STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055557	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREEKSIDE CARE CENTER	**35253 AVENUE H YUCAIPA, CA 92399**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure when the facility did not update the weight of one of the three sampled residents (Resident A) the week after Resident A's admission. This failure could have resulted to more weight loss and improper interventions applied to the care of Resident A. Findings: An unannounced visit was conducted on November 14, 2019 to investigate a complaint regarding quality of care. A record review of the Admission Record for Resident A, indicated the facility admitted Resident an on September 24, 2019 with [DIAGNOSES REDACTED]. The record also indicated Resident A was discharged on [DATE] to (name of general acute care hospital). A record review of the Weight Summary for Resident A, indicated Resident A weighed 135 pounds (lbs.) on September 25, 2019. The report indicated no other weigh done for Resident A. During an interview with the Director of Nursing (DON) on November 14, 2019 at 3:57 PM, the DON stated weight should be taken weekly from admission for four weeks, then monthly afterwards. She stated that this is their policy. The DON stated only one weight was recorded for Resident A for his admission, which was 135 lbs. She stated another weight should have been taken the week after Resident A was admitted . A record review of the Dietary Nutritional Assessment for Resident A, dated October 2, 2019, indicated his admission weight was 121 lbs. (which was different from the 135 lbs. recorded on the Weight Summary on September 25, 2019, the day after his admission to the facility). The report indicated the current weight for Resident A was 135 lbs. The section of the report, Summary of Resident Interview, indicated .RNA (resident nursing assistant) weighing today for weekly wt. (weight) . The indicated Resident Goals was stable weight or slow weight gain. During a concurrent record review of the Dietary Nutritional Assessment for Resident A, dated October 2, 2019, and telephone interview with the Director of Nursing (DON 2) on July 15, 2020 at 10:07 AM, DON 2 stated if Resident A's weight was taken on October 2, 2019 as mentioned on the nutritional assessment report, it was not recorded in their system and not addressed by the RD (registered dietician). DON2 stated the entered weight of 121 lbs. as admission weight on the Dietary Nutritional Assessment for Resident A, doesn't seem right. DON2 stated the admission weight recorded on September 25, 2019 was 135 lbs. During a concurrent record review of the Dietary Nutritional Assessment for Resident A, dated October 2, 2019, and telephone interview with the Dietary Manager (DM) on July 15, 2020 at 10:15 AM, the DM stated she creates the resident's dietary profile, so she (RD) can go over when she is here. The DM stated she could not recall if she was the one who entered the weights on Resident A's Dietary Nutritional Assessment. The DM stated there was supposed to be another one taken after admission weight and there was none. A record review of the Triage (screening for urgency) Report of (name of general acute care hospital) for Resident A, dated October 8, 2019 at 1:03 PM, indicated Resident A's weight was 45 kilogram or 99 pounds (a loss of 36 pounds in two weeks). A record review of the facility's policy and procedure, Weight Assessment and Intervention, dated September 2008, indicated, .1. The nursing staff will measure resident weights on admission and weekly for four weeks thereafter .2. Weights will be recorded . in the individual's medical record. 3. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietician in writing. Verbal notification must be confirmed in writing .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE