STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285204	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL HAVEN	**424 HARRISON BEEMER, NE 68716**

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E 0039 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct testing and exercise requirements.** Based on interview and record review; the facility staff failed to include documentation of any table top or actual emergency exercises in the facility Emergency Preparedness Plan and the facility failed to participate in a collaborative and cooperative planning efforts based full scale exercise. This had the potential to affect all of the facility residents. The facility identified a census of 27 and the sample size was 16. Findings are: Record review of the facility Emergency Preparedness Plan revealed that the plan did not include documentation of any participation in a community based full scale exercise or tabletop exercises to test the emergency plan. Interview on 3/5/20 at 2:55 PM with facility Administrator confirmed that the facility had not participated in any community based full scale exercise, had not participated in a second exercise and had not conducted a tabletop exercise to test the emergency preparedness plan to ensure it was operational.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09D7 Based on observations, record review and interviews; the facility failed to implement interventions to prevent potential aspiration for Resident 8 and to assess causal factors and develop and/or revise interventions to prevent ongoing falls for Resident 6. The sample size was 6 and the facility census was 27. Findings are: A. Frazier Free Water Protocol (process which allows a person to safely drink small amounts of regular water when they have been placed on a thickened liquid diet to help prevent potential dehydration) dated 10/23/19 revealed when a resident had a swallowing disorder it placed them at risk for aspiration pneumonia, a type of pneumonia which can occur if food or liquid gets into the lungs. The following steps were identified related to the protocol: -mouth care was to be completed in the mornings, before and after meals and snacks, before drinking water and before going to bed; -mouth cares consisted of brushing teeth and then rinsing with Perox-a-Mint (peroxide based mouthwash); -allowed to drink water any time before meals and 30 minutes after meals; -never to take medications with water. Medications were to be taken in pudding, applesauce or thickened liquids; -must drink thickened liquids at meals; and -cues and supervision were recommended when drinking water. B. Review of Resident 8's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 12/11/19 revealed [DIAGNOSES REDACTED]. Review of a Nursing Progress Note dated 8/1/19 at 6:10 PM revealed the resident had a moist, productive cough. Review of a Nursing Progress Note dated 8/3/19 at 6:27 AM revealed the resident was not acting right with slurred and garbled speech. The resident indicated something is wrong. The resident was transferred to the emergency room for evaluation. Review of a Progress Note dated 8/3/19 at 2:19 PM revealed the resident was admitted to the hospital for possible pneumonia. Review of a Plan of Treatment for Outpatient Rehabilitation dated 8/7/19 revealed an evaluation was completed by the Speech Therapist due to dysphagia (difficulty swallowing) and recent hospitalization with aspiration pneumonia. Recommendations were made for the resident to have a mechanical soft diet with thickened liquids and to utilize the chin tuck (maneuver in which, just before swallowing, a person drops the chin to or toward the chest to help with the delay in the swallowing trigger) when drinking fluids. Review of the resident's current Care Plan dated 9/5/19 revealed the resident was hospitalized for [REDACTED]. The resident was at nutritional risk related to [DIAGNOSES REDACTED]. The resident was at risk for dehydration due to order for thickened liquids. The following interventions were identified: -monitor for signs of dehydration; dry skin, concentrated urine, constipation and dry lips; -provide set-up assist and cues with oral cares: -nosey cups (an adapted drinking cup with a u-shaped cut out on one side. This special cut out provides space for the nose, allowing the user to tilt the cup for drinking without bending the neck or tilting the head) for thickened liquids; and -mechanical soft diet. Review of a Plan of Treatment for Outpatient Rehabilitation dated 10/2/19 revealed the resident was evaluated by the Speech Therapist due to the resident's desire to have the thickened water discontinued. Resident received therapy through 11/6/19. The resident was unable to utilize the chin tuck despite reminders and demonstrated an immediate cough when chin tuck was not used. Recommendations received to continue the mechanical soft diet and thickened liquids with chin tuck. Review of a Progress Note dated 3/4/20 at 5:42 AM revealed the resident had a non-productive cough with congested lung sounds which were diminished at the bases. During an observation on 3/4/20 at 11:11 AM, a copy of the Frazier Free Water Protocol was posted on the closet door of Resident 8's room. The protocol identified the resident had a swallowing disorder and was at risk for aspiration. During an observation of Resident 8's room on [DATE] at 8:45 AM, a Styrofoam cup which contained approximately 150 cubic centimeters (cc) of regular unthicken water was positioned on a bedside table in the resident's room. During an interview on [DATE] at 10:18 AM, Nurse Aide (NA)-E confirmed the following: -the resident was currently on the Frazier Free Water Protocol; -according to the protocol, the resident was able to have regular water between meals but the resident was to complete oral cares before and after drinking the water which including brushing teeth and rinsing with a peroxide based mouthwash; -the resident had episodes of confusion and was not always able to follow directions; -the resident did not have a peroxide based mouthwash available in the resident's room for oral cares; -staff were currently not assisting the resident with oral cares or providing set-up assistance; -staff only provided the resident with thickened water in the resident's room; and -staff were not providing the resident with any supervision with drinking the unthicken water. During an interview on [DATE] at 10:55 AM the Director of Nursing confirmed staff were to assist the resident with oral cares and to provide supervision when drinking the regular water to prevent potential aspiration. C. Review of Resident 6's MDS dated [DATE] revealed the resident had severe cognitive impairment with [DIAGNOSES REDACTED]. The resident required extensive assistance of 2 staff with transfers, bed mobility, dressing, toilet use and personal hygiene and was frequently incontinent of bowel and bladder. Review of a Nursing Progress Note dated [DATE] at 2:53 PM revealed the resident was admitted from the hospital after surgical repair of fractured left hip. Review of a Nursing Progress Note dated [DATE] at 6:15 PM revealed the resident was found in the dining room, lying on the resident's back on the floor. The resident complained of pain to back and to the left hip. Review of a Resident Incident Report and a Post-Fall assessment dated [DATE] at 7:00 PM revealed the resident attempted to stand independently from wheelchair and fell . The following fall prevention interventions were initiated: -pummel cushion (cushion which has an upward-projecting protuberance at its front part which helps prevent a resident from slipping down on the seat) to the seat of the resident's wheelchair; -sensor alarm (an electronic pressure sensitive sensor pad designed for use in chairs or beds which will alarm if a resident tries to get up without assistance) to bed and to wheelchair; -hi/low bed; -staff to anticipate the resident's needs; and -fall mat to the floor next to the resident's bed. Review of a Progress Note dated [DATE] at 11:55 PM revealed the resident crawled out of bed onto the floor. The resident was assisted up off the floor and back into bed. Review of a Nursing Progress Note dated [DATE] at 11:56 PM revealed the

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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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) resident crawled out of bed and onto the floor again. The resident was very incontinent. review of the resident's medical record revealed [REDACTED]. Review of a Nursing Progress Note dated 1/29/20 at 8:34 PM revealed the resident rolled out of bed and obtained a skin tear to the resident's left forearm. review of the resident's medical record revealed [REDACTED]. Review of a Nursing Progress Note dated 2/12/20 at 8:22 PM revealed the resident's sensor alarm was sounding. Resident 6 was found on the fall mat which was on the floor next to the resident's bed. review of the resident's medical record revealed [REDACTED]. Interview with Registered Nurse (RN)-D on [DATE] at 8:26 AM confirmed staff had been trained to assess causal factors after each resident fall. The staff were to then review current interventions and revise as needed, or develop new interventions in an effort to prevent ongoing falls.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D8 Based on observations, record review and interviews; the facility failed to evaluate weight loss, to develop and/or revise interventions to prevent ongoing weight loss and to ensure nutritional interventions were implement for 6 (Residents 3, 6, 10, 12,14 and 227) of 6 sampled residents. The facility census was 27. Findings are: A. Review of a facility policy titled Weight Loss/Gain (revised 9/10/18) revealed the following procedures to be followed in an attempt to improve the weight status of residents: -residents to be weighed on admission to obtain a baseline; -residents to be weighed at least monthly or as ordered by the physician when the residents received their baths. Residents were to be weighed on the same scale to prevent any variations; -an unanticipated weight loss/gain of 3 pounds (lbs.) in 1 month or daily was to be documented on a Speed Note and given to the Charge Nurse. The resident was to be a reweigh in 24 hours and the physician was to be notified; -a copy of the Speed Note was to be given to the Dietary Manager (DM) and the Director of Nursing (DON) for follow-up; -significant weight loss/gain was identified as a 3 lb. loss in 1 month or daily if ordered, a gain or loss of 5 percent (%) in 30 days, a gain or loss of 7.5 percent in 90 days and a gain or loss of 10% in 180 days; -Weight Loss/Gain Committee consisting of the DON, DM and the Registered Dietician (RD) were to address weight loss/gain on a monthly basis or earlier if required and would then determine a plan of care; and -if deemed a significant weight loss/gain the RD was to assess and make recommendations as needed and would then notify the physician. B. Review of Resident 14's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 1/1/20 revealed following: -severe cognitive impairment; -[DIAGNOSES REDACTED]. with no nutritional approaches identified. Review of Resident 14's current Care Plan dated 7/9/19 revealed the resident was at nutritional risk due to need for a therapeutic/mechanical diet with nectar thick liquids and need for assistance at meals. The following nutritional interventions were identified: -1/24/20 puree diet with nectar thick liquids; -monitor meal and fluid intakes at each meal; -offer/provide a snack when resident awakens in the morning; -seated at an assisted table so that assist, supervision and encouragement can be provided as needed; -120 milliliters (ml) of Med Pass (nutritional supplement with added calories) with chocolate syrup offered 3 times a day; and -resident allowed to sleep late in the mornings due to behaviors. Noon and evening meals eaten in the dining room. Review of the resident's Weight Change History report revealed the following: -12/11/19 weight was 160 lbs. -1/17/20 weight was 162 lbs. -1/24/20 weight was 156 lbs. (down 6 lbs. or a 4 % weight loss in 1 week). Review of a Dietician Progress Note by the RD dated 1/28/20 at 9:29 AM revealed the resident had returned from a recent hospitalization with a [DIAGNOSES REDACTED]. Current diet identified as regular, puree texture with nectar thick liquids. Meal intakes were 25-75 % with staff assistance. Resident was not getting up for breakfast but had an order for [REDACTED]. Review of the resident's Weight Change History report revealed the resident's weight on 2/12/20 was 152 lbs. (down 10 pounds in 1 month or a 6% loss). The resident's weight on 3/4/20 was 153 lbs. (up 1 lb. in 1 month). Review of Resident 14's Meal Intakes for 2/1/20 to 2/29/20 revealed the following: -no documentation of the breakfast meal intake for 2/3/20 and on 2/19/20. The remainder of the breakfast meal intakes revealed the resident consumed 0%; -noon