STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055039	A. BUILDING _____ B. WING _____	05/20/2016

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GOOD SAMARITAN REHAB AND CARE CENTER	1630 N. EDISON STREET STOCKTON, CA 95204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Recertification survey. Representing the Department of Public Health: HFEN, 32525 HFEN, 29721 HFEN, 32096 HFEN, 36524 The facility's census was 93 with a sample size of 19 residents plus 1 random resident. Entity Reported Incident #CA00488892 was investigated during the survey. There were no regulatory violations identified.	F 000	Please accept this Plan of Correction as my credible allegation of compliance. Debbie Zarilla Debbie Zarilla Administrator	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and clinical record review, the facility failed to provide medically-related social services for one random resident (20) and 1 of 19 sampled residents (15) when: 1. Diabetic podiatry care was not provided for Random Resident 20; and	F 250	7-6-16 F-250 The facility will provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Resident 15 has been referred to Zeiter Eye for evaluation, and has an appointment on June 17, 2016. The Social Service Director will review all resident health records who are seen by the optometrist, after each visit for follow up needs. Resident 20 was seen by the Podiatrist on 5-18-16 for nail care. Accepted 6/17/16 CAK	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Zarilla — TITLE: administrator — (X6) DATE: 6-15-16

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 250	Continued From page 1 2. There was no follow-up regarding the status of prescription eyeglasses for Resident 15. These failures placed Random Resident 20 at increased risk for foot complications and resulted in Resident 15 going without eyeglasses. Findings: 1. Random Resident 20 was readmitted to the facility in the Summer of 2015 with diagnoses that included diabetes, and peripheral vascular disease (PVD, blood vessel disease outside the heart and brain). A review of the most recent Minimum Data Set (MDS, an assessment tool) indicated Random Resident 20 was "Severely impaired" cognitively and "never/rarely made decisions." In an observation on 5/17/16 at 10:10 a.m., Random Resident 20 was observed lying in bed. The resident was noted to have had long and dirty toe nails that were hanging over her toes on both feet. The second toe nail of the resident's foot was observed to have been nearly detached from the nail bed. In a concurrent observation of Random Resident 20 and interview with the Director of Nursing (DON) on 5/17/16 at 10:24 a.m., the DON acknowledged that the resident's toe nails were long and unsanitary, and verified the presence of the nearly detached toe nail. Review of the facility's April 2009 policy and procedure titled,"Podiatry Care & Services" included the facility shall provide podiatry services to residents who had, "...diagnosis of Diabetes	F 250	The Social Service Director updated resident 20:s care plan to reflect Podiatry care on 5-18-2016, The Social Service Director will review all resident's health record with the Dx .of Diabetes to ensure that Podiatry care has been addressed. The Social Service Director will send a list of resident's who need Podiatry care to the Podiatrist on a monthly basis. The DON will reffere resident's to the social service department, who need podiatry care on a monthly basis and follow up with the Social Service Director, to ensure the Podiatry care needs have been met. The DON will monitor the Podiatry care of the resident's, on a monthly basis and discuss the need for follow up with the Social Service Director. This will be addressed at the Quarterly Quality Assurance Meeting in July 2016.and will be part of the QA Program on an ongoing basis.	

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F 250	Continued From page 2 Mellitus, PVD..." During further review of Random Resident 20's clinical record, there was no documented evidence of a physician's order for podiatry consultation or care. In an interview on 5/17/16 at 3:56 p.m., the Social Service Director (SSD) verified that Ransom Resident 20 had no podiatry care recorded, nor was there a care plan for the care of the resident's feet related to the diagnoses of diabetes and PVD. The SSD stated the podiatry care was arranged by the Social Services Department in coordination with the nursing Department. The SSD acknowledged Random Resident 20 was a diabetic resident and should have been cared for by a podiatrist. 2. Resident 15 was admitted to the facility early this year with diagnoses that included cancer. Review of Resident 15's clinical record included vision consultation notes dated 3/8/16 with a prescription for eyeglasses stapled to it. A review of the facility's policy and procedure titled, "Ophthalmology/Optometry Consult" included, "Social Services shall be responsible for monitoring and tracking of necessary consult... follow up consultation." In an interview on 5/19/16 starting at 2:27 p.m., the Social Serviced Director (SSD) acknowledged the presence of the prescription for Resident 15's eyeglasses dated 3/8/16, and explained the [Consultation Group] provided eyeglasses "normally" within a month of the prescription date. The SSD further stated that Resident 15 should	F 250	BLANK	

