STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555773	A. BUILDING _____ B. WING _____	**03/30/2020**

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

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 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 follow its policy for withholding medications for one or three sampled resident's (Resident 3) when: 1. Licensed Vocational Nurse 1 (LVN 1) failed to notify Resident 3's physician of a low blood sugar level. 2. LVN 1 withheld [MED] (medication to regulate blood sugar levels in diabetic residents) without a physician's orders [REDACTED]. Findings: 1. During a concurrent interview and record review on February 12, 2020, at 10:47 AM, with LVN1 A review of Resident 1's Medication Activity Record (MAR - record of medications, treatments, observations and result of testing ordered by MD) and progress notes indicated that Resident 3's blood sugar was 58 on February 12, 2020 at 7:00 AM. The doctors order indicated to notify the MD of a blood sugar less than 60. After reviewing the MAR and progress notes, LVN1 stated that there is not a note indicating that the MD was notified. She stated that the MD should have been notified. During a concurrent interview and record review on February 12, 2020, at 11:10 AM, with Minimum Data Set (MDS - Clinical Assessment of Residents) Nurse, and review of MAR, MD's order and progress notes indicated, Resident 1 had blood sugar of 51 on February 5, 2020, and 58 February 12, 2020, this morning. The MAR and MD's order indicated that the MD is to be notified of blood sugars less than 60. MDS Nurse stated the records indicated that the MD was not notified of these blood sugars below 60. The MDS Nurse stated whenever there is a blood sugar below 60, the physician should be notified. MDS Nurse then stated if the physician is not notified, a resident can go into a diabetic coma. MDS Nurse was unable to locate documentation of interventions for the low blood sugars in the records. During an interview on February 12, 2020, at 12:35 PM, with the Director of Staff Development (DSD), he stated licensed nurses are to follow the physician's orders [REDACTED]. During an interview on February 12, 2020, at 11:08 AM, with the Director of Nursing (DON), She stated if the physician is not notified of low blood sugars, the resident can have extreme episodes of low blood sugar and become unresponsive and in extreme cases even death. During a review of the facility's policy and procedure titled, Change in Resident's Condition or Status, May 2017, indicated, under Policy Interpretation and Implementation - 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): .i. specific instruction to notify the Physician of changes in the resident's condition. 2. During an interview on February 12, 2020, at 11:01 AM, with Registered Nurse 1 (RN1) he stated that Resident 3's [MED] was held this morning. During a concurrent review of Resident 3's record and interview with MDS Nurse on February 12, 2020, at 11:10 AM, with the MDS Nurse stated the physician's orders [REDACTED]. The MDS Nurse confirmed that there are no parameters for holding the long acting [MED]. MDS Nurse states that a resident can have high blood sugar if he doesn't receive his [MED]. During an interview on February 12, 2020, at 12:17 PM, LVN1 states that she would not hold the long acting [MED] without an order. LVN1 stated that if the blood sugar is under 100, she would call the doctor and see what the doctor wanted her to do. During an interview on February 12, 2020, at 12:20 PM, with RN1, he stated that is was a nursing judgement to hold the long acting [MED]. RN1 stated staff did not get an order from the MD to hold it. RN1 also stated we should have gotten and order and if Resident 3 doesn't get the long acting [MED], his blood sugar can get high. During an interview on February 12, 2020, at 12:32 PM, with DON, she stated that with long acting [MED] the licensed nurses would need to call the doctor to get an order to hold it if they had any concerns. During an interview on February 12, 2020, at 12:35 PM, with DSD, the DSD stated with long acting [MED] the licensed nurses cannot hold without a physician's orders [REDACTED]. During a review of the facility's policy and procedure titled, Administering Medication, December 2012, indicated, under Policy Statement - Medications shall be administered in a safe and timely manner, and as prescribed and under Policy Interpretation and Implementation .3. Medications must be administered in accordance with the orders, including any required time frame .5. If dosage is believed to be inappropriate or excessive for a resident, or medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns. During a review of the facility's policy and procedure titled, Medication Holds, April 2007, indicated, under Policy Interpretation and Implementation .4. The Attending Physician must provide an explicit order as to when to restart a medication that has been held, either at the time the order is given to hold the medication or subsequently.

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.