meal the resident consumed 0% on 2/5, 2/11, 2/14, and 2/15 (4 out of 29 days) and 25% on 2/2, 2/3, 2/4, 2/6 through 2/12, 2/17, 2/19, 2/21, 2/23, 2/25 and 2/26 (16 out of 29 days); and -evening meal the resident consumed 0% on 2/1 and 25% on 2/2, 2/4, 2/6, 2/15, 2/20, 2/24 and 2/29 (7 out of 19 days). Review of Resident 14's medical record revealed no evidence the RD assessed Resident 14 after the resident's 10 lb. weight loss on 2/12/20 and the resident's poor dietary intakes. In addition, there was no documentation to indicate additional nutritional interventions were developed despite the resident's ongoing weight loss. Review of Resident 14's Meal Intakes for 3/1/20 to [DATE] revealed the resident consumed 0% of the breakfast meals; 0 % of the noon meal on 3/9 and 25% of the noon meal on 3/2, and on 3/4 and 25% or less of the evening meal on 3/1, 3/5 and 3/6. During an observation on 3/4/20 at 11:42 AM, Resident 14 was seated at an assisted table in the dining room. The resident was served a puree diet which consisted of ham, a corn casserole, green beans and a dessert. Nursing Assistant (NA)-B was seated at the table, but did not provide Resident 14 with assistance or cues to continue eating. The resident ate less than 25% of the meal. Observations on [DATE] from 11:15 AM to 12:30 PM revealed the following: -11:15 AM NA-E and Medication Aide (MA)-F assisted Resident 14 up and out of bed; -11:35 AM the resident was assisted out to the dining room and positioned at a table; -12:04 PM the resident was served puree diet which consisted of ham balls, macaroni and cheese, green beans and a pear upside down cake. In addition, the resident was served an 8 ounce glass of thickened water and the resident's Med Pass nutritional supplement; -12:30 PM the resident drank all of the Med Pass supplement but consumed only bites of the resident's meal. No staff was seated next to the resident to provide assist, cues or encouragement to continue eating. During an interview on [DATE] at 1:30 PM, Registered Nurse (RN)-D confirmed the following: -resident has been care planned to allow to sleep until 11:00 AM or later to decrease behaviors; -the resident's Med Pass nutritional supplement is given to the resident when the resident is assisted out of bed and if it is late, the resident is offered the nutritional supplement at the noon meal; -the resident does require increased assistance and cues with dietary intakes due to declining health status. Interview with the RD on 3/10/20 at 11:19 AM confirmed the RD was unaware of the resident's 10 lb. weight loss from 1/17/20 to 2/12/20. The RD had not evaluated the resident, and had not revised or developed new interventions for the resident, despite the resident's weight loss. C. Review of Resident 6's MDS dated [DATE] revealed the resident had severe cognitive impairment with [DIAGNOSES REDACTED]. The resident required limited staff assistance with intakes and had a weight of 114 lbs. Review of the resident's Weight Change History report revealed the following: -[DATE] the resident's weight was 128 lbs. -12/5/19 the resident's weight was 122 lbs. -12/10/19 the resident's weight was 120 lbs. Review of a Dietary Progress Note dated 12/10/19 at 9:17 AM by the RD revealed the resident was a new admission. The note indicated the resident required supervision with meal intakes and the resident made frequent attempts to leave the table during meals. The resident's current body weight was 128 lbs. and the resident was consuming 25-100% of food at meals. No recommendations were identified even though the resident was down 8 lbs. or had a 6% weight loss in 1 week. Review of the resident's current Care Plan dated 12/16/19 revealed the resident was at risk for impaired nutritional status due to [DIAGNOSES REDACTED]. The following interventions were identified: -meal and fluid intake to be record each meal; and -provide cues and assist as needed with dietary intakes, resident seated at an assist table. Review of the resident's Weight Change History report revealed the resident's weight on 1/1/20 was 112 lbs. (down 16 lbs. in 1 month or a 12.5% weight loss). Review of a Dietary Progress Note by the Registered Dietician dated 1/6/20 revealed a new recommendation to fortify the resident's meals and to provide with an afternoon snack. Review of a Dietary Progress Note dated 1/14/20 (8 days after recommendation was made by the RD) at 6:28 AM revealed a new order for the resident's meals to be fortified and for the resident to receive a Magic Cup (nutritional supplement with added calories and nutrients) in the afternoons. Review of an Acceptance % of Planned Dietary Intervention Record for 1/14/20 to 1/31/20 revealed the resident was provided with the Magic Cup nutritional supplement on 1/14, 1/16, 1/24, 1/25, 1/26, 1/27 and on 1/30 (7 out of 18 days). Review of an Acceptance % of Planned Dietary Intervention Record for 2/2020 revealed the resident received the Magic Cup nutritional supplement on 2/1, 2/2, 2/4, 2/6, 2/16, and on 2/28 (6 out of 29 days). Review of the resident's Weight Change History report revealed the resident's weight on 2/12/20 was 111 lbs. and on 2/25/20 the resident's weight was 114 lbs. Review of an Acceptance % of Planned Dietary Intervention Record for 3/1/20 to 3/5/20 revealed the resident received the Magic Cup nutritional supplement on 3/3 and on 3/4. Interview with the DM on [DATE] at 1:17 PM confirmed the following: -Resident 6 had a weight loss of 16 pounds in one month; -1/6/20 the RD made a recommendation to fortify the resident's meals and for a Magic Cup nutritional supplement in the afternoons. These weight loss interventions were not initiated until 1/14/20 (8 days later); and -staff failed to document the Magic Cup nutritional supplement was offered to the resident every afternoon at 3:00 PM as a weight loss intervention. D. Review of Resident 3's MDS dated [DATE] revealed the resident weighed 216 pounds. Review of Resident 3's Care Plan

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) dated 12/3/19 revealed the resident was at nutritional risk with a history of nausea and vomiting and the need for a soft diet with a goal to eat at least 50% of meals. Interventions included the following: -mechanical soft foods; -preference for fruit rather than desserts; and -Crystal Light (a sugar free beverage) at lunch and supper. Review of Resident 3's Weight Change History revealed: -a weight on 12/29/19 of 232 pounds; -a weight on 1/22/20 of 225 pounds; and -a weight on [DATE] of 215 pounds. Review of Resident 3's Dietitian Notes revealed: -On 11/26/20 Resident 3's weight was 230 pounds, diet was regular mechanical soft with small portions and Crystal Light, meal intake was 25-100%, and no new recommendations were made. -On 12/12/19 the RD spoke with Resident 3 and provided education related to excessive use of salt, the potential impact on the resident's health status, and made a recommendation to use a salt substitute. - On 3/2/20 Resident 3's weight was 215 pounds, diet was regular mechanical soft with small portions and Crystal Light, meal intake was 25-50%, the dietitian would continue to follow, and no recommendations were made. Observations of Resident 3 revealed: -On 3/4/20 at 12:20 PM Resident 3 was seated in the dining room and ate a bite of meat, a dish of pears, and drank a cup of coffee. -On [DATE] at 9:06 AM Resident 3 was seated in the dining room and ate 1 piece of toast, a dish of peaches, and drank a glass of orange juice, a cup of coffee, and sips of water. -On [DATE] at 12:55 PM Resident 3 was seated in the dining room and ate a bite of meat, a dish of mixed fruit, and drank glass of cranberry juice and a cup of coffee. -On 3/10/20 at 8:29 AM Resident 3 was seated in the dining room and ate 2 pieces of toast, and drank a glass of juice and a cup of coffee. An Interview with the RD and DON on 3/10/20 at 11:30 AM confirmed that Resident 3 lost 17 pounds (7%) from 12/29/19 through [DATE], had a documented decline in dietary intake, and no nutritional interventions were implemented. E. Review of Resident 10's MDS dated [DATE] revealed the resident weighed 195 pounds, had a [MEDICAL CONDITION] disorder, an intellectual disability, and had severe cognitive impairment. Review of Resident 10's Care Plan dated 9/16/19 revealed the resident was at nutritional risk due to a swallowing problem and cognitive impairment with a goal to maintain weight between 218 and 222 pounds. Interventions included the following: -regular diet (cut up meat before serving), -weight to be obtained per facility policy, -record meal and fluid intake, -fortified meals (added 12/15/19), and - Med Pass (high calorie and protein supplement) 90 ml 2 times daily (added 1/29/20). Review of Resident 10's Weight Change History revealed: -a weight on 9/5/19 of 220 pounds, -a weight on 10/9/19 of 206 pounds, -a weight on 11/6/19 of 198 pounds, and -a weight on 12/18/19 of 191 pounds. Review of Resident 10's Dietitian Notes revealed: -On 11/26/19 a present weight of 195 pounds, resident improvement with adjustments in [MEDICAL CONDITION] medications, dietary intake of 50-100% of meals with assistance, a plan to continue following resident weights/intakes, and no recommendations for nutritional interventions. -On 12/15/19 a present weight of 195 pounds, mechanical soft diet, dietary intake of 50-100%, and a recommendation to fortify meals. An Interview with the RD and DON on 3/10/20 at 11:30 AM confirmed that Resident 10 lost 25 pounds (11%) from 9/5/19 through 12/15/19 and a dietary intervention was not implemented until 12/15/19. F. Review of Resident 12's MDS dated [DATE] revealed the resident weighed 132 pounds and required supervision with eating. Review of Resident 12's Care Plan dated 12/19/19 revealed: the resident was at nutritional risk with a goal to maintain weight within a range of 130-135 pounds. Interventions included the following: -fortified meals, -thin liquids, -weight to be obtained per facility policy, -record meal and fluid intake, -nutritional supplements as ordered (added 2/4/20), -medication for appetite stimulant (added 2/10/20), and -the resident declined nutritional supplements, alternate menu items, and resident's stated preferences (undated). Review of Resident 12's Weight Change History revealed: -a weight on 12/9/19 of 137 pounds, -a weight on 1/9/20 of 125 pounds, and -a weight on 1/31/20 of 118 pounds. Review of Physician order [REDACTED]. Cup 2 times a day, and for [MEDICATION NAME] (medication that stimulates appetite) 800 milligrams daily. Review of Dietitian Notes revealed: -On 12/12/19 Resident 12 voiced a displeasure regarding an altered consistency (pureed food and thickened liquids) diet, denied swallowing problems, and requested normal consistency foods and fluids. Recommendations were made for fortified meals, a Magic Cup 2 times daily, and further consultation with the Speech Language Pathologist (SLP) to determine safety with an advanced diet, -On 12/18/19 the resident's diet was upgraded to a regular consistency food and fluids, -On 1/23/20 a recommendation was made for a 3 day trial of Med Pass 90 ml 2 times daily, -On 1/27/20 a recommendation was made to trial 206 juice (high calorie juice supplement) due to resident refusing Med Pass, -On 1/30/20 a recommendation to continue to offer meal alternatives and start a soft cookie and juice daily at 3:00 PM, and -On 2/4/20 a recommendation to start Ensure 1 can 2 times a day. An Interview on 3/10/20 at 11:30 AM confirmed Resident 12 was started on supplements within 3 days of admission, however the resident refused the Magic Cup, had an average dietary intake of less than 25% of fortified meals, and lost 19 pounds (13%) between 12/9/19 and 1/31/20. Additional dietary supplements were not implemented until 2/4/20. G. Review of Resident 227's current Care Plan revealed the resident was admitted to the facility following a [MEDICAL CONDITION]'s left hip while living at home. Review of Resident 227's Weight Change History revealed: - On 2/19/20 the resident weighed 154 pounds - On 2/21/20 the resident weighed 150lbs - On [DATE] the resident weighed 148lbs - On 3/3/20 the resident weighed 146lbs (a loss of 8lbs or 5.19% in 13 days) Review of a Progress Note dated 3/10/20 at 9:09 AM revealed Resident 227's current weight on 3/10/20 was 143lbs (a loss of 11lbs or 7.14% in 20 days). Interview with the RD on 3/10/20 at 10:33 AM confirmed the resident's current weight when checked on 3/10/20 was 143lbs. The RD was unaware that Resident 227 was admitted at 154lbs but rather was given information of the resident's starting weight being 150lbs. The RD stated weights were provided from the facility on a paper form as the RD did not have access to the weights in the electronic medical record. The RD confirmed the resident did not have any additional weigh loss prevention interventions put into place (as the supplements the resident took were also taken at home). The RD confirmed the process of looking at weigh loss needed revised.