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 _____	**05/14/2020**

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe environment free from abuse and neglect for one of 88 residents (Resident 1) when a Licensed Vocational Nurse 1 (LVN 1) failed to do the following for a resident who had just returned from the general acute care hospital for a complaint of chest pain: 1. Failed to assess Resident 1 upon readmission from the emergency room for pain and to take vital signs (temperature, pulse, respirations and blood pressure). 2. Failed to medicate Resident 1 for repeated episodes of nausea and vomiting for several hours as per physician's orders [REDACTED]. 3. Failed to notify Resident 1's physician that Resident 1 had returned from the emergency room with vomiting, severe abdominal pain, high blood glucose level and the prescribed insulin coverage had not been given. These failures resulted in Resident 1 suffering unnecessary pain, having a rapid decline in her health which ended in her death within eight hours of returning to the facility. Findings: 1. A review of Resident 1's clinical record, the face sheet (Contains demographic information), indicated Resident 1 was admitted to the facility on [DATE], and died in the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's history and physical dated [DATE], indicated Resident 1 was deaf (impaired hearing or unable to hear) and had an arteriovenous fistula (AV shunt, a surgically created connection between an artery (a blood vessel that carries blood away from the heart to the rest of the body) in left upper arm (LUE). Resident 1 was alert and capable of making decisions. During a review of Resident 1's Nurses Progress Notes indicated the following: a. [DATE] at 2:10 PM, Resident 1 has not returned from the [MEDICAL TREATMENT] center. Charge Nurse/Registered Nurse Supervisor (CN/RNS) called the center and informed Resident 1 complained of (C/O) chest pain and (was)transported to the hospital. b. [DATE] at 6:54 AM, Resident 1 returned from emergency room (ER) on [DATE] at 11:20 PM, in a wheelchair (W/C) accompanied by one attendant. All labs came back within normal limits (WNL). Resident 1 was treated for [REDACTED]. [MEDICATION NAME] (medication for nausea and vomiting) given x1. No medications taken by Patient. Will continue to monitor. There was no documented assessment of Resident 1's vital signs, or level of pain upon return from the general acute care hospital. A review of Resident 1's, Weights and Vitals (vital signs) Summary, dated [DATE] through [DATE], indicated that no vital signs had been documented after [DATE], at 5:21 AM, when Resident 1 left for [MEDICAL TREATMENT]. During an interview with the Director of Nurses (DON), on [DATE], at 12:25 PM, the DON confirmed Resident 1 had no assessment or V/S completed after returning from the hospital on [DATE] at 11:20 PM. The DON stated, Resident 1 should have been placed on 72- hour charting when returning from the hospital with chest pain and the physician should have been notified. During a telephone interview with LVN 1 on [DATE], at 2:30 PM, LVN 1 confirmed, Resident 1 returned from (Name of Hospital) on [DATE] at 11:20 PM, after being evaluated in the emergency for complaint of chest pain. LVN 1 stated she did not complete an assessment or take V/S when Resident 1 returned. When asked the reason an assessment of Resident 1 and vital signs was not completed upon return from the emergency room , LVN 1 stated, I was too busy to complete an assessment and take V/S and then ran out of time. 2. During further review of Resident 1's Nurses Progress Notes the notes indicated the following: a. [DATE] at 9:07 AM, Resident 1 was administered [MEDICATION NAME] (medication to treat diarrhea) A-D Tablet 2 Milligrams (MG-unit of measure) twice for diarrhea. b. [DATE] at 4:32 PM, Resident 1 did not go to [MEDICAL TREATMENT] due to her stomachache. Informed a new chair time (reservation at the [MEDICAL TREATMENT] center) was arranged for tomorrow at 8:00 AM. Social Services Worker (SSW) will continue to follow. RNS (Registered Nurse Supervisor) and CN (Charge Nurse) made aware. c. [DATE] at 8:36 PM, Resident 1 refused to go to [MEDICAL TREATMENT], different