2012</p>				

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	<p>11/15/11 -118.5; 11/22/11 - 116.5; 11/29/11 - "in hosp (in hospital);" 12/01/11 per 24 hour report - 114.</p> <p>The Nurse's Notes indicated the following:</p> <p>On 7/25/11 at 10:00 a.m., the resident was found hoarding most of breakfast from the dining room and wrapped in her napkins. She stopped at the housekeeping cart in the hallway and proceeded to throw it away. The resident indicated she wasn't hungry. The resident was educated she did not need to take it from the table as her intake from the meal was calculated.</p> <p>On 8/8/11 at 6:45 p.m., the resident was observed to place wrapped items in the basket of the E-Z stand. Three-fourths of manicotti from supper was observed wrapped in a napkin. When this writer attempted to speak to the resident about her "behavior," the resident shook her finger at her and said "No, No, Liar, Liar." One to one and redirections were unsuccessful with the resident.</p> <p>On 8/11/11 at 11:00 a.m., staff reported to nurse the resident had placed her breakfast cereal and toast and put in into the Hoyer lift pad. 1 to 1 education was</p>						

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	<p>completed to leave the food in the dining room.</p> <p>On 8/15/11 at 12:00 p.m., the resident was observed to put her left over food wrapped in a napkin into a pocket on the stand up lift. The resident was educated she did not have to eat 100 % of her meals and was not good to hide her food. The resident indicated she understood and "won't do it anymore."</p> <p>On 10/16/11 at 11:10 (a.m./p.m. not specified), therapy was notified as resident was complaining of difficulty swallowing her small pills and while eating at times.</p> <p>On 10/16/11 or 10/17/11, no information was indicated related to the resident's weight.</p> <p>On 10/18/11 at 9:00 p.m., a new physician order was received to schedule modified barium swallow.</p> <p>On 10/21/11 at 3:00 p.m., the hospital notified the facility of the swallow study results. The resident had trace of aspiration with all consistencies except nectar thick. Recommendations were NPO (nothing by mouth) or pureed with nectar thick fluids.</p>						

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	<p>On 10/21/11 at 3:30 p.m., the diet was changed per Speech therapy order. The resident was in agreement to try the pureed diet over the weekend.</p> <p>On 11/7/11 at 12:50 p.m., order written for health shakes daily at 10 a.m. and 2 p.m. as nursing measure due to weight loss. Kitchen was notified.</p> <p>On 11/11/11 at 1:30 p.m., a CNA witnessed the resident throwing away something in housekeeping's trash after lunch. The CNA discovered the resident had thrown away her lunch wrapped in a napkin.</p> <p>On 11/13/11 at 2:05 p.m., a CNA reported the resident had thrown her lunch wrapped in a napkin away in her room's trash. Writer indicated she would advise Social Services Director.</p> <p>On 11/28/11 at 8:45 p.m., Resident ate bites of supper but hiding the majority of the food in her napkins.</p> <p>On 11/30/11 at 9 p.m., the resident was observed to keep hiding her food in her napkin and then threw it away in her room so staff would not know she wasn't eating.</p> <p>The "THERAPY COMMUNICATION TO NURSING," dated 10/17/11 and</p>				

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NAME OF PROVIDER OR SUPPLIER  MULBERRY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058		
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	<p>signed by the scheduled nurse on the unit and the speech therapist, indicated the problem/need was the resident was having difficulty with swallowing even small pills and had had a recent weight loss. Speech therapy was to evaluate and treat as indicated.</p> <p>The Speech therapy notes indicated the following:</p> <p>On 10/17/11, the Speech Therapist indicated an evaluation request was received for Resident #B due to nursing had reported the resident was having difficulty swallowing, including swallowing the smallest pills. She also had a recent weight loss. Staff had reported the resident would put her food in her wheelchair side bag and take it back to her room where she would throw it away when no one was looking.</p> <p>On 10/18/11, this Speech Therapist did see Resident #B hide her food, and this may have been due to her difficulty in initially swallowing or may be a contribution. She would await the results of the modified Barium swallow study which had been requested from her physician.</p> <p>The "VIDEO SWALLOW STUDY," dated 10/21/11, indicated the</p>				

