| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **055504** | A. BUILDING _____ B. WING _____ | **06/16/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **COUNTRY VILLA SOUTH CONV CTR** | **3515 OVERLAND AVENUE LOS ANGELES, CA 90034** |

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 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to review and revise the nutrition and hydration care plan (written guide that organizes information about the resident's care) to maintain an acceptable usual body weight or desirable body weight range for one of two sampled residents (Resident 1) who had weight loss. This deficient practice had the potential for Resident 1's nutritional needs not to be addressed. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A record review of Resident 1's weight logs indicated weight on 11/6/2019 was 96 pounds (lbs), on 2/2/2020 was 92 lbs, on 3/3/2020 was 87 lbs, on 4/1/2020 was 84 lbs, and on 5/1/2020 was 81 lbs. The log did not have a weight loss percentage calculation for 3 months and 6 months. A weight loss calculation for 3 months indicates a weight loss percentage of 4.16%. A weight loss percentage calculation for 6 months indicates a weight loss percentage of 15.6%. According to facility's weight log records, a greater than 10% weight loss in 6 months was deemed severe change. A review of the care plan for Nutrition and Hydration, dated 11/11/2019, indicated Resident 1 was at risk for weight loss, decreased food intake, and reported food intake less than 75 percent (%). The goals of the care plan indicated Resident 1 will achieve adequate nutritional intake of at least 75 percent each meal and Resident 1 will have no significant weight changes of 5% or more. A record review of Resident 1's Quarterly Minimum Data Set (MDS - a standardized assessment and screening tool), dated 2/12/2020, indicated the resident was severely impaired (never or rarely made decisions). The MDS indicated Resident 1 needed extensive assistance with one person assist with transfer, toilet use, and personal hygiene. The MDS indicated Resident 1 needed supervision with setup help for eating. During an interview on 5/11/2020 at 10:20 a.m., the Certified Nursing Assistant 1 (CNA 1) stated she charted meal intakes for Resident 1 and charting was accurate. CNA 1 stated that towards the end of the month of April 2020, Resident 1 was eating 30 to 40 % at the most. CNA 1 stated 30% meal consummation was low. CNA 1 stated she did not notify anyone regarding Resident 1's decrease in food intake. During an interview on 5/11/2020 at 10:40 a.m., and concurrent record review, the Licensed Vocational Nurse 1 (LVN 1) stated that according to Resident 1's activities of daily living log for April 2020, there was a decrease in meal percentage consumption and according to the weight log, Resident 1 was gradually losing weight. LVN 1 stated she did not implement the care plan for weight loss, because she did not notice any weight loss before. LVN 1 stated losing more than 5 percent is not meeting care plan goals for weight loss. LVN 1 stated Resident 1 needed to be reassessed and the care plan revised. LVN 1 stated the care plan for nutrition and hydration was not revised. During an interview on 5/11/2020 at 11:29 a.m., the Director of Nursing (DON) stated there should had been a percentage weight loss done for Resident 1 on the weight log. The DON stated his calculations for Resident 1's weight loss for 6 months was 15.6%. The DON stated 15% was severe weight loss and not meeting care plan goals. The DON stated Resident 1 was not meeting hydration and nutrition care plan goal of 75% meal consumption. The DON stated Resident 1's care plan for nutrition and hydration should have been revised to meet her new condition. The DON stated the care plan was not revised. The DON stated the current care plan was not effective and should have been updated. A review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, revised November 2018 stated the care plan will be periodically reviewed and revised by IDT after each assessment. In addition, the care plan will also be reviewed and revised at the following times: change in condition, to address changes in behavior and care, and other times as appropriate or necessary. |
| F 0692<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide enough food/fluids to maintain a resident's health.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to prevent an unplanned significant weight loss for one of two sampled residents (Resident 1). This deficient practice resulted in Resident 1's unplanned significant weight loss of 15 pounds (lbs - unit of measurement) which was 15.6 % in six months. Findings: A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the physician's orders [REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. A physician order, dated 5/08/2020, indicated Resident 1 was ordered speech therapy evaluation and [MEDICATION NAME] (man-made chemical used to treat loss of appetite and weight loss) 400 milligrams by mouth once a day. A review of Resident 1's weight logs indicated weight on 11/6/2019 was 96 pounds (lbs), on 2/2/2020 was 92 lbs, on 3/3/2020 was 87 lbs, on 4/1/2020 was 84 lbs, and on 5/1/2020 was 81 lbs. The log did not have a weight loss percentage calculation for 3 months and 6 months. A weight loss calculation for 3 months indicates a weight loss percentage of 4.16%. A weight loss percentage calculation for 6 months indicates a weight loss percentage of 15.6%. According to facility's weight log records, a greater than 10% weight loss in 6 months was deemed severe change. A review of Resident 1's Nutritional assessment dated [DATE] indicated Resident 1's weight was 96 pounds (lbs) and Ideal Body Weight (IBW -a weight that is believed to be maximally healthful for a person, based chiefly on height but modified by factors such as gender, age, build, and degree of muscular development) was 100 lbs. A review of the care plan for Nutrition and Hydration, dated 11/11/2019, indicated Resident 1 was at risk for weight loss, decreased food intake, and reported food intake less than 75 percent (%). The goals of the care plan indicated Resident 1 will achieve adequate nutritional intake of at least 75 percent each meal and Resident 1 will have no significant weight changes of 5% or more. A review of Resident 1's Quarterly Minimum Data Set (MDS - a standardized assessment and screening tool), dated 2/12/2020, indicated the resident was severely impaired (never or rarely made decisions). The MDS indicated Resident 1 needed extensive assistance with one person assist with transfer, toilet use, and personal hygiene. The MDS indicated Resident 1 needed supervision with setup help for eating. During an interview on 5/11/2020 at 10:20 a.m., the Certified Nursing Assistant 1 (CNA 1) stated she charted meal intakes for Resident 1 and charting was accurate. CNA 1 stated that towards the end of the month of April 2020, Resident 1 was eating 30 to 40 % at the most. CNA 1 stated 30% meal consummation was low. CNA 1 stated she did not notify anyone regarding Resident 1's decrease in food intake. During an interview on 5/11/2020 at 10:40 a.m., and concurrent record review, the Licensed Vocational Nurse 1 (LVN 1) stated that according to Resident 1's activities of daily living log for April 2020, there was a decrease in meal percentage consumption and according to the weight log, Resident 1 was gradually losing weight. LVN 1 stated losing more than 5 percent is not meeting care plan goals for weight loss. During an interview on 5/11/2020 at 11:29 a.m., the Director of Nursing (DON) stated there should had been a percentage weight loss done for Resident 1 on the weight log. The DON stated his calculations for Resident 1's weight loss for 6 months was 15.6%. The DON stated 15% was severe weight loss and not meeting care plan goals. The DON stated Resident 1 was not meeting hydration and nutrition care plan goal of 75% meal consumption. The DON indicated there was no documented evidence an Interdisciplinary Team (IDT - a group of health care professionals from different fields who coordinate resident care) meeting was done in regards to the weight loss. During an interview on 5/21/2020 at 3:42 p.m., |

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 0692<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>the Registered Dietitian (RD -a licensed professional in human nutrition and the regulation of diet) stated significant weight loss was loss of 2 pounds or 2 % weekly, 1 month 5% weight loss, 3 months 7.5% weight loss, and 6 months 10% weight loss. The RD stated the weight loss percentage for Resident 1 at 6 months was more than 15% weight loss which was significant weight loss. The RD stated she was not involved in the IDT meetings before for Resident 1. The RD stated Resident 1's weight loss was discussed on the last IDT on 5/13/2020 right before Resident 1 was transferred out to another facility. RD stated interventions for nutrition and hydration were not effective for Resident 1 and should have been re-evaluated and instituted new interventions. The RD indicated there was no documented evidence an Interdisciplinary Team (IDT - a group of health care professionals from different fields who coordinate resident care) meeting was done in regards to the weight loss. During an interview on 5/22/2020 at 9:52 a.m., the RD stated interventions implemented for Resident 1 were not effective to prevent continued weight loss. The RD stated we did not do any revised interventions before April 2020 when she placed an order for [REDACTED]. The RD stated Resident 1 should have done a swallow evaluation. The RD stated the lack of swallow evaluation contributed to her continued weight loss. During an interview on 5/22/2020 at 10:38 AM, the Speech Language Pathologist (SLP - experts in communication and treating many types of communication and swallowing problems) stated she did not do a swallow evaluation for Resident 1. The SP stated that when residents begin to lose weight, she should get a consult for swallow evaluation but did not get one for Resident 1 until May 2020. The SP stated Resident 1 should have gotten a swallow evaluation earlier. The SP stated that because there was no swallow consult for Resident 1, it contributed to Resident 1's weight loss. The SP stated no one consulted or spoke to her about other interventions or any interventions for weight loss. The SP stated she should have been consulted as soon as Resident 1 was losing weight. The SP stated refusal to take [MEDICATION NAME], prolonged or continued food intake of less than 50%, and severe weight loss of 15% in 6 months are all indications for potential gastric tube feeding intervention. A review of the facility's policy and procedure titled, Evaluation of Weight and Nutritional Status, revised January 2019, indicated the facility will work to maintain an acceptable nutritional status for residents by monitoring and evaluating the resident's response, or the lack of response to the interventions revising or discontinuing the approaches as appropriate, or justifying the continuation of current approaches. The policy indicated, Weight Loss as significant weight loss 2% in one week, 5% &/or 5lb in one month, 7.5% in three months, or 10% in six months, as well as unplanned weight loss that occurs over time that does not meet the guidelines for significant weight loss and does not trigger review of the Nutritional Status. |