STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056333	A. BUILDING _____ B. WING _____	09/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOUNTAIN VIEW CONV HOSP	13333 FENTON AVENUE SYLMAR, CA 91342

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the family of significant weight loss for one of three sampled residents (Resident 1). This deficient practice had the potential to result in responsible parties not being able to exercise their right to choose the desired plan of care for the resident. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated Resident 1 was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 3/7/20, indicated Resident 1 had the ability to make self understood and the ability to understand others. The MDS record indicated Resident 1 needed limited assistance to total dependence with activities of daily living (ADLs - term used in healthcare to refer to daily self-care activities). A review of Resident 1's Weights and Vitals Summary record indicated the following weights record: On 4/2/20, Resident 1 weighed 120 pounds (lbs - measurement of weight). On 5/6/20 , Resident 1 weighed 113 lbs. On 5/11/20, Resident 1 weighed 113 lbs. Resident 1 had a significant weight loss of 7 pounds or 5.8% in one month. During a concurrent interview and record review on 9/4/20, at 12:16 p.m., the Licensed Vocational Nurse 2 (LVN 2) stated for any significant weight variance, staff was to notify Resident 1's responsible party. LVN 2 confirmed there was no documented evidence that Resident 1's responsible party was notified. LVN 2 stated for any significant weight variance, the nurse was to notify the responsible party of the resident. A review of the facility's policy, revised 5/17, titled Change in a Resident's Condition or Status, indicated our facility shall promptly notify the resident, his or her attending Physician, and representative of changes in the resident's medical/mental condition and/or status. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive person-centered plan of care for weight loss, for one of three sampled residents (Resident 1). The deficient practice had the potential to result in inconsistent implementation of the care plan that may lead to a delay or lack of delivery of care and services. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 3/7/20, indicated Resident 1 had the ability to make self understood and the ability to understand others. The MDS record indicated Resident 1 needed limited assistance to total dependence with activities of daily living (ADLs - term used in healthcare to refer to daily self-care activities). A review of Resident 1's Weights and Vitals Summary record indicated the following weights with corresponding dates: On 4/2/20, Resident 1 weighed 120 pounds (lbs - measurement of weight). On 5/6/20, Resident 1 weighed 113 lbs. On 5/11/20, Resident 1 weighed 113 lbs. Resident 1 had a significant weight loss of 7 pounds or 5.8% in one month. During a concurrent interview and record review on 9/4/20, at 12:16 p.m., the Licensed Vocational Nurse 2 (LVN 2) stated for any significant weight variance, the staff were to develop a person-centered care plan. LVN 2 confirmed there was no documented evidence that Resident 1 had a person-centered care plan that was developed and implemented for Resident 1's weight loss. During an interview on 9/4/2020, at 1:17 p.m., the Director of Nursing (DON) stated the care plans were important guidelines to provide care to the residents. A review of the facility's policy, revised on 9/2008, titled Weight assessment and Intervention, indicated the nursing staff will measure resident weight on admission, the next day, and weekly for two weeks thereafter. The threshold for significant unplanned weight loss will be based on the following criteria: 1 month - 5% weight loss is significant; greater than 5% is severe; 3 months - 7.5% weight loss is significant; greater than 7.5% is severe; 6 months - 10% weight loss is significant; greater than 10% is severe. Care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the physician, nursing staff, the Dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. Individualized care plan shall address, to the extent possible: The identified cause of weight loss; Goals and benchmarks for improvement; and Time frames and parameters for monitoring and reassessment.
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 perform a Change of Condition (COC) assessment for severe weight loss, for one of three sampled residents (Resident 1). This deficient practice placed Resident 1 at risk for unsafe patient care and could lead to a delay in the ability to evaluate the appropriateness of the care delivered. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated Resident 1 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 3/7/20, indicated Resident 1 had the ability to make self understood and had the ability to understand others. The MDS record indicated Resident 1 needed limited assistance to total dependence with activities of daily living (ADLs - term used in healthcare to refer to daily self-care activities). A review of Resident 1's Weights and Vitals Summary record indicated Resident 1's corresponding weights and dates: On 4/2/20, Resident 1 weighed 120 pounds (lbs - measurement of weight). On 5/6/20 , Resident 1 weighed 113 lbs. On 5/11/20 , Resident 1 weighed 113 lbs. Resident 1 had a significant weight loss of 7 pounds or 5.8% in one month. During a concurrent interview and record review on 9/4/20 at 12:16 p.m., the Licensed Vocational Nurse 2 (LVN 2) confirmed there was no documented evidence that a Change of Condition assessment completed for Resident 1. LVN 2 stated for any significant weight variance the nurse was to complete a Change in Condition (COC) assessment. A review of the facility's policy titled Weight assessment and Intervention, revised on 9/2008, indicated the threshold for significant unplanned weight loss will be based on the following criteria: 1 month - 5% weight loss is significant; greater than 5% is severe; 3 months - 7.5% weight loss is significant; greater than 7.5% is severe; 6 months - 10% weight loss is significant; greater than 10% is severe. A review of the facility's policy, revised 5/17, titled Change in a Resident's Condition or Status, indicated our facility shall promptly notify the resident, his or her attending Physician, and representative of changes in the resident's

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) medical/mental condition and/or status. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions.