STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555715	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Gardens Nursing Home	7246 S. Rosemead Blvd. Pico Rivera, CA 90660

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview and record review, the facility failed to notify the Resident 1 ' s responsible party (RP 1), Resident 2, and Resident 2 ' s responsible party (RP 2) of their rights to participate in the resident care conference to discuss the plans of care and discharge goals for two of two sampled residents (Resident 1 and Resident 2). This deficient practice violated RP 1, Resident 2, and RP 2 ' s rights to be active participants in their care. Findings: 1. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 ' s diagnoses included generalized muscle weakness, anemia (a common blood disorder that occurred when the body had fewer red blood cells than normal), Type 2 diabetes mellitus (a disease that occurred when blood sugar was too high), dementia (the impaired ability to remember, think, or make decisions that interfered with doing everyday activities), schizoaffective disorder (a serious mental illness that affected how a person thought, felt, and behaved), and anxiety (feelings of fear, dread, and uneasiness that might occur as a reaction to stress). During a review of Resident 1 ' s Minimum Data Set ([MDS]- a standardized resident assessment and care screening tool), dated 8/5/2024, the MDS indicated Resident 1 ' s cognitive (the ability to think and process information) skills for daily decisions making was severely impaired. During a review of Resident 1 ' s History and Physical (H&P), dated 1/6/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Resident Care Conference Note, dated 1/23/2024, the note indicated there was no documented invite notification to RP 1 to attend the care conference. The note indicated Resident 1 attended the care conference. During a review of Resident 1 ' s Resident Care Conference Note, dated 2/8/2024, the note indicated there was no documented invite notification to RP 1 to attend the care conference. The note indicated Resident 1 attended the care conference on 2/8/2024. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Resident Care Conference Note, dated 5/9/2024, the note indicated there was no documented invite notification to RP 1 to attend the care conference. The note indicated Resident 1 attended the care conference on 5/9/2024. During a review of Resident 1 ' s Resident Care Conference Note, dated 8/8/2024, the note indicated there was no documented invite notification to RP 1 to attend the care conference. The note indicated Resident 1 attended the care conference on 8/8/2024. During a concurrent of interview and record review on 8/21/2024 at 2:30 PM with the Director of Rehabilitation (DOR), Resident 1 ' s Resident Care Conference form, dated 8/8/2024 was reviewed. The form indicated there was no documented notification to RP 1. The DOR stated he did not recall the last time he communicated with RP 1 regarding Resident 1 ' s rehabilitation progress. The DOR stated he should communicate with RP 1 during the care conference. The DOR stated the SSD or the nurses usually initiated the call to the resident ' s RP to attend the care conference. The DOR stated it was important to update RP 1 regarding Resident 1 ' s rehabilitation progress so RP 1 would know what was going on with the resident. The DOR stated it should be documented on the Resident Care Conference form if the resident or RP did not want to attend the care conference. During a concurrent of interview and record review on 8/21/2024 at 2:49 PM with the SSD, Resident 1 ' s Resident Care Conference forms, dated 1/23/2024, 2/8/2024, 5/9/2024, and 8/8/2024 were reviewed. The forms indicated Resident 1 attended the care conferences but there was no documented notification to RP 1. The SSD stated Resident 1 attended the care conference, and the SSD did not recall contacting RP 1. The SSD stated even if the resident attended the care conference, the SSD still needed to notify the RP. The SSD stated she should notify the RP at least one week ahead of the care conference. The SSD stated the risk of not notifying the RP was that the RP would not be aware of what was going on with the resident nor the resident ' s plan of care. During a concurrent of interview and record review on 8/21/2024 at 2:59 PM with the Director of Nursing (DON), Resident 1 ' s Resident Care Conference forms, dated 1/23/2024, 2/8/2024, 5/9/2024, and 8/8/2024 were reviewed. The forms indicated Resident 1 attended the care conferences but there was no documented notification to RP 1. The DON stated the facility did not notify RP 1, and it was not appropriate to include only Resident 1 in the care conference since Resident 1 did not have the capacity to understand or make decisions. 2. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s diagnoses included anemia, Type 2 diabetes mellitus, schizoaffective disorder, and osteoarthritis (a chronic joint disease that caused the breakdown of joint tissues over time) to both hips. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions making was severely impaired. During a review of Resident 2 ' s Resident Care Conference Note, dated 1/4/2024, the note indicated there was no documented invite notification to RP 2 to attend the care conference. The note indicated no documentation regarding Resident 2 ' s participation on 1/4/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s Resident Care Conference Note, dated 4/4/2024, the note indicated no documented invite notification to RP 2 to attend the care conference. The note indicated there was no documentation regarding Resident 2 ' s participation on 4/4/2024. During a review of Resident 2 ' s Resident Care Conference Note, dated 6/27/2024, the note indicated there was no documented invite notification to RP 2 to attend the care conference. The note indicated there was no documentation regarding Resident 2 ' s participation on 6/27/2024. During a concurrent observation and interview with Resident 2 on 8/21/2024 at 8:55 AM, in Resident 2 ' s room, Resident 2 was observed sitting up in his two-wheel rollator (a walking frame equipped with wheels and a seat) next to his bed. Resident 2 stated his name and that he had been in this facility for one year. Resident 2 stated he had not attended any care conference meeting ' s with staff to discuss his plan of care. Resident 2 stated he did not know his plan of care. During an interview with the Social Service Director (SSD) on 8/21/2024 at 10:04 AM, the SSD stated staff should document on Resident Care Conference note if the resident, family, or RP would like to attend the care conference or not. The SSD stated it was important to invite the residents and their RP to attend the care conference so they could understand the resident ' s plan of care. The SSD stated residents and their RPs would not be able to know what was going to happen with their plan of care if the resident and their RP were not notified about the care conference. During a concurrent of interview and record review on 8/21/2024 at 2:59 PM with the DON, Resident 2 ' s Resident Care Conference forms, dated 1/4/2024, 4/4/2024, and 6/27/2024, were reviewed. The forms indicated there was no documented notification to Resident 2 ' s RP nor documentation of Resident 2 ' s participation. The DON stated the purpose of Resident Care Conference was to collaborate as a team to develop interventions to provide the best care for residents. The DON stated it was the resident ' s right to be participate in decision making and care planning. The DON stated according to the document reviewed, the facility did not respect the resident ' s right. The DON stated all staff should respect the resident ' s rights. The DON stated it was important to respect and honor the resident ' s request. The DON stated the negative outcome was not providing proper care to residents. The DON stated it was the facility policy to respect resident ' s rights. During a review of the facility ' s Policy and Procedure (P&P) titled Resident Rights, revised 11/2010, the P&P indicated all residents had the rights to participate in decisions and care planning. The P&P indicated residents were entitled to fully exercise their rights and privileges possible. The P&P indicated the facility would make every effort to assist each resident in exercising rights to assure the resident was always treated with respect, kindness, and dignity. During a review of the facility ' s P&P titled Interdisciplinary Team (IDT) / Resident Care Plan Conference Review (RCC), dated 11/2027, the P&P indicated social service staff were responsible to ensure the resident/resident representative was provided sufficient notification of scheduled care conference meetings to plan and participate in care. The P&P indicated social service staffs shall document on the Resident Care Conference notes when resident/resident representative was unable to participate with reason.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to notify the physician for one of two sampled residents (Resident 1) following Resident 1 sustaining a five (5) pound (lb., unit of measurement) weight loss between May 2024 and June 2024, and again following a nine (9) lb. weight loss between May 2024 and August 2024. This deficient practice placed Resident 1 at risk for delayed intervention and care plan adjustments, possibly resulting in further avoidable unplanned weight loss and not meeting her nutritional needs. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 1 ' s admitting diagnoses included anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), dementia (group of thinking and social symptoms that interferes with daily functioning), and generalized muscle weakness. During a review of Resident 1 ' s History and Physical (H&P), dated 1/6/2024, the H&P indicated Resident 1 did not have the capacity to understand or make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive assessment and care-planning tool), dated 8/5/2024, the MDS indicated Resident 1 had severely impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions) and required supervision or touching assistance while eating. During a review of the untitled facility document, dated 8/9/2024, the document indicated Resident 1 ' s monthly weights from February 2024 to August 2024. The document indicated Resident 1 weighed 111 lbs. in May 2024, and then 106 lbs. in June 2024. The document further indicated Resident 1 weighed 102 lbs. in August 2024. During a review of the facility document titled Weekly Weights, dated 8/20/2024, the document indicated Resident 1 ' s weekly weights for the month of August 2024. The document indicated Resident 1 weighed 102 lbs. on 8/5/2024, then weighed 101 lbs. on 8/19/2024. During a concurrent observation and interview, on 8/21/2024 at 10:41 AM, in the dining room, Resident 1 was observed sitting up in a wheelchair. Resident 1 could not state where she was or what year it was. Resident 1 appeared thin and pale. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 8/21/2024 at 3:52 PM, with the Director of Nursing (DON), Resident 1 ' s monthly and weekly weights dated February 2024 to August 2024 were reviewed. The DON stated Resident 1 sustained a five (5) lb. weight loss between May 2024 and June 2024. The DON stated this was considered a significant change in Resident 1's status. The DON reviewed the undated facility policy and procedure (P&P) titled Change of Condition, and stated the P&P indicated licensed nursing staff were supposed to notify Resident 1 ' s attending physician of this significant change. The DON reviewed Resident 1 ' s medical record and stated there was no documentation in Resident 1 ' s medical record to indicate Resident 1 ' s physician had been notified of the significant weight loss between May 2024 and June 2024. The DON further stated Resident 1 continued to lose weight from June 2024 to August 2024, experiencing a weight loss of more than 7.5%, and stated there was no documentation indicating Resident 1 ' s physician had been notified. The DON stated it was important to notify the physician of unplanned weight loss to determine if new orders were needed, or if changes to the plan of care were required. During an interview on 8/21/2024 at 2:55 PM, with Medical Doctor (MD) 1, MD 1 stated he was Resident 1's attending physician and was familiar with her diagnoses and plan of care. MD 1 stated Resident 1's unplanned weight loss was a change of condition he would want to be notified of as it would require further evaluation of the resident and adjustments to her plan of care. MD 1 stated that it would be important to identify the cause of the weight loss and intervene. MD 1 stated he did not recall being notified of Resident 1's weight loss, and stated that if there was no documentation, it likely was not done. During a review of the undated facility P&P titled Change of Condition, the P&P indicated the licensed nurse was responsible for notifying the attending physician promptly when there was a significant change in the resident ' s physical status. The P&P further indicated all attempts to notify physicians was supposed to be noted in the resident ' s medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 47286 Based on interview and record review, the facility failed to revise the nutritional care plan for one of two sampled residents (Resident 1) following Resident 1's five (5) pound (lb., unit of measurement) weight loss between May 2024 and June 2024, and again following a nine (9) lb. weight loss between May 2024 and August 2024. This deficient practice placed Resident 1 at risk for not receiving the required interventions to prevent further avoidable unplanned weight loss and inability to meet her nutritional needs. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 1 ' s admitting diagnoses included anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), dementia (group of thinking and social symptoms that interferes with daily functioning), and generalized muscle weakness. During a review of Resident 1 ' s History and Physical (H&P), dated 1/6/2024, the H&P indicated Resident 1 did not have the capacity to understand or make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive assessment and care-planning tool), dated 8/5/2024, the MDS indicated Resident 1 had severely impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions) and required supervision or touching assistance while eating. During a review of the untitled facility document, dated 8/9/2024, the document indicated Resident 1 ' s monthly weights from February 2024 to August 2024. The document indicated Resident 1 weighed 111 lbs. in May 2024, and then 106 lbs. in June 2024. The document further indicated Resident 1 weighed 102 lbs. in August 2024. During a review of the facility document titled Weekly Weights, dated 8/20/2024, the documented indicated Resident 1 ' s weekly weights for the month of August 2024. The document indicated Resident 1 weighed 102 lbs. on 8/5/2024, then weighed 101 lbs. on 8/19/2024. During a review of Resident 1 ' s Care Conference Note, dated 8/8/2024, the note indicated the Interdisciplinary Team conducted a quarterly review of Resident 1 ' s plan of care. The note indicated dietary staff did not attend the care conference and indicated Resident 1 had not experienced a significant change since the prior quarterly care conference. The note did not address Resident 1 ' s nine (9) lb. weight loss between May 2024 and August 2024. During a review of Resident 1 ' s Quarterly Nutrition Progress Notes, dated 8/9/2024, the progress note indicated Resident 1 weighed 102 lb. and indicated Resident 1 ' s weight was stable and indicated staff were to continue the current care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Registered Dietician (RD, health professional who specializes in nutrition and diet) Progress Note, dated 8/14/2024, the progress note indicated Resident 1 was underweight and indicated the RD made recommendations for revisions to Resident 1 ' s care plans. During a review of Resident 1 ' s undated care plan titled Nutrition Care Plan, the care plan indicated the care plan was initiated on 1/8/2024 and revised on 3/2024 and 4/2024. The care plan indicated there were no revisions to the care plan following Resident 1 ' s five (5) lb. weight loss between May 2024 and June 2024, or following the recommendations made by the RD on 8/14/2024. During a concurrent interview and record review, on 8/21/2024 at 11:43 AM, with the Director of Staff Development (DSD), Resident 1 ' s monthly weights from May 2024 to August 2024, and Resident 1 ' s Nutrition Care Plan, initiated on 1/8/2024 were reviewed. The DSD stated there were no revisions to Resident 1 ' s care plans following Resident 1 ' s weight loss. The DSD also stated staff were aware of Resident 1 ' s severe weight loss of more than 7.5% in three months on 8/5/2024. The DSD stated Nutrition Weight Variance Meetings were conducted every Friday, and stated Resident 1 should have been included in the Nutrition Weight Variance Meeting on 8/9/2024 to review her nutrition care plan and address her weight loss. During an interview on 8/21/2024 at 1:43 PM, with the Dietary Supervisor (DS), the DS stated Resident 1 was not referred to the Nutrition Weight Variance Committee until 8/21/2024 and stated Resident 1 was never previously under monitoring by the Nutrition Weight Variance Committee for her five (5) lb. weight loss that occurred between May 2024 and June 2024. During a concurrent interview and record review, on 8/21/2024 at 3:52 PM, with the Director of Nursing (DON), Resident 1 ' s monthly and weekly weights dated February 2024 to August 2024 were reviewed. The DON stated Resident 1 sustained a five (5) lb. weight loss between May 2024 and June 2024, and an overall nine (9) lb. weight loss between May 2024 and August 2024. The DON reviewed the undated facility policy and procedure (P&P) titled Comprehensive Care Plans, and stated the P&P indicated staff were supposed to update the comprehensive care plan to reflect the changes to goals and approaches following a change in condition. The DON reviewed Resident 1 ' s Nutrition Care Plan, initiated 1/8/2024, and stated there were no revisions made to the care plan following Resident 1 ' s weight loss. The DON also stated the care plan did not reflect the recommendations made by the RD on 8/14/2024. The DON stated Resident 1 continued to sustain further weight loss, and now weighed 101 lb. During a review of the undated facility P&P titled Comprehensive Care Plans, the P&P indicated facility staff were supposed to update the comprehensive care plan to reflect the changes to goals, approaches, as necessary resulting from condition changes and needs.

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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** 47286 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) was referred to the facility ' s Nutrition Weight Variance Committee following a five (5) pound (lb. , unit of measurement) weight loss between May 2024 and June 2024, and again following a nine (9) lb. weight loss between May 2024 and August 2024. This deficient practice resulted in Resident 1 sustaining an additional one (1) lb. weight loss in August 2024, and placed her at increased the risk sustaining further avoidable unplanned weight loss and not meeting her nutritional needs. Findings: During a review of Resident 1 ' s Admission Record, the record indicated Resident 1 was originally admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 1 ' s admitting diagnoses included anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), dementia (group of thinking and social symptoms that interferes with daily functioning), and generalized muscle weakness. During a review of Resident 1 ' s History and Physical (H&P), dated 1/6/2024, the H&P indicated Resident 1 did not have the capacity to understand or make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive assessment and care-planning tool), dated 8/5/2024, the MDS indicated Resident 1 had severely impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions) and required supervision or touching assistance while eating. During an interview on 8/21/2018 at 10:23 AM, with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 1 required assistance from staff to eat her meals. CNA 3 stated Resident 1 sometimes ate less than half of her meals or refused the meal completely. During a review of the untitled facility document, dated 8/9/2024, the document indicated Resident 1 ' s monthly weights from February 2024 to August 2024. The document indicated Resident 1 weighed 111 lb. in May 2024, and then 106 lb. in June 2024. The document further indicated Resident 1 weighed 102 lb. in August 2024. During a review of the facility document titled Weekly Weights, dated 8/20/2024, the documented indicated Resident 1 ' s weekly weights for the month of August 2024. The document indicated Resident 1 weighed 102 lb. on 8/5/2024, then weighed 101 lb. on 8/19/2024. During a concurrent observation and interview, on 8/21/2024 at 10:41 AM, in the dining room, Resident 1 was observed sitting up in a wheelchair. Resident 1 could not state where she was or what year it was. Resident 1 appeared thin and pale. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/2024 at 12:08 PM, with the Registered Dietician (RD, health professional who specializes in nutrition and diet), the RD stated she started working at the facility in July 2024. The RD stated she did not see Resident 1 until 8/14/2024 to address her nine (9) lb. weight loss between May 2024 and August 2024. During an interview on 8/21/2024 at 1:43 PM, with the Dietary Supervisor (DS), the DS stated Resident 1 was not referred to the Nutritional Weight Variance Committee until 8/21/2024 and was never previously under monitoring by the Nutrition Weight Variance Committee for her five (5) lb. weight loss that occurred between May 2024 and June 2024. During a concurrent interview and record review, on 8/21/2024 at 3:52 PM, with the Director of Nursing (DON), Resident 1 ' s monthly and weekly weights dated February 2024 to August 2024 were reviewed. The DON stated Resident 1 sustained a five (5) lb. weight loss between May 2024 and June 2024. The DON reviewed the facility policy and procedure (P&P) titled Weight and Height Monitoring, undated, and stated the P&P indicated a weight loss of five (5) lb. in one month was considered a significant loss and stated the P&P indicated Resident 1 should have been referred to the next scheduled Nutrition Weight Variance Committee Meeting. The DON stated the purpose of the Nutrition Weight Variance Committee was to closely monitor residents with weight loss and update the plan of care and interventions to prevent further weight loss. The DON stated Resident 1 continued to lose weight from June 2024 to August 2024, experiencing a weight loss of more than 7.5% over the course of three months. The DON stated delayed referral and intervention placed Resident 1 at further risk for continued unplanned weight loss due to late referral and intervention and stated that since the severe weight loss was identified on 8/5/2024, Resident 1 has continued to sustain unplanned weight loss. During an interview on 8/21/2024 at 2:55 PM, with Medical Doctor (MD) 1, MD 1 stated he was Resident 1's attending physician and was familiar with her diagnoses and plan of care. MD 1 stated he was not notified of Resident 1's unplanned weight loss, and stated the weight loss required further evaluation of the resident and adjustments to her plan of care. MD 1 stated weight loss could have many causes and stated Resident 1 had multiple comorbidities (a disease or medical condition that is simultaneously present with another or others) that could contribute to further weight loss if not identified. MD 1 also stated it was important to monitor and intervene for poor meal intake. During a review of the undated facility P&P titled Weight and Height Monitoring, the P&P indicated it was the facility ' s policy to identify residents at risk for significant weight loss and implement preventive care plans as appropriate. The P&P further indicated a resident who experienced a loss of five (5) lbs. in 30 days was a significant weight loss, and that resident should be referred to the next scheduled Nutrition Weight Variance Committee Meeting.