STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555773	A. BUILDING _____ B. WING _____	C 06/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUCCA VALLEY NURSING	57333 JOSHUA LANE YUCCA VALLEY, CA 92284

(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 the investigation of a Facility reported incident Facility Reported Incident Number: CA00780883 Representing the Department:Health Facilities Evaluator Nurse: 41794 The inspection was limited to the specific Facility Reported Incident investigated and does not respresent the findings of a full inspection of the facility. One deficiency was identified for the Facility Reported Incident: CA00780883	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide timely assessments for one of three sampled residents (Resident 1) when	F 637		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 06/16/22

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 637	Continued From page 1 Resident 1 fell out of bed and was not monitored after her fall on April12, 2022. The failure caused Resident 1, a clinically compromised resident, to be transferred to the hospital. Findings: During a review of Resident 1 ' s face sheet (a document that provides demographic data) indicated the resident was admitted to the facility on April 12, 2022, at 3:00 PM with diagnosis of alcoholic cirrhosis of liver (liver is permanently damaged with scar tissue), and ascites, (swelling of legs and stomach area), palliative care, (provide comfort care), anxiety disorder, and history of falling. The resident ' s daughter has Power of Attorney. During an interview with Licensed Vocational Nurse, (LVN 1) on April 27, 2022, at 11:00 AM, LVN 1 stated she assesses or evaluate every resident that has fallen. She further stated she would call the physician and the responsible party. LVN 1 stated she also updates the Care Plan, (helps nurses organizes patient care) and performs neuro (evaluates mental, motor, sensory and reflexes) checks every 15 minutes for 72 hours. LVN 1 further stated she would contact the physician if there were any changes of condition on the resident. A review of Resident 1's nursing progress note dated April 12, 2022, at 9:00 PM documented by Registered Nurse, (RN 1) indicated Resident 1 had an unwitnessed fall from her bed. RN 1 contacted Hospice to report the fall and was told by Hospice that Resident 1 had fallen prior to	F 637		

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F 637	Continued From page 2 admission to the facility. During a concurrent interview and record review, on April 27, 22 at 11:15 AM with LVN 1, she stated Certified Nursing Assistant, (CNA 1) reported to her, that Resident 1 was not alert on April 13, 2022, at 8:00 AM. LVN 1 went to assess Resident 1 and found Resident 1 was difficult to arouse, (wake up) and answer questions. She further stated she called the physician to report Resident 1 ' s change of condition, and the physician ordered for Resident 1 to be transferred to the hospital immediately. During a concurrent interview and review of Resident 1 ' s chart with the Director of Nurses, (DON) on April 27, 2022, at 11:30 AM. The DON stated there was no documentation of any nursing assessment on Resident 1 after her fall on April 12, 2022. The DON could not provide an explanation why the RN did not document any assessment on Resident 1 after the fall. A review of the facility's policy and procedure titled "Fall Prevention Program" dated September 2016. The purpose is to prevent accidents that is free from hazards over which the facility has control ...In Post Falls, licensed nurses will assess the resident for injuries and necessary treatments. Licensed nurses will notify attending Physician and responsible party and implement any new orders. Licensed Nurses will document ongoing assessments including neuro checks for unwitnessed falls or falls with known head injuries each shift for 72 hours	F 637		

POC for 2567 Reported Incident # CA00780883

Prefix Tag: F 637

Resident involved in investigation admitted to our facility 4/12/2022 at @14:45. Resident was indeed alert and oriented x 3, mildly confused but able to consent to Hospice. Resident had unwitnessed fall later that evening @ 2100. LVN 1 stated she notified Hospice, however, after investigation, neither Hospice, nor family were notified. LVN 1 charted assessment findings in PCC. LVN 1 made no further entries going forward.

LVN 1 failed to do required Change of Condition charting, nor any risk management entries. LVN 1 failed to place resident on neuro checks per policy.

LVN 1 was placed on immediate suspension and ultimately terminated.

All staff have been in serviced on Risk Management charting, Change of Condition Charting, Fall risk assessment and specific details of expectations. Also included in in service is placement of 72 hour neuro checks s/p unwitnessed fall or obvious head injury.

All in services are attached to this POC.