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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155681 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>03/07/2012 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>AUTUMN WOODS HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2911 GREEN VALLEY RD<br>NEW ALBANY, IN 47150 |
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| F0000 | <p>This visit was for the Investigation of Complaint IN00104766.</p> <p>Complaint IN00104766 - Substantiated, Federal/State deficiencies related to the allegation are cited at F282 and F325.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: March 6 and 7, 2012</p> <p>Facility number: 002657<br/>Provider number: 155681<br/>AIM number: 200308930</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type:<br/>SNF: 48<br/>SNF/NF: 40<br/>Total: 88</p> <p>Census payor type:<br/>Medicare: 26<br/>Medicaid: 27<br/>Other: 35<br/>Total: 88</p> <p>Sample: 9</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC</p> | F0000 |  |  |
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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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|                    | 16.2.<br><br>Quality review completed on March 9, 2012 by Bev Faulkner, RN   |               |   |                      |

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| F0282<br>SS=D  | <p>483.20(k)(3)(ii)<br/>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the physician's orders were followed for 3 of 9 residents reviewed related to physician's orders in the sample of 9. (Residents B, C, and E)</p> <p>Findings include:</p> <p>1. The clinical record for Resident C was reviewed on 3/7/12 at 12:25 p.m.</p> <p>Physician orders for March 2012 included an order, originally received 12/16/11, for "Waffle boots to keep heels protected." Also included was an order, originally received 12/25/11, for "Float heels at all times while abed."</p> <p>The Medication Record for March 2012 indicated with a nurse's initials that the boots were in place each of the three shifts from 3/1 through the 6:00 a.m. to 2:00 p.m. shift on 3/7/12.</p> <p>During observation on 3/7/12 at 12:00 noon, Resident C was rolled in her wheel chair from the dining room to her room.</p> | F0282   | <p>1. The MD order for Resident C for waffle boots and floating heels is being followed. The MAR for Residents B &amp; E were updated to accurately reflect the MD orders for fortified shakes &amp; wound treatment. 2. All MD orders for wound treatment will be audited and cross-checked with each resident MAR to ensure accuracy thus ensuring MD orders are followed. 3. Nurses and QMAs will be in-serviced by the ADHS or DHS by 4/6/12, with emphasis on following MD orders and accurately transcribing orders to the MAR. 4. Rounds will be conducted by the DHS or ADHS to monitor and ensure MD orders are carried out and delivered to the residents. These will be conducted 5 times per week for one month then 3 times per week for 2 months. Audits of new orders for wound treatment will be conducted by cross-checking those orders to the resident MAR to ensure accuracy of transcription. A minimum of 5 orders per week will be checked for one month then at least one order per week check for 2 months. Results of these audits will be evaluated by the QA committee and audits will</p> | 04/06/2012  |  |   |  |

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|  | <p>Waffle boots were observed in a chair at the bedside, and the resident was not wearing waffle boots.</p> <p>During observation on 3/7/12 at 3:35 p.m., with LPN #16, Resident C was observed resting in bed. LPN #16 lifted the resident's bed covers. The resident was wearing socks on her feet. The resident was not wearing waffle boots and her heels were not floated. The heels were directly on the mattress. During interview at this time, LPN #16 indicated the waffle boots were placed on the resident when she retired for the night.</p> <p>During observation on 3/7/12 at 4:40 p.m., Resident C was observed seated in her wheel chair at the dining table. The resident was wearing socks and slipper-type shoes. She was not wearing waffle boots.</p> <p>2. The clinical record for Resident B was reviewed on 3/7/12 at 10:55 a.m. The record indicated the resident was admitted on 2/8/12 following hospitalization.</p> <p>A physician's order, dated 2/13/12, indicated, "1) D/C [discontinue] NAS [no added salt] diet &amp; give fortified food diet.<br/>2) Clarify - 8 oz fortified shakes BID [twice daily] B/W [between] meals at AM &amp; PM [morning and evening]</p> |   | continue until 100% compliance is reached for 3 consecutive months.   |   |  |   |  |

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|                    | <p>snacks."</p> <p>A physician's order, dated 2/14/12, included, but was not limited to, "Dietary supplements as directed."</p> <p>A Change of Diet slip, dated 12/15/12 (sic), indicated, "Present Diet Order: D/C NAS. New Diet Order: Fortified food diet. Give 8 oz fortified shakes BID b/w meals at AM &amp; PM snack."</p> <p>The Medication and Treatment Records for February 2012 lacked documentation the fortified shakes were provided to the resident.</p> <p>Resident First Conference Notes, dated 3/1/12, included, but were not limited to, "Care giver comments: ...1) Snacks vanilla &amp; strawberry ordered @ snack times twice daily has not been getting dietitian request &amp; family @ 10 A [a.m.] and 2 P [p.m]."</p> <p>During interview on 3/7/12 at 3:40 p.m., the Director of Nursing (DON) indicated she did not locate documentation that the fortified shakes were provided for Resident B in February 2012. She indicated that information is sometimes on the Medication Administration Record and sometimes on the Treatment Administration Record. At this time she</p> |               |   |                      |

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|  | <p>provided a computer print out of a document indicating the resident's average intake of morning and afternoon snacks for 2/1/12 through 3/7/12. The DON indicated the information was based on input by the nursing aides related to a resident's intake. The DON indicated the information would include all snacks consumed by the resident, including puddings, yogurts, and other foods provided at morning and afternoon snack times.</p> <p>A Change of Diet slip, dated 3/1/12, was received from the Director of Food Services on 3/7/12 at 4:45 p.m. The slip indicated, "Present Diet Order: Fortified Food Diet. New Diet Order: fortified Food Diet. Vanilla or Strawberry shakes q [every] AM at 10:00 a.m. and 2 PM every afternoon."</p> <p>The Medication Administration Record for March 2012 through the morning of 3/7/12, indicated fortified shakes were being provided twice daily "upon arising" and at "bedtime" from 3/1 though 3/7/12.</p> <p>3. The clinical record for Resident E was reviewed on 3/7/12 at 11:25 a.m. Physician's orders for March 2012 indicated an order was received 2/20/12 for "Maxorb Ex Ag/Silv [Maxorb Extra AG Silver Alginate]12" rope cleanse</p> |   |   |   |  |   |  |

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|  | <p>sacrum w/[with] wound cleanser- apply skin prep to surrounding area - apply Maxorb AG rope and cover w/adhesive foam dsg [dressing] - chg [change] every other day &amp; prn [as needed] loose/soiled."</p> <p>The Medication Record for March 2012 indicated the dressing was changed routinely on the 6:00 a.m. to 2:00 p.m. shift on March 1, 2, 4, 5, and 7, 2012, instead of every other day as ordered. None of the dressing changes were indicated to be on an as needed basis.</p> <p>During interview on 3/7/12 at 3:10 p.m., the Director of Nursing reviewed the Medication Record for March 2012 and indicated the plan for the dressing change was scheduled two days in a row, then skip a day, instead of every other day as ordered. She indicated dressing was actually changed more frequently than ordered. She indicated she thought the Medication Record had just been marked wrong for dates the dressing should have been changed.</p> <p>This federal tag is related to Complaint IN00104766.</p> <p>3.1-35(g)(2)</p> |   |   |   |  |   |  |