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F 250	Continued From page 3 have already received the eyeglasses. The SSD verified Resident 15 had not yet received the eyeglasses and acknowledged there was no follow-up regarding the status of resident's glasses. The SSD stated that there should have been a follow-up regarding Resident 15's eyeglasses.	F 250		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and clinical record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status, such as body weight for 1 of 19 sampled residents (5) when Resident 5's was recorded as having a severe weight loss with no documented evidence of This failure had the potential to result in inadequate weight management for Resident 5. Findings:	F 325	F-325 The facility will ensure that residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the residents clinical condition demonstrates that this is not possible; and receive a therapeutic diet when there is a nutritional problem. Resident 5's current weight is 193 pounds. The desired weight of the resident is 190-200 pounds. The RD saw the resident on 5-18-2016 and updated the plan of care. The Physician on 5-17-2016 and updated the residents health record. The DON updated the residents care plan on 5-18-2016 and addressed the residents desire to lose weight.	7-6-16

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F 325	Continued From page 4 Resident 5 was a long term resident to the facility since 2012 and most recently readmitted in May, 2016 from the acute hospital. Review of the 9/7/15 Quarterly Minimum Data Set (MDS, an assessment tool) and the 12/14/15 Annual MDS indicated Resident 5 had a 23 pound (lbs) weight loss from 212 lbs to 189 lbs during the three month assessment period. This represented a 10.8 percent weight loss that was considered a "severe weight loss." Further review of Resident 5's clinical record included: > The 2015 "Monthly/Weekly Weight Record" indicated Resident 5's admission weight was 245 lbs, with a loss of 8 lbs in September, 2 lbs in October, and 20 lbs in November. > The physician notes, "[Physician Group Name]" for October, November, and December 2015 did not indicate any clinical basis for Resident 5's severe weight loss or for nutritional status. > Care Plan for "Weight Loss" dated 1/7/15, 7/10/15, 9/16/15, and 11/5/15 indicated the resident's goals included "No further weight loss" and 7/10/15 and 9/16/15 care plan goals included to gain 5 pounds. "RD [Registered Dietitian] consult" was one of the care plan interventions. > There was no RD consultation notes regarding the resident weight loss since 5/25/15 in which the RD documented, "Intended weight loss RT [Resident] goal to weigh 220-230# [pound] per resident." In a telephone interview on 5/18/16 at 10:46 a.m.,	F 325	The RD completed a nutritional assessment on 5-18-2016 and addressed the resident's desired weight of 190-200 pounds. Resident's current is 193 pounds, The nursing department will use a written referral slip to communicate with the RD as needed. The DON will review all residents' weight on a monthly basis and address any weight concerns in the care plan and any referral needs to the RD for dietary intervention. The Administrator will receive a copy of the monthly weights of all residents and will discuss any concerns with the DON. This will be addresses at the Quarterly Quality Assurance Meeting in July 2016. And will be part of the QA Program on an ongoing basis.	

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F 325	Continued From page 5 Resident 5's attending physician stated that Resident 5 wished to lose weight and there were no concerns with the resident's weight loss. The physician stated he was informed of the resident's severe weight loss. The physician stated he examined the resident, reviewed the lab results, and discussed the resident's weight issue with nursing staff but "forgot to document" in his progress notes. In an interview on 5/18/16 at 1:55 p.m., the RD, in the Director of Nursing (DON) presence, verified there was no nutritional assessment or RD weight loss consultation for Resident 5 since 5/25/15 because no RD consultation referral was received. The DON acknowledged RD consultation referral was not made as indicated in the care plan due to a "communication breakdown." In an interview on 5/19/16 at 8:50 a.m., the DON stated Resident 5 wished to lose weight and presented 3/4/2012 "Nutrition Screening" that indicated, "...resident wishes to lose more weight and his goal is between 180-200#." The DON acknowledged the care plan was inaccurate in that the resident's goal to "lose weight" was contradicted with the care plan goals related to not losing weight further, and to gain 5 lbs.	F 325		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F-371 The facility will maintain the Kitchen in a sanitary condition. The food items that were stored undated and unlabeled were disposed of on 5-17-2016, by the dietary supervisor.	7-10-16

