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 _____	08/12/2020

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a Resident Personal Inventory form of resident's personnel belongings on admission for one of three residents. This failure had the potential to result in Resident 1's belongings being lost with no documentation of personal items possibly affecting his independence and social well-being. Findings: A review of the clinical record for Resident 1, the admission record (a document that includes resident identification and a brief medical history) indicated being admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. During an observation/interview with Resident 1 on March 3, 2020 at 3:30 PM, Resident 1 was dressed in his own clothes, sitