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 _____	**03/18/2020**

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a Registered Nurse (RN) to administer Intravenous (IV) medication to two of three sampled residents (Residents 1 and 2). This failure resulted in three missed doses of Intravenous antibiotics and had the potential to result in exacerbation of an infection . Findings: During a concurrent record review and interview on November 4, 2019, at 9:45 AM, with LVN1, reviewing the Medication Activity records (MAR - shows when and if a medication, treatment or assessment was done) for Resident 1 and Resident 2: A. The MAR for Resident 1 indicated that [MEDICATION NAME] (Antibiotic medication to treat infections) 1 gram IV daily was missed on 11/2/19. LVN1 states that the [MEDICATION NAME] was missed that day because there was no RN to give it that day. B. The MAR for Resident 2 indicated that Meropenem (Antibiotic medication to treat infections) 500 mg IV every 12 hours was not given on November 2, 2019 at 7 AM and 7 PM. LVN1 states that the Meropenem was missed because there was no RN to give it that day. During an interview on November 4, 2019, at 10:31 AM, with the Director of Staff Development (DSD), the DSD states that scheduled RN did not contact the DSD that she was not coming in to work and all other RN staff who were not scheduled could not come in when he called them. The DSD stated that the IV antibiotics were missed because of this. During an interview on November 4, 2019, at 10:56 AM, with LVN1, she stated that she came in to work to drop off paperwork then noticed that there was no RN on duty and asked who gave the IV medication. LVN1 stated that someone needs to be accountable. She states that she is frustrated that No one jumped on it. During an interview on November 4, 2019, at 11:46 AM, with the ADM, the ADM stated he got a text on Saturday, November 2, 2019 at 10:58 AM stating the RN wasn't there and two IV's had not been signed off. He states that he shouldn't have to find out the RN was not there to give the antibiotic four hours after the fact it wasn't given. He states that the facility is supposed to have an RN for 8 hours a day but did not have one that day. ADM states that they are in between Director of Nurses (DON) and hopefully we will have one in three weeks. During a review of the facilities policy and procedure titled, Administering Medications, dated December 2012, indicated, under the Policy Statement, Medications shall be administered in a safe and timely manner, and as prescribed. Under Policy Interpretation and Implementation, 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.

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.