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F 371	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy and procedure review, the facility failed to maintain the kitchen in a sanitary condition for a census of 93 when: 1. Multiple food items were stored undated; and 2. The oven and the light fixture had dust buildup. These failures had the potential to place the residents at risk for foodborne illness. Findings: 1. During the Initial Tour of the kitchen on 5/17/16 starting at 9 a.m., multiple undated food items were stored in the freezer available for use as follows: -Two bags of 32 oz (ounces) Brussels sprouts -Four bags of 32 oz Italian green beans -Two bags of 32 oz Japanese mixed vegetables -One pack of 3 pounds white turkey roll -One pack of 3 pounds sliced cooked ham -One bag of 2 pounds breaded fish There were five 4 oz undated chocolate shakes, and a 20 oz jar of Mayonnaise with the expiration date of 2/8/16 available for use in the walk-in refrigerator. Review of the facility's undated policy and	F 371	The Dietary Supervisor in serviced the dietary staff on labeling and dating of food items before storage on 5-19-2016. The oven was cleaned on 5-17-2016, removing all dust by the dietary staff. The light fixture was cleaned of dust on 5-17-2016, by the dietary staff. The assistant supervisor will do daily rounds to ensure this is no dust build up in the kitchen and will check food items for proper labeling and dating. The Dietary Supervisor will do at least weekly rounds of the department to ensure that the kitchen meets the sanitary standards, and will check that food items are dated and labeled properly. The RD will do sanitation rounds on a monthly basis, and give a written report to the Dietary Supervisor and Administrator, for corrective actions if needed.	

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F 371	Continued From page 7 procedure titled, "General Receiving of Delivery of Food and Supplies," included to assure high quality food and supplies, the facility was to "Label all items with the delivery date or a use-by date." Review of the facility's undated policy titled, "Storage of Food and Supplies" included storing food properly and in a safe manner that "No food will be kept longer than the expiration date on the product." In a concurrent interview on 5/17/16 starting at 9 a.m., the Dietary Manager (DM) verified the above findings and stated all food items were supposed to have been dated, and the expired food item, "should have been discarded." 2. During the Initial Tour of the kitchen on 5/17/16 starting at 9 a.m., the oven adjacent to the stoves was observed to have had accumulated blackish gray dust on the vent grids and the oven top. The light fixture above the stoves was observed to have dust buildup. In a concurrent interview on 5/17/16 starting at 9 a.m., the Assistant Dietary Manager acknowledged the buildup dust on the oven and the light fixture and stated it should have been cleaned.	F 371	This will be addressed at the Quarterly Quality Assurance Meeting in July 2016. And be part of the QA program on an ongoing basis.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	F-431 The facility will ensure expired treatment supplies are disposed properly. The treatment carts on station one, two and three with expired treatment supplies were disposed of immediately.	7-6-16

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F 431	Continued From page 8 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure expired treatment supplies were not available for use. This failure had the potential for residents to receive treatment with supplies that were ineffective. Findings: During an inspection of the nursing station 3	F 431	The expired treatment supplies in Central supply were disposed of immediately. The DON will in-service the License staff and Central supply personnel, on the proper disposal of treatment supplies on June 25, 2016. The pharmacy nurse consultant will check the treatment carts and central supply room for expired treatment supplies on their visits, and report any negative findings to the DON an Administrator, for follow up if needed The PM supervisor will check the treatment carts on a weekly basis for expired supplies, and report any negative finding to the DON, for follow up if needed. The Assistant DON will spot the treatment carts for expired treatment supplies at least on a monthly basis, and report to the DON and Administrator any negative finding for follow up if needed.	