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	<p>"History/Dysphasia Symptoms: weight loss, difficulty (c with line over it) (with) pills, food feeling stuck in throat." The recommendations were NPO, long-term alternative nutrition, and if patient/family would refuse NPO and/or alternative feeding, a pureed diet with nectar thick liquids was indicated.</p> <p>The ""NUTRITIONAL PROGRESS NOTES," dated 10/26/11, indicated the Registered Dietician had completed an MDS review as of 10/25/11 and to see the nutrition assessment.</p> <p>The "NUTRITION ASSESSMENT," dated 10/26/11, indicated the resident's weight was stable with the "actual" weight was 161 lbs. as indicated on 10/02/11. The resident's current diet/supplement/tube feeding was puree with nectar thick liquid changed to mechanical soft no concentrated sweets and thin liquids. Her eating ability indicated she needed tray set up with problems swallowing. She was indicated as alert and able to understand and follow directions. Her average oral intake was 25% to 75%. The "ASSESSMENT/NUTRITION DIAGNOSES STATEMENTS" indicated the resident had inadequate oral intake related to current medical condition as evident by (AEB) less than 75% intake</p>						

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NAME OF PROVIDER OR SUPPLIER  MULBERRY HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058			
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	<p>and had difficulty swallowing related to current medical conditions AEB failed swallow study - mechanical alternative diet. The interventions were honor food preference, encourage intake, honor diet waiver and provide mechanical soft diet.</p> <p>The ""NUTRITIONAL PROGRESS NOTES," dated 11/2/11, indicated the Registered Dietician was "notified of new monthly wt (weight) = 122.5 # (pounds)." The resident was reweighed 4 times with a consistent weight at 122 #. The resident was with 38.5 # 23.9% wt loss in 30 days, down 36#, 22.7% in 180 days. After a discussion with the resident , the resident agreed to whole milk with meals, supercereal, ice cream at night, cottage cheese at lunch and pudding at dinner. The medication, Remeron (appetite stimulant), was also recommended.</p> <p>The "CARE PLAN," originally dated 10/26/11 and updated 11/1/11, indicated the problem was "Potential for alteration in Nutritional and/or Fluid Balance status related to: difficulty swallowing / Dysphagia; Impaired skin integrity - shearing; h/o (history of) constipation; DX (diagnoses) of: Diabetes, hx of CVA (cerebrovascular accident)." The interventions were to weigh the resident per physician order or policy, diet per physician order, honor food preferences,</p>						

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NAME OF PROVIDER OR SUPPLIER  MULBERRY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058
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	<p>encourage oral intake, monitor labs as available, fortified foods per order, monitor for decline in ability to chew or swallow, and consult RD (Registered Dietician) for decline in food and/or fluid intake. The interventions to include specified fortified foods was added on 11/2/11.</p> <p>Review of nurses' notes indicated the resident acquired an open area on 8/7/11 at 10:00 p.m. A 1.5 centimeter (cm) by 1 cm sheared area was noted to the left lower buttock. The wound base was red with white/pink margins.</p> <p>On 8/8/11 at 4 a.m., the resident refused the writer to access the left buttock open area.</p> <p>On 10/11/11 (no time), the resident's left buttock remained clean and dry. The resident refused to get out of electric wheelchair "for a little while to be down" or get into her recliner.</p> <p>The "WOUND/SKIN CONDITION EVALUATION REPORT" indicated the following: Initially on 8/7/11- type was shearing and measured 1.5 cm in length (l) x (by) 1 cm in width (w)with less than (&lt;) 0.1 cm depth; On 9/26/11 - shearing and measured 1.3</p>			

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	<p>cm x 0.4 cm x 0.3 cm; On 10/3/11 - shearing and measured 1.2 cm x 0.4 cm x 0.2 cm; On 10/10/11 and 10/17/11 - shearing and measured 1.2 cm x 0.4 cm x 0.2 cm; On 10/24/11 - shearing and measured 1.2 cm x 0.4 cm x n/a; slow healing was noted; On 11/03/11 and 11/07/11 - shearing and measured 0.9 cm x 0.7 cm x 0.2 cm; On 11/15/11 - shearing and measured 0.9 cm x 0.7 cm x 0.1 cm; On 11/21/11 - shearing and measured 0.8 cm x 0.7 cm x 0.1 cm; On 11/29/11 - shearing and measured 1.7 cm x 0.6 cm x 0.1 cm; Admitted to the hospital on 12/03/11.</p> <p>The "SOCIAL SERVICE PROGRESS NOTES" indicated the following:</p> <p>On 8/12/11 the writer indicated she was notified this week the resident was hiding food in the Hoyer basket/sling on the unit. When this writer inquired, the resident indicated "too much, just too much." When the writer asked if she wanted smaller portions, the resident smiled and thanked this writer. Nursing and kitchen were notified.</p> <p>On 8/30/11 the resident continues to have episodes of hiding food although the food portions were made smaller. Nursing to</p>				

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NAME OF PROVIDER OR SUPPLIER  MULBERRY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058
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	<p>continue to update Social Services.</p> <p>On 10/24/11 the resident asked why her diet was changed to pureed. The writer asked her if she was having problems swallowing or if she choked, and the resident stated "oh yes, and it was so scary." In addition, a note was added to include the resident was still having episodes of hiding food as reported by staff. Continue to encourage and educate resident on the importance of consumption.</p> <p>On 11/22/11 at 2:30 p.m., continue to observe and encourage resident to not take food back with her to throw away.</p> <p>The "MEAL TRACKER" indicated the following:</p> <p>August 2011 - meal consumption ranged from "bites" on 8/28/11 for breakfast to 100%.</p> <p>On 8/8/11 for dinner, the information indicated she had eaten 100%.</p> <p>On 8/11/11 and on 8/15/11 both at lunch, the resident had eaten 75%.</p> <p>September 2011 - meal consumption ranged from "bites" for lunch on 9/11/11 to 100%.</p> <p>October 2011 - meal consumption ranged</p>			

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NAME OF PROVIDER OR SUPPLIER  MULBERRY HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058			
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	<p>from "bites" at breakfast for 10/22 and 10/23 and at lunch on 10/8 and 10/11 to 100%.</p> <p>On 10/18/11 the resident had eaten 25% for each meal.</p> <p>On 10/15 and 10/16, the resident was indicated as with family with no information of meal consumption.</p> <p>On 10/26/11 at supper/dinner, the resident had eaten in her room with no information of meal consumption indicated.</p> <p>No information was indicated for breakfast on 10/14, 10/20; for lunch on 10/23; and for dinner/supper on 10/08/11.</p> <p>November 2011 - meal consumption ranged from "bites" for supper/dinner on 10/27 and 10/28 to 100%.</p> <p>On 11/11 at lunch, 75% was indicated as consumed.</p> <p>On 11/13 at lunch, 100% was indicated as consumed.</p> <p>On 11/28 at supper/dinner, bites were only indicated as consumed.</p> <p>No information was indicated for the lunch meal on 11/23/11 or the supper/dinner meal on 10/30/11.</p> <p>On 2/14/12 at 10:00 a.m. during initial tour and during an interview, Unit Manager #1 indicated the weight book was located at the nurse's station. She also indicated several residents were on</p>						

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	<p>weekly weights due to not eating well, new admissions, had lost weight while in the hospital, and one resident was attempting to lose weight.</p> <p>On 2/14/12 at 10:35 a.m. during initial tour and during an interview, LPN #2 indicated some weights were ordered to be done weekly. She indicated staff would watch how well the residents were eating and if there were no issues, monthly weights would be done. She also indicated she attempted to have the same CNA do the same resident's weight if possible.</p> <p>On 2/14/12 at 3:00 p.m. during an interview, Unit Manager #1 indicated if a family would request a weight, the weight should be done with the weight documented.</p> <p>On 2/14/12 at 8:00 p.m. during a confidential interview, Resident #B's family member indicated while he was visiting Resident #B on 10/17/11, a staff member, who he could not remember her name, indicated the resident was having trouble swallowing her small pills. He indicated he asked staff to weigh Resident #B at this time. The resident was assisted from her electric wheelchair to the sitting scales where she was weighed at 122 pounds. He indicated he remembered the</p>			

