STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555772	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY CARE CENTER	**8515 CHOLLA AVE 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 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** Based on interview and record review, the facility failed to follow their policy and procedure to notify the resident's Responsible Party (RP) of the physician's orders [REDACTED]. This failure resulted in a lack of inclusion of the Responsible Party's right to make decisions in Resident 1's treatment for [REDACTED]. The clinical record indicated that his daughter is the Responsible Party (RP). During a review of the Minimum Date Set (MDS-an assessment tool used for Residents at skilled nursing facilities to facilitate the appropriate care required to meet the resident's needs), dated November 20, 2019, the MDS indicated, his Brief Interview for Mental Status (BIMS) was 3 which reveals severely impaired cognition. During an observation on December 3, 2019, at 1:10 PM, after staff just finished assisting Resident 1 with lunch, he did not engage in any conversation when attempting to speak with him. During an interview on November 21, 2019, at 12:30 PM, with the RP, the RP stated, she was not notified of the new medication, [MEDICATION NAME], being administered to her Father. A review of Resident 1's Medical Nutrition Therapy Review, dated August 30, 2019, indicated, Resident 1 is noted with decreased appetite and decreased oral intake of average 25 to 30% . Recommendations: 1. MD to consider appetite stimulant of [MEDICATION NAME] or [MEDICATION NAME]. During a review of Resident 1's Physician Orders, dated September 1, 2019 to December 2, 2019, the Physician order [REDACTED]. During an interview on December 3, 2019, at 1:45 PM, with the Director of Staff Development (DSD), she stated, Resident 1 had a decrease in appetite and meal consumption was down to 25 to 30% and lost five pounds. The DSD stated we did not know about it until after a surveyor brought it to our attention and we held an Interdisciplinary Team (IDT) Meeting and the MD prescribed [MEDICATION NAME] to help with his weight loss. The DSD stated that the RP was not notified of the change in medication ordered. The DSD stated that the RP should have been notified of any changes in Resident 1's condition and treatment for [REDACTED].Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changed in the residents medical/mental condition and/or status. Under Policy Interpretation and Implementation .4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. there is a significant change in resident's physical, mental, or psychosocial status. And 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. During a review of the facilities policy and procedure titled, Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, dated September 2017, indicated, under Treatment/Management .4. The physician will limit prescribing of appetite stimulants to situations in which underlying causes cannot be identified or treated, other pertinent interventions have not worked or are not feasible, these medications have a valid indication, and improving appetite and weight is consistent with the individual's condition, prognosis, and wishes.

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.