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| F0309<br>SS=D  | <p>483.25<br/>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br/>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a plan was in place for management of low blood sugar for 3 of 6 residents reviewed related to diabetic care in a sample of 9. (Residents C, F, and G) The facility also failed to provide care as planned related to diabetic foot ulcers for 1 of 2 residents reviewed related to wounds in a sample of 9. (Resident C)</p> <p>Findings include:</p> <p>1. A. Lunch trays were observed to be delivered on the Legacy Lane unit on 3/7/12 at 11:55 a.m., and staff began serving residents seated in the unit dining room. At noon, MDS Coordinator #2 entered the unit and went immediately to Resident C who was seated in her wheelchair. As she gently shook Resident C, MDS Coordinator #2 asked the unit's nurse, LPN #10, "Has she been asleep all morning?" MDS Coordinator #2 began wheeling the resident to her room and indicated, "She's a little lethargic at the</p> | F0309   | <p>1. Residents C, F, &amp; G have MD orders to provide guidance to manage a hypoglycemic incident. Resident C's plan of care is being followed.2. Orders will be obtained for all diabetic residents to ensure parameters are established to manage hypoglycemic episodes.<br/>3. Nurses will be in-serviced by the ADHS or DHS by 4/6/12 to ensure they obtain parameters to handle hypoglycemia per MD order. Nursing staff will be in-serviced regarding following the residents plan of care to include interventions for wounds.<br/>4. Rounds will be conducted by the DHS or ADHS to monitor and ensure the resident plan of care is being followed for residents. These will be conducted 5 times per week for one month then 3 times per week for 2 months. Orders will be checked for new diabetic residents admitted during the daily CQI process to ensure parameters to manage hypoglycemia are obtained. Results of these audits will be evaluated by the QA committee and audits will continue until</p> | 04/06/2012  |  |   |  |

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|  | <p>moment." MDS Coordinator #2 asked LPN #10 if Resident C was diabetic and indicated the resident would be assessed. While LPN #10 obtained pulse oximeter, blood pressure/pulse cuff, and blood sugar monitor, MDS Coordinator #2 attempted to arouse Resident C and keep her awake. The resident opened her eyes briefly and wriggled slightly, repeatedly. During interview at the time of the assessment, MDS Coordinator #2 indicated, "Her sugar's 49. We need to get something in her - get some juice and bring it down here." LPN #10 left the unit and returned with a cup of orange juice. MDS Coordinator #2 and LPN #10 attempted to have the resident drink the juice with and without a straw, but she was not able. MDS Coordinator #2 indicated, "Does she have a Glucagon order if we can't get this in her?" After more attempts to administer the juice, which the resident was unable to take, MDS Coordinator #2 indicated, "Let's get the Glucagon." LPN #10 left the room at 12:10 p.m. MDS Coordinator #2 remained with the resident and made repeated attempts to arouse and keep her awake. The resident opened her eyes briefly and wriggled slightly, repeatedly. LPN #10 returned to the resident's room with a Glucagon kit and prepared the medication for administration. LPN #10 opened the instruction sheet provided</p> |   | <p>100% compliance is reached for 3 consecutive months.</p>   |                      |   |

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|                    | <p>with the medication and discussed with MDS Coordinator #2 whether the medication should be given subcutaneously or intramuscularly. MDS Coordinator #2 indicated it was best to read the package insert to be sure, and LPN #10 read the instructions and administered the medication intramuscularly into the left deltoid at 12:15 p.m.</p> <p>The clinical record for Resident C was reviewed on 3/7/12 at 12:25 p.m. At that time, the record lacked documentation of a physician's order for management of hypoglycemia.</p> <p>The Physician Orders for March 2012 included, but were not limited to, "Novolin R 100 u [units]/ml vial Accu-cks [Accuchecks] AC [before meals] &amp; HS [at bedtime] SS [sliding scale]: 151-200 = 2 units; 201-250 = 4 units; 251 - 300 = 8 units; 351- 400 = 10 units; 401 - 450 = 12 units; 451 - 500 = 14 units; Call MD is greater than 500." Documentation lacked a physician's order related to low blood sugars.</p> <p>The Medication Record indicated the resident's blood sugar was 80 on 3/7/12 at 6:30 a.m., and the resident received the routinely ordered 20 units of Humulin 70/30 at that time, and no sliding scale</p> |               |   |                      |

