STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676433	A. BUILDING _____ B. WING _____	**06/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MEDICAL RESORT AT WILLOWBROOK	**13220 BRETON RIDGE ST HOUSTON, TX 77070**

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 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status for 1 (Resident #4) of 5 residents reviewed for nutrition. -The facility failed to reweigh Resident #4 after his weight showed a severe weight loss of 15.3% in 37 days. -The facility failed to monitor Resident #4's weight monthly. -The facility failed to communicate Resident #4's severe weight loss of 15.3% to the Nurse Practitioner and Dietitian. This failure could affect any resident who had severe weight loss and placed them at risk of declining health. Findings include: Resident #4 Record review of Resident #4's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #4's 5-day MDS assessment dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment. He required extensive assistance with one person for eating. He was 74 inches tall and weighed 251 pounds on admission. Record review of Resident #4's baseline care plan dated 4/25/20 revealed he was independent with eating and was on a regular diet. Record review of Resident #4's Weight Summary revealed Resident #4 weighed 251.4 pounds on 4/29/20 and 212.8 pounds on 6/5/20. Both weights were recorded by the ADON. There was no recorded weight for May 2020. Record review of Resident #4's progress notes revealed no contact with the doctor about the severe weight loss. Interview on 6/12/20 at 2:32 p.m. with the ADON, she said she took over weighing the residents 1 to 2 weeks ago. She said the previous DON was responsible for weights, but he no longer worked at the facility. She said the Dietitian would review the weights remotely. She said some residents were on daily weights for 14 days because there may have been a discrepancy with the scale or with the staff who were weighing the residents. Interview on 6/12/20 on 3:12 p.m. with the Administrator, he said he noticed weights were inconsistent. He said the previous DON took charge of the weights and as a result put certain residents on daily weights and assigned one CNA to weigh everyone for consistency purposes. He said the Dietitian was aware of the inconsistent weights. He said the weight inconsistencies had not been documented and they had not had a Quality Assurance meeting since March. Observation and interview on 6/12/20 at 4:04 p.m. of Resident #4, he was lying in bed in his room. He said he lost weight because he was eating light meals and did not eat heavy like he used to. He said he did get enough to eat. Interview on 6/12/20 at 4:07 p.m. with LVN S, she said Resident #4 went to the hospital on [DATE] and returned on 5/17/20. Interview on 6/12/20 at 4:12 p.m. with Resident #4's NP, she said the facility did not tell her that Resident #4 lost weight. She said they should have weighed him at least monthly and he may need a dietitian consult. She said his mentation had improved and she was not aware of any problems with meal intake. Telephone interview on 6/12/20 at 4:31 p.m. with the Dietitian, she said she was not sure what happened to Resident #4's missing May weight. She said she requested a reweigh for Resident #4 today. Interview on 6/12/20 at 4:43 p.m. with ADON, she said Resident #4 was reweighed and weighed 212 pounds. Telephone interview on 6/12/20 at 4:50 p.m. with the Dietitian, she said she was notified about resident weight loss today by the Corporate Nurse. Interview on 6/12/20 at 4:57 p.m. with the ADON, she said the online system did not alert her of Resident #4's significant weight loss when she inputted it. She said if there has been a significant weight loss she normally reweighs the resident and informs the Dietitian. She said the Dietitian could identify why they had weight loss and could offer supplements. She said she was responsible for weight monitoring but had recently been working on the floor due to nurses calling in. Record review of the facility's Weight Assessment and Intervention policy dated April 2012 read in part, .The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents . Weight Assessment: 1. The nursing staff will measure resident weights on admission, the next day. If no weight concerns are noted at this point, weights will be measure monthly thereafter .3. Any weight change of 5% or more since the last weight assessment will be retaken for confirmation . .

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.