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	<p>date/time due to several family members, including out of town relatives, had participated in a special occasion celebration on 10/16/11. He also indicated he found out she was hiding food from another resident in the facility, who had told him in July 2011.</p> <p>On 2/15/12 at 11:25 a.m. during an interview, the Dietary Manager indicated a resident would be put on the "NAR (Nutrition at Risk)" list if new admission for 4 weeks, who was identified as losing weight, and/or a resident who was not eating.</p> <p>On 2/15/12 at 11:35 a.m. during an interview, the Registered Dietician indicated Resident #B would move her food around on her plate as if she had eaten some of it. She indicated smaller portions were tried in August, but the resident still did not eat well. She also indicated she was unaware of the resident hiding her food and had thought she was spitting up into her napkins. She was unaware of the resident's weight loss until it was reported to her on 11/2/11. With weight loss she indicated she would recommend fortified foods per the resident's preferences before she would use supplements.</p> <p>On 2/15/12 at 12:00 p.m. during an</p>				

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NAME OF PROVIDER OR SUPPLIER  MULBERRY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 502 W JACKSON ST MULBERRY, IN 46058
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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
	<p>interview, Speech Therapist #2 indicated the nurse reported to her Resident #B was having difficulty swallowing and did not want to eat. She also indicated nursing had informed her of a recent weight loss, which her son was concerned about this. She indicated she did not remember what her weight loss had been, but it should have been documented. She indicated she communicated information utilizing the "THERAPY COMMUNICATION TO NURSING" form. She would distribute this original form/information in the resident's record, and copies to the unit manager and/or charge nurse, Director of Nursing, Director of Therapy, and to the Unit Manager's office box to be sure the unit manager would be aware of the information.</p> <p>On 2/15/12 at 1:20 p.m. during an interview, the DON indicated a resident's meal intake was determined by what was left on the resident's plate.</p> <p>On 2/15/12 at 2:55 p.m. during an interview, CNA #3 indicated a resident's food intake was determined by how much was left on the plate.</p> <p>On 2/15/12 at 3:50 p.m. during an interview, the DON indicated the resident went to the hospital on 12/3/11 and not 11/29/11. At this same time, she</p>			

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	<p>provided a 24 hour report form indicating Resident #B's weight was completed on 12/01 with a weight of 114 lbs.</p> <p>The "WEIGHT TREND RECORD" policy was provided by the Director of Nursing on 2/15/12 at 10:45 a.m. This current policy indicated the following:</p> <p>"Purpose:</p> <ol style="list-style-type: none"> <li>To consistently document a resident's monthly or weekly weight data.</li> <li>To identify any significant unexpected and undesired weight gains or losses.</li> </ol> <p>Policy: A resident's weight will be monitored consistently to quickly identify any unexpected weight changes....</p> <p>Responsibility: Dietary Manager, C.N.A., Licensed Nurses...."</p> <p>The policy for NAR (Nutritionally at Risk), which was kept in the weight book at the nurse's station, was provided by Unit Manager #1 on 2/15/12 at 12:10 p.m. This current policy indicated the following:</p> <p>"Policy: Residents at nutritional risk will be reviewed weekly by the NAR</p>						

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	<p>committee until stable.</p> <p>Subject: residents at Nutritional Risk Procedure and Guidelines:</p> <p>...2. Any resident showing an unplanned or significant weight loss in 30-90-180 days will be placed on NAR and reviewed weekly until determined stable by committee.</p> <p>...10. Any resident with a weekly weight difference of 3 pounds more or less will be reweighed. Monthly re-weights are required if weight is 5 pounds more or less."</p> <p>This federal tag relates to Complaint IN00103421.</p> <p>3.1-46(a)(1)</p>				