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|  | <p>insulin.</p> <p>The Medication Record indicated the resident's blood sugars before the noon meal, scheduled at 11:30 a.m., were as follows in March 2012: 3/1/12: 110, no insulin administered; 3/2/12 130, no insulin administered; 3/3/12: 383, 10 units insulin administered; 3/4/12: 172, 2 units insulin administered; 3/5/12: 95, no insulin administered; 3/6/12: 129, no units administered; and 3/7/12: 49, no units administered.</p> <p>The resident's care plan indicated a problem, dated 12/26/11, of risk for uncontrolled/unstable glucose level. Goals related to the problem indicated, "Resident will maintain blood glucose levels that are within acceptable limits for resident." Interventions included, but were not limited to, "Provide resident education to include...what to do in the event of hypo/hyperglycemia, safety measures."</p> <p>During interview on 3/7/12 at 1:25 p.m., the Director of Nursing indicated the facility has no policy related to management of hypoglycemia (low blood sugar), and it was left to nursing judgment.</p> <p>During interview on 3/7/12 at 1:30 p.m.,</p> |   |   |   |  |   |  |

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|                    | <p>the Director of Nursing indicated when Resident C experienced hypoglycemia, LPN #10 called the resident's doctor to obtain orders to administer Glucagon and had recorded the order at this time.</p> <p>Review of the record at this time indicated an order for, "Give Glucagon 1 ml IM [intramuscularly] for BS [blood sugar] less than 50 as needed." The order was marked as "PRN [as needed]."</p> <p>B. Physician orders for March 2012 for Resident C included an order, originally received 12/16/11 for "Waffle boots to keep heels protected." Also included was an order, originally received 12/25/11, for "Float heels at all times while abed."</p> <p>The Medication Record for March 2012 indicated with a nurse's initials that the boots were in place each of the three shifts from 3/1 through the 6:00 a.m. to 2:00 p.m. shift on 3/7/12.</p> <p>During observation on 3/7/12 at 12:00 noon, Resident C was rolled in her wheel chair from the dining room to her room. Waffle boots were observed in a chair at the bedside, and the resident was not wearing waffle boots.</p> <p>During observation on 3/7/12 at 3:35 p.m., with LPN #16, Resident C was observed resting in bed. LPN #16 lifted</p> |               |   |                      |

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|                    | <p>the resident's bed covers. The resident was wearing socks on her feet. The resident was not wearing waffle boots, and her heels were not floated. The heels were directly on the mattress. During interview at this time, LPN #16 indicated the waffle boots were placed on the resident when she retired for the evening.</p> <p>During observation on 3/7/12 at 4:40 p.m., Resident C was observed seated in her wheel chair at the dining table. The resident was wearing socks and slipper-type shoes. She was not wearing waffle boots.</p> <p>Pressure/Stasis/Arterial/Diabetic Ulcer Assessments sheets indicated the following:</p> <p>On 12/25/11, the resident developed a Stage 2 diabetic ulcer to the bottom of the left foot. On 2/10/12, the intervention of "Waffle boots" was added in the "Comments" section of the description of the wound. The waffle boots were also listed on 2/17, 2/24, and 3/2/12 as intervention related to the care of the wound.</p> <p>On 2/19/12, the resident developed a Stage 2 diabetic ulcer to the right inner ankle. "Waffle boots" were listed as an intervention in the "Comments" section of</p> |               |   |                      |

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|  | <p>the description of the wound on 2/26/12 and 3/1/12.</p> <p>2. The clinical record for Resident F was reviewed on 3/7/12 at 3:55 p.m. The record indicated the resident had diagnoses including, but not limited to, diabetes mellitus.</p> <p>The physician's orders for March 2012 indicated the resident received routine insulin injections, and the resident's blood sugar was to be checked four times a day with insulin administered on a sliding scale as needed for blood sugar management. The order for sliding scale insulin included, "...&gt; [greater than] 400 = 12 units and call MD." The record lacked documentation of an order for management of hypoglycemia.</p> <p>The resident's care plan indicated a problem, dated 6/3/11, of risk for uncontrolled/unstable glucose level. Goals related to the problem indicated, "Resident will maintain blood glucose levels that are within acceptable limits for resident." Interventions included, but were not limited to, "Provide resident education to include...what to do in the event of hypo/hyperglycemia, safety measures."</p> <p>Also listed in the problem column was: "7/3/11 - hypoglycemic reaction."</p> |   |   |   |  |   |  |