staff came to try and convince her to go, and still refused. Called [MEDICAL TREATMENT] and got her rescheduled for Tuesday at [DATE] at 8:00 AM. There was no documented evidence the physician had been notified that Resident 1 refused her [MEDICAL TREATMENT] due to abdominal pain and diarrhea. During a review of Resident 1's physician's orders [REDACTED]. [MEDICATION NAME] (medication given for pain or to reduce fevers) 1 Tablet 325 MG by mouth (PO) every (Q) 4 hours as needed for general discomfort. Order date [DATE]. b. [MEDICATION NAME] (Medication for nausea and vomiting) Tablet 4 MG- Give 1 tablet by PO Q 8 hours as needed for nausea and vomiting (N/V). Order date [DATE]. A review of Resident 1's Medication Administration Record [REDACTED]. [MEDICATION NAME] Tablet 325 MG PO last administered on [DATE] at 10:05 AM. b. [MEDICATION NAME] 4 MG PO administered on [DATE] at 6:02 AM (Seven hours after Resident 1 returned from the ER and had started vomiting). Review of Resident 1's Nurses Progress Notes dated [DATE] at 6:02 AM, indicated Resident 1 given 1 tablet of [MEDICATION NAME] 4 MG PO Q 8 hours as needed for N/V. During an interview with the Social Service Worker (SSW) on [DATE] at 12:15 PM, the SSW stated she had been helping Resident 1 who had been complaining of a stomachache the last two days before she died . The SSW stated she had to reschedule Resident 1's [MEDICAL TREATMENT] appointment to [DATE]. The SSW further stated when speaking with Resident 1's room-mate, she expressed concerns about Resident 1's death and stated, Resident 1 yelled in pain and vomited all night. A review of Licensed Vocational Nurse 1 (LVN 1) statement provided to the Director of Staff Development (DSD) dated [DATE], indicated, During the evening of [DATE], while taking care of Resident 1, Resident 1 had vomited clear emesis and complained of a stomachache. My Certified Nurses Assistants (CNA) were instructed to clean up Resident 1 and the floor many times during the night. LVN 1 went into Resident 1's room to check on her and stated, Resident 1 was moaning loudly and continued to say she had a stomachache. During an interview with the Director of Nurses (DON), on [DATE], at 12:25 PM, the DON confirmed Resident 1 was not appropriately monitored after returning from the hospital. The DON stated, Resident 1 was not provided good care by LVN 1. The DON further stated, Resident 1 should have been administered medication in a timely manner for vomiting and offered medication for C/O abdominal pain. During a telephone interview with LVN 1 on [DATE], at 2:30 PM, LVN 1 confirmed Resident 1 returned from (Name of Hospital) on [DATE] at 11:20 PM, and had vomited multiple times before she had administered any anti-nausea medication and she had not offered any pain medication when Resident 1 had C/O pain several times that night. LVN 1 further stated, I was too busy, and I was sending my CNA's (certified nursing assistants) to check on her. During an interview with Resident 2, (Resident 1's room-mate), on [DATE], at 3:00 PM, Resident 2 confirmed Resident 1 came back from the hospital on [DATE] late in the evening, vomiting and C/O a stomachache. Resident 2 stated, Resident 1 was deaf, kept vomiting and cried all night long of a severe stomachache. When staff would come in, they would yell at both of us to be quiet. Resident 2 stated in the early morning, when Resident 1 had vomited, LVN 1 came in and said, We are too busy to clean you up. When staff left the room someone said, [***] . Resident 2 further stated, I knew when the room was quiet Resident 1 had passed away and I could not help her. 3. Review of Resident 1's Nurses Progress Notes dated [DATE] at 7:58 AM, indicated Resident 1 during morning medication pass was in bed rocking back and forth and had emesis x1. [MEDICATION NAME] 4 MG was given to Resident 1. Her 6:00 AM Blood Sugar (BS) was 397. No insulin was administered to Resident 1. Resident 1 was heard in every room yelling until around 6:50 AM. Change of shift the CNA stated she was not sure if Resident 1 was breathing. Oncoming nurse and this nurse ran down to Resident 1's room to check. Resident 1 was unresponsive. No pulse, or Blood Pressure (B/P), was found.

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Cardio-Pulmonary Resuscitation (CPR-emergency procedure that combines chest compressions with ventilation to manually preserve brain function) was started and 911 was called. Paramedics arrived, CPR was done for 20 minutes and they were unable to revive Resident 1. It was called a 7:38 AM (Resident 1 was pronounced dead). Resident 1's sister was notified at 8:00 AM. Review of Resident 1's physician's orders [REDACTED].-inject right under the skin) every day (QD). In addition, Resident 1 had an order to receive sliding scale insulin meaning orders for insulin are to be administered based on the results of Resident 1's finger stick blood sugars (BS) with [MEDICATION NAME] (medication used to control high BS) insulin-Flex-Pen Solution Pen-Injection 100 Units (U)/Milliliters (ML-unit of measure) inject per sliding scale ,[DATE]- no insulin. Before meals (AC) and at bed time (HS) as follows: a. Blood sugar ,[DATE]- give -8 U of insulin b. Blood sugar ,[DATE]- give 12 U of insulin c. Blood sugar ,[DATE]-give 15 U of insulin d. Blood sugar ,[DATE]-give 18 U of insulin e. Blood sugar ,[DATE]- give 20 U of insulin f. Blood sugar 400 or greater call MD A review of Resident 1's MAR indicated [REDACTED]. The BS documented on [DATE] at 6:00 AM was 397 and the prescribed dose of 20 units of [MEDICATION NAME]was not administered. There was no documentation to indicate the physician was notified it was not given nor that she had been vomiting all night. During a telephone interview with LVN 1 on [DATE], at 2:30 PM, LVN 1 confirmed, she did not notify Resident 1's physician during the night that she had been vomiting and had been yelling out in severe abdominal pain. LVN 1 stated she did not notify Resident 1's physician that her BS was 397 and withheld her insulin because she was vomiting. When LVN 1 was asked if the protocol would be to notify the physician when a resident has a change of condition (COC-significant change in the resident's physical/emotional/emotional/mental condition), LVN 1 stated, I should have called but, I was too busy. During an interview with Director of Staff Development (DSD), on [DATE], at 3:20 PM, the DSD stated LVN 1 should have initiated a, COC, placed on 72-hour charting, called Resident 1's physician and notified him regarding her vomiting, severe abdominal pain and her BS being 397. The DSD stated he is in- charge of training staff and provided no additional training for LVN 1 after an allegation for abuse was made by Resident 2 and no COC was completed for Resident 1 A review of LVN 1's employee file for training since hire date indicated she was hired on [DATE]. She had signed as having received the following trainings: a. Mandated Reporter (related to abuse and neglect)-dated [DATE] b. Staff Abuse Training/Elder Abuse-dated [DATE] c. Pre/Post Elder Abuse Test-dated [DATE] d. Resident Rights/Abuse Prevention- dated [MEDICAL CONDITION] A review of the disciplinary action form dated [DATE] for LVN 1 indicated (Name of Facility and Rehabilitation Education/Counseling Notice), Violations: Safety issue. Any further occurrences will result in Termination. During an interview with the DON on [DATE], at 3:45 PM, the DON confirmed LVN 1 was terminated on [DATE]. An Interview with the DON and DSD and review of policies and procedures on [DATE], indicated the following: A review of facility's policy and procedure titled, Prevention, Reporting and Correction of Inappropriate Conduct Including Abuse, Neglect and Mistreatment of [REDACTED]. A review of the facility's policy and procedure titled. Abuse Investigation and Reporting, Revised 2017, indicated . All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state, and federal agencies and thoroughly invested by facility management: Findings of abuse investigation will also be reported. Role of Investigator: 1. Individual conducting the investigation will, as a minimum. b. Review the Resident's medical record to determine events leading up to the incident. J. Review all events leading up to the alleged incident. Reporting: All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property for will be reported by the facility Administrator or designee. A review of the facility's policy and procedure titled, Charge Nurse undated, indicated . The primary purpose of your job position is to provide direct nursing care to supervise the day to day nursing activities performed by nurse's assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and degree of quality care is always maintained. Must not pose a direct threat to health or safety of individuals in the workplace. A review of the facility's policy and procedure titled, Resident Rights dated [DATE], indicated . Employees shall treat all residents with kindness, respect, and dignity. A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status. Revised 2017, indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/ or status; 2. A, Significant Change of change is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions: b. Impacts more than one area of the Resident's health status. A review of the facility's policy and procedure titled, Administering Medications, dated [DATE] indicated. Medications shall be administered in a safe and timely manner, and as prescribed.