The submission of the Plan of Correction does not constitute agreement on the part of Mountain Home Health and Rehabilitation Center that the deficiency cited with the report represent deficient practices on the part of Mountain Home Health and Rehabilitation Center. This plan represents our ongoing pledge to provide quality care that is rendered in accordance with all regulatory requirements.

Tag: F367---Therapeutic Diet Prescribed By Physician

Corrective action for identified residents:

Resident #2, #6 and #7 had tray service corrected to match appropriate diet per spreadsheet and physician orders.

How other residents with the potential for deficient practice identified:

All residents with therapeutic diets were reviewed and meal service was corrected to match meal spreadsheet and physician orders.
<table>
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|       | Review of her medical record revealed the resident's glycosylated hemoglobin (HgbA1c - a three month average of blood sugars) was within normal limits. Her nutritional status care plan dated 2/1/09 specified interventions to ensure the resident received adequate nutrition included a therapeutic diet as ordered. Observations made on 7/13/11 at 12:10 p.m. revealed Resident #2 was served lunch in her room. The meal included a four (4) ounce pudding cup. Later at 12:25 p.m. the resident was interviewed and reported she ate what she was served including the pudding on her lunch tray. On 7/13/11 at 12:30 p.m. the Dietary Manager (DM) was interviewed and reported dietary aides were trained to review the day's menu for meal preparation and service to residents. He reported that menus utilized by the dietary staff did not specify portion sizes. The DM reviewed the menu spreadsheets that coordinated with the 7/13/11 lunch meal service and confirmed the spreadsheet specified "CHCF" dieters were to be served a ⅔ cup (two ounce) portion of pudding. He stated he did not realize there was a difference between therapeutic diet portion sizes and the non-therapeutic diet portion sizes. He stated the diabetic residents, including Resident #2, should not have received a four (4) ounce serving of pudding during the lunch meal of 07/13/11. 2. Resident #6 was admitted to the facility on 9/18/10 with diagnoses that included diabetes. The most recent Minimum Data Set (MDS) dated 3/23/11 specified the resident had no cognitive
<table>
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<tr>
<th>F 367</th>
<th>Systematic changes made to ensure deficient practice does not reoccur:</th>
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<tr>
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<td>In-service for all staff regarding tray condiments matching diet orders; CCHF diet condiment requirements; review of diet manual and following correct portions. Dietary manager reviewed Meal Tracker program and corrected all dessert items to match spreadsheet. Dietary Manager or designated employee will complete daily monitoring and spot check of correct items on meal trays prior to leaving kitchen.</td>
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**Facility monitoring process:**

Dietary Manager or designated employee will complete daily monitoring and spot check of correct items on meal trays prior to leaving kitchen. Dietary manager will monitor weekly for a month and monthly for 3 months and then quarterly for one year to insure continued compliance and report to the QA&A.
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Impairment and received a therapeutic diet. Review of the medical record revealed physician's orders dated 9/18/10 that revealed Resident #6 should receive a "CCHO (consistent carbohydrate) low salt diet." The physician orders also revealed Resident #6 was ordered to have sliding scale insulin (SSI) and scheduled insulin for diabetes. Review of Resident #6's medical record revealed the resident's glycosylated hemoglobin (HgbA1c - a three month average of blood sugars) was high. Resident #6's nutritional status care plan dated 9/30/10 specified the resident was to receive a therapeutic diet as ordered for adequate nutrition.

On 7/13/11 at 12:17 p.m. Resident #6 was served her lunch meal in her room that included a four (4) ounce cup of pudding which she ate.

On 7/13/11 at 12:30 p.m. the Dietary Manager (DM) was interviewed and reported dietary aides were trained to review the day's menu for meal preparation and service to residents. He reported that menus utilized by the dietary staff did not specify portion sizes. The DM reviewed the menu spreadsheets that coordinated with the 7/13/11 lunch meal service and confirmed the spreadsheet specified "CCHO" diets were to be served a ¼ cup (two ounce) portion of pudding. He stated he did not realize there was a difference between therapeutic diet portion sizes and the non-therapeutic diet portion sizes. He stated the diabetic residents, including Resident #6, should not have received a four (4) ounce serving of pudding during the lunch meal of 07/13/11.

3. Resident #7 was admitted to the facility on
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6/22/10 with diagnoses that included diabetes and hypertension among others. The most recent Minimum Data Set (MDS) dated 3/2/11 specified the resident had moderate cognitive impairment. Review of Resident #7’s medical record revealed physician’s orders dated 6/22/11 for Resident #7 to receive an “1800 ADA (American Diabetic Diet) CCHO (consistent carbohydrate) high fiber diet.” Further review of the physician’s orders revealed the resident was ordered to receive sliding scale insulin (SSI) and scheduled insulin for diabetes. Review of recent laboratory values revealed the resident’s average blood sugar (glycosylated hemoglobin) was within normal limits. The resident’s nutritional status care plan dated 7/9/10 specified he was to receive a therapeutic diet as ordered for adequate nutrition.

On 7/13/11 at 12:20 p.m Resident #7 was served his lunch tray that included a four (4) ounce cup of pudding which he ate.

On 7/13/11 at 12:30 p.m the Dietary Manager (DM) was interviewed and reported dietary aides are trained to review the day’s menu for meal preparation and service to residents. He reported that menus utilized by the dietary staff did not specify portion sizes. The DM reviewed the menu spreadsheets that coordinated with the 7/13/11 lunch meal service and confirmed the spreadsheet specified “CCHO” diets were to be served a ¾ cup (two ounce) portion of pudding. He stated he did not realize there was a difference between therapeutic diet portion sizes and the non-therapeutic diet portion sizes. He stated the diabetic residents, including Resident #7, should not have received a four (4) ounce
<table>
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 367</td>
<td>Continued From page 4 serving of pudding during the lunch meal of 07/13/11.</td>
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<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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