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|  | <p>Interventions indicated, "[Symbol for change] in insulin. [Check mark] accu [check mark] [check blood sugar] X 24 [symbol for hours] q [every] 4 [symbol for hours]."</p> <p>3. The clinical record for Resident G was reviewed on 3/7/12 at 4:05 p.m. The record indicated the resident had diagnoses including, but not limited to, diabetes mellitus.</p> <p>The physician's orders for March 2012 indicated the resident received routine insulin injections, and the resident's blood sugar was to be checked four times a day with insulin administered on a sliding scale as needed for blood sugar management. The order for sliding scale insulin included, "...[blood sugar] over 450 = call MD." The record lacked documentation of an order for management of hypoglycemia.</p> <p>The resident's care plan indicated a problem, dated 6/3/11, of risk for uncontrolled/unstable glucose level. Goals related to the problem indicated, "Resident will maintain blood glucose levels that are within acceptable limits for resident." Interventions included, but were not limited to, "Provide resident education to include...what to do in the event of hypo/hyperglycemia, safety</p> |   |   |                      |   |

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|                          | measures."<br><br>3.1-37(a)  |                     |  |                            |

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| F0325<br>SS=D      | <p>483.25(i)<br/>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 the resident experiencing weight loss received fortified nutritional shakes as recommended by the Registered Dietitian and ordered by the physician. Also, the facility failed to ensure the resident's food preferences were assessed, as planned by the dietitian. The deficient practice affected 1 of 3 residents reviewed related to weight loss in a sample of 9. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 3/7/12 at 10:55 a.m. The record indicated the resident was admitted on 2/8/12 following hospitalization.</p> <p>The Vital Signs and Weight Record indicated the resident's weight on 2/9/12 was 118 pounds, and on 2/13/12, the</p> | F0325         | <p>1. Resident B is receiving fortified shakes as recommended by the dietitian and ordered. Food preferences were reviewed with the Resident B. 2. All residents with MD orders for fortified shakes will be reviewed and cross-checked on the MAR to ensure accurate transcription. In addition, this list will be cross-referenced with the list receiving fortified shakes from the Food Services department. All residents will be reviewed by the Director of Food Services to ensure food preferences are up-to-date. 3. Nurses and QMAs will be in-serviced by the ADHS or DHS to ensure nurses understand to follow MD orders and know how to accurately transcribe orders to the MAR. The DFS and ADFS will be in-serviced by the ED by 4/6/12 to ensure understanding of obtaining resident food preferences and implementing. 4. During the daily CQI process, orders received due</p> | 04/06/2012           |

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|  | <p>weight was 110.6.</p> <p>The Nutrition Assessment and Data Collection, signed by the Registered Dietitian and dated 2/13/12, indicated, "...resident w/ [with] significant wt [weight] loss of 6.7% since admission...daughter reports appetite [arrow pointing down - decreased] &amp; resident just picks at food. Resident says she likes the foods &amp; shakes. On diuretic &amp; + [positive] edema - potential for wt fluctuations. On NAS [no added salt] diet [symbol for secondary to] edema. However, will liberalize [symbol for secondary to] wt loss. Plan: 1) D/C [discontinue] NAS diet &amp; give fortified food diet. 2) Clarify - 8 oz fortified shakes BID [twice daily] at AM &amp; PM [morning and evening] snacks."</p> <p>A physician's order, dated 2/13/12, indicated, "1) D/C NAS diet &amp; give fortified food diet. 2) Clarify - 8 oz fortified shakes BID B/W [between] meals at AM &amp; PM [morning and evening] snacks."</p> <p>The resident's Care Plan, dated 2/13/12, included, but was not limited to, "Problem: Resident at nutrition risk: AEB [as evidenced by]: Significant weight changes within last 30/180 days: Loss." Goals, with a Target Date of 5/12,</p> |   | <p>to dietitian recommendations will be cross-checked with the MAR to ensure accurate transcription. These orders will also be reviewed with Food Services to ensure communication. A minimum of 5 per week will be checked for 3 months. Results of these audits will be evaluated by the QA committee and audits will continue until 100% compliance is reached for 3 consecutive months.</p> |   |  |   |  |

