facility monitored the effects of interventions and modified the approaches as indicated. For compliance with F501, the policy affects enhancement in an indirect way via establishment of clinical practice guidelines as bases for resident care policies that the medical director would help develop, review, and implement for the facility.
Conclusion/Discussion: In a nursing home with non-academic interdisciplinary staff, the medical director should seek collaboration in institutionalization of Resolution A06 since such cooperation could increase the medical director's contributions to education and policies that enhance the facility's compliance with F501 as a single requirement and as an adjunct to other regulations (e.g., F309 for pain).
Disclosures: All authors have stated there are no disclosures to be made that are pertinent to this abstract.

Complications of Megestrol acetate in a Nursing Home Resident

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Introduction/Objective: Weight loss in Nursing Home (NH) residents is often multifactorial. Management usually involves evaluation and interventions by multiple health professionals. However the morbidity, mortality and the regulations associated with weight loss often push clinicians to consider the option of drug therapy. We report a case of Megestrol acetate (MA) use in a NH resident associated with potentially life threatening complications.
Design/Methodology: Case
Results: 63 year old male NH resident with adult polycystic kidney disease, s/p stroke, s/p subarachnoid aneurysm clipping, seizure, end stage renal disease on hemodialysis lost 36 lbs over three months with no clear etiology after evaluation; MA was started to improve appetite. Three weeks later, he began to develop recurrent episodes of hypotension during dialysis and was unable to tolerate the procedure. Physical examination was remarkable only for an old right hemiparesis and hemodialysis catheter. There was no obvious source of infection. ACTH stimulation test revealed baseline cortisol level <1(5-25 μg/dl) and 30 minute cortisol level was 14, consistent with secondary adrenal insufficiency (SAI). Physiologic cortisol replacement was started, MA was discontinued and steroids were tapered over a period of 10 weeks.
There was transition of care to another medical team. Though his weight remained stable, patient had BMI of 17, therefore MA was started. Four weeks later, he developed hypotensive episodes again. A thorough history revealed SAI. MA was tapered and he is currently being weaned off steroids.
Conclusion/Discussion: MA is a synthetic progestin approved by the FDA in 1993 for treatment of significant weight loss, anorexia and cachexia in patients with HIV/AIDS and cancer. The mechanism by which it improves appetite and weight is unclear. There is sparse data from clinical trials to support the use of MA in elderly patients. MA should be titrated up from the lowest possible dose (160-2400 mg/day) as higher doses are associated with greater incidence of adverse reactions. Side effects include adrenal suppression, Cushing's syndrome, glucose intolerance, osteoporosis and thrombo-embolic events. MA binds to glucocorticoid receptors with twice the affinity of cortisol and suppresses the pituitary-adrenal axis. If MA needs to be discontinued, it must be tapered slowly as abrupt withdrawal can lead to significant adrenal insufficiency. This case illustrates a serious side effect of MA. Given the paucity of clear evidence for the benefits of this drug in the elderly, clinicians should exercise caution while prescribing MA.
Disclosures: All authors have stated there are no disclosures to be made that are pertinent to this abstract.

Complying with Regulatory Requirements for Medical Directors in the Nutrition Care of Nursing Home Residents

Presenting Author: *Linda Handy, MS, RD, Handy Dietary Consulting*
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Introduction/Objective: How fictional characters (Medical Director and Interdisciplinary Team) in 3 Nursing Homes determine survey compliance and quality improvement systems, and subsequent consequences. This is based upon a training manual for practical application of regulatory requirements: Surveyor MO for Nutritional Status (Regulation F 325), 2009.
Design/Methodology: Regulation F 325: Detailed evaluation of how a facility maintains nutritional status, including individuals who should participate in assessment of nutritional status, related causes, & consequences (including Attending Physicians) to:
a. Help define nature of nutritional problems & identify causes such as anorexia & weight loss
b. Taylor interventions to the resident's specific causes & monitor continued relevance of those interventions
c. Increase quality of life through liberalizing dietary restriction & establishing guidelines (education & monitoring) for resident who refusal dietary restrictions

Regulation F 501: Evaluation of surveyor's interpretive guidance & deficiency decision making for roles of the Medical Director which include: Assisting in development & implementation of clinical practice guidelines in nutrition (based on current standards of care), intervening on behalf of resident with nutritional &/or fluid issues, & responding to surveyor questions during survey.
Regulation F 385: Identification of Medical Director's role in monitoring & supervising Attending Physician to:
a. Ensure assessment & development of treatment regimens relevant to tube feeding, nutritional management, or hydration issues (using current standards of practice or 'best clinical practice guidelines' such as AMDA's CPG for Altered Nutrition and Hydration)
b. Respond appropriately to change of condition & decline
c. Identifying need for & continuing use of medication related to nutrition interventions (e.g., appetite, depression, supplementation), identifying & addressing adverse consequences related to medications (e.g., altered taste, dry mouth, lethargy, nausea, confusion), & lab monitoring for medications

Regulation F 386: Identification of Medical Director's role in monitoring & supervising Attending Physician to:
a. Review resident's total program of nutrition care including beneficial & adverse effects of medications & treatment
b. Provide relevant progress note at each visit

Results: An immediate jeopardy was called in Regulation F 325 Nutritional Status during the survey in one of the nursing homes where Medical Director's role was minimal. Lack of identifying & implementing best practice guidelines & policies was identified. Lack of coordinating medical staff to ensure nutritional status of resident was maintained. This contrasts with a nursing home where the role of the Medical Director met intent of regulations with effective collaboration & leadership.
Conclusion/Discussion: The Medical Director has a vital role in regulatory compliance by helping a facility identify, evaluate, and address/resolve clinical concerns and issues that: a) Affect resident nutrition care, medical care or quality of life; and b) Are related to provision of those services by physicians and other licensed health care practitioners.
Disclosures: Linda Handy, MS, RD has stated there are no disclosures to be made that are pertinent to this abstract.

Demographics and Acute Medical Needs of Assisted Living Facility Residents

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Introduction/Objective: Background. Increasing numbers of older adults live in assisted living residences (ALRs). Primary care medical practices focusing on the care of older adults who dwell in ALR are developing to meet these patient's special needs. To our knowledge, the types of patients in an ALR medical practice and the use of acute medical care by ALR dwellers have not been previously characterized. Objectives: To characterize the patients participating in an ALR primary care program and their use of acute medical care services.
Design/Methodology: This study was a retrospective chart review of patients enrolled in the Strong Health Geriatrics Group ALR program between October 1, 2008 and March 31, 2009. Strong Health Geriatrics Group ALR