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F 431	Continued From page 9 medication room on 5/17/16 beginning at 2 p.m., the following expired treatment supply was observed: >Foam dressing -4 in x 4 in, 2 pouches expiration date of 3/16 During an inspection of Nursing Station 1's medication room on 5/17/16 at beginning 2:46 p.m., the following expired treatment supplies were observed: > Petrolatum gauze non-adhering dressings -1 in x 8 in, 1 pouch expired 10/13; -4 pouches expired 7/15; -3 in x 9 in, 19 pouches expired 4/15; and -29 pouches expired 6/15. During a concurrent interview with Licensed Nurse (LN) on 5/17/16 starting at 2 p.m., LN verified the above treatment supplies were expired. During an inspection of Central Supply on 5/17/16 beginning at 3 p.m., the following expired treatment supplies were observed: > Gel pad hydrogel saturated -2 in x 2 in, five pouches expired 8/15, -7 pouches expired 10/15 During a concurrent interview with LN on 5/17/16 at 3:15 p.m., she stated, "It's all expired." In an interview with Asssistant Director of Nursing (ADON) on 5/17/16 at 3:18 p.m., the ADON stated all expired supplies should have been removed. During an inspection of the treatment cart on 5/18/16 at 7:15 a.m. the following items were observed:	F 431	This will be addressed at the Quarterly Quality Assurance Meeting in July 2016, and will part of the QA program on an ongoing basis.	

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F 431	Continued From page 10 > Petrolatum gauze non-adhering dressing -1 in x 8 in, 3 pouches expiration date of 10/13, -19 pouches expired 7/15, -12 pouches expired 8/15; and > Xeroform occlusive patch -4 in x 4 in, 15 pouches expiration date of 3/16 A review of the facility's undated policy titled "Storage of Medications" indicated, "Outdated...medications...are removed from the stock..." During a concurrent interview with ADON on 5/18/16 at 7:22 a.m., the ADON stated "It's all expired." She further stated the expectation for nurses is to check and remove expired treatment supplies.	F 431		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to meet the required bedroom size of 80 square feet per resident for three of 48 resident rooms (18, 22, and 45). This limitation in space had the potential to result in overcrowding or blockage of exits in the event of an emergency. Findings: During the Initial Tour of the facility on 5/17/16 at 9:30 a.m., resident Rooms 18, 22, and 45	F 458	F-458 The facility has requested from CMS a waiver for rooms 18, 22, 45. I am requesting a continued waiver in room 18, 22, 45 which do not meet the required square footage. The total number of residents affected is eight, without any adverse effects. I will continue to monitor the residents and staff for any concerns, complaints and that all rooms are comfortable, accommodating, with low noise levels. The tree rooms involved have a shared community bathroom.	7-6-16

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F 458	Continued From page 11	F 458		

appeared uncluttered and orderly with noted clear pathways to all beds in the rooms.

During the Environmental Tour with the Maintenance Supervisor on 5/19/16 at 10:30 a.m., the following measurements were obtained for Rooms 18, 22, and 45:

> Room 18, a three-bed room, measured 11.2 feet by 16.8 feet which equaled 171.4 square feet. A free-standing closet in the room measured 1.7 feet by 4 feet or 6.8 square feet. The room measurement minus the closet equaled 164.6 square feet. The required measurement is 240 square feet for a three bed-room. The residents' room allowed for 54.9 square feet per resident as opposed to 80 square feet per resident.

> Room 22, a three-bed room, measured 17.25 feet by 10.25 feet which equaled 176.8 square feet. A free-standing closet in the room measured 1.7 feet by 4 feet or 6.8 square feet. The room measurement minus the closet equaled 170.0 square feet. The required measurement is 240 square feet for a three bed-room. The residents' room allowed for 56.7 square feet per resident as opposed to 80 square feet per resident.

> Room 45, a two-bed room, measured 10 feet by 10.25 feet which equaled 102.5 square feet. The required measurement is 160 square feet for a two bed-room. The residents' room allowed for 51.25 square feet per resident as opposed to 80 square feet per resident.

All room measurements allowed for a five- foot door clearance.

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CNA 1 was interviewed on 5/19/16 at 9:35 a.m.,

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	055039	A. BUILDING _____ B. WING _____	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN REHAB AND CARE CENTER	1630 N. EDISON STREET STOCKTON, CA 95204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 458	Continued From page 12 regarding the transfer of the two residents in Room 45 to their wheelchairs. The CNA stated both residents required a 2-person transfer and staff had no difficulty maneuvering in the room. Based on the findings during the Recertification survey, the Department determined that the room variations (1) are in accordance with the special needs of the residents; and (2) will not adversely affect residents' health and safety. The Department recommends continuation of the room size waiver for Rooms 18 and 22, each housing three residents, and Room 45 housing 2 residents.	F 458	I will also monitor that there will be no adverse effects to the resident's health and safety and that the residents Rights will not be violated. This will be addressed at the Quarterly Quality Assurance Meeting in July 2026, and will be part of the QA Program on an ongoing basis	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and clinical record review, the facility failed to ensure clinical records were complete and accurate for 1 of 19 sampled residents (5) when:	F 514	F-514 The facility will maintain the clinical record on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. The Administrator spoke with resident 5's Physician to ensure that he clinical record is complete an accurate, with the residents desired to lose weight. Resident 5's Physician documented on the desired weight loss on 6-15-2016.	7-6-16

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F 514	Continued From page 13 > Resident 5's physician did not complete notes that included the clinical basis for the resident's severe weight loss; > There was inaccurate care planning for Resident 5's weight loss. This failure had the potential to result in inadequate weight management for Resident 5. Findings: Resident 5 was a long term resident to the facility since 2012 and most recently readmitted in May, 2016 from the acute hospital. Review of the 9/7/15 Quarterly Minimum Data Set (MDS, an assessment tool) and the 12/14/15 Annual MDS indicated Resident 5 had a 23 pound (lbs) weight loss from 212 lbs to 189 lbs during the three month assessment period. This represented a 10.8 percent weight loss that was considered a "severe weight loss." The 2015 "Monthly/Weekly Weight Record" indicated Resident 5's admission weight was 245 lbs, with a loss of 8 lbs in September, 2 lbs in October, and 20 lbs in November. The physician notes, "[Physician Group Name]" for October, November, and December 2015 did not indicate any clinical basis for Resident 5's severe weight loss. In a telephone interview on 5/18/16 at 10:46 a.m., Resident 5's attending physician stated that Resident 5 wished to lose weight and there were no concerns with the resident's weight loss. The	F 514	The DON updated resident 5's care plan on 5-18-2016, to reflect the resident desire to lose weight. Resident's desired weight is 190-200 pounds, and current weight is 193 pounds. The DON will monitor resident 5's weight at the monthly weight meeting to ensure that the residents goal in maintained. The DON will give a copy of the monthly weights to the RD for dietary intervention if needed. The Administrator will receive a copy of the monthly weights and discuss any negative finding with the DON, for corrective actions if needed. This will be addressed at the Quarterly Quality Assurance Meeting in July 2016, and will be part of the QA Program on an ongoing basis.	

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F 514	Continued From page 14	F 514		

physician stated he was informed of the resident's severe weight loss. The physician stated he examined the resident, reviewed the lab results, and discussed the resident's weight issue with nursing staff but "forgot to document" in his progress notes.

According to the care plan for "Weight Loss" dated 1/7/15, 7/10/15, 9/16/15, and 11/5/15, Resident 5's goals included "No further weight loss" and 7/10/15 and 9/16/15 care plan goals included to gain 5 pounds.

In an interview on 5/19/16 at 8:50 a.m., the DON stated Resident 5 wished to lose weight and presented a 3/4/2012 "Nutrition Screening" that indicated, "...resident wishes to lose more weight and his goal is between 180-200#." The DON acknowledged the care plan was inaccurate in that the resident's goal to "lose weight" was contradicted by the care planned goals related to not losing weight further, and to gain 5 lbs.

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