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|  | <p>included, but were not limited to, "Adequate intake to promote stable wt &amp; nutrition status."</p> <p>A physician's order, dated 2/14/12, included, but was not limited to, "Dietary supplements as directed."</p> <p>A Change of Diet slip, dated 12/15/12 (sic) indicated, "Present Diet Order: D/C [discontinue] NAS [no added salt] New Diet Order: Fortified food diet. Give 8 oz fortified shakes BID b/w meals at AM &amp; PM snack."</p> <p>The Medication Administration and Treatment Records for February 2012 lacked documentation the fortified shakes were provided to the resident.</p> <p>The Vital Signs and Weight Record indicated the resident's weight on 2/21/12 was 106.6 pounds, and a reweight on 2/22/12 indicated the weight was 106.2.</p> <p>Nutrition Progress Notes, dated 2/20/12, indicated, "Wt monitoring - trending undesired wt loss - requested reweight to verify. Receiving fortified food diet w/8 oz fortified shakes (vanilla/strawberry) to be given b/w meals at AM &amp; PM snacks. Acceptance variable....Will request...DFS [Director of Food Services interview for food preferences. Will cont. [continue] to</p> |   |   |   |  |   |  |

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|  | <p>monitor."</p> <p>The Vital Signs and weight Record indicated the resident's weight on 2/26/12 was 103.2 pounds.</p> <p>Resident First Conference Notes, dated 3/1/12, included, but were not limited to, "Care giver comments: ...1) Snacks vanilla &amp; strawberry ordered @ snack times twice daily has not been getting dietitian request &amp; family @ 10 A [a.m.] and 2 P [p.m]."</p> <p>During interview on 3/7/12 at 3:20 p.m., the Director of Food Services indicated the staff was behind on assessment of resident food preferences. He indicated no food preferences had been assessed for Resident B.</p> <p>During interview on 3/7/12 at 3:40 p.m., the Director of Nursing (DON) indicated she did not locate documentation that the fortified shakes were provided for Resident B in February 2012. She indicated that information is sometimes on the Medication Administration Record and sometimes on the Treatment Administration Record. At this time she provided a computer print out of a document indicating the resident's average intake of morning and afternoon snacks for 2/1/12 through 3/7/12. The</p> |   |   |   |  |   |  |

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|  | <p>DON indicated the information was based on input by the nursing aides related to a resident's intake. The DON indicated the information would include all snacks consumed by the resident, including puddings, yogurts, and other foods provided at morning and afternoon snack times.</p> <p>A Change of Diet slip, dated 3/1/12, was received from the Director of Food Services on 3/7/12 at 4:45 p.m. The slip indicated, "Present Diet Order: Fortified Food Diet. New Diet Order: fortified Food Diet. Vanilla or Strawberry shakes q [every] AM at 10:00 a.m. and 2 PM every afternoon."</p> <p>The Medication Administration Record for March 2012 through the morning of 3/7/12, indicated fortified shakes were being provided twice daily "upon arising" and at "bedtime" from 3/1 though 3/7/12.</p> <p>This federal tag is related to Complaint IN00104766.</p> <p>3.1-46(a)(2)</p> |   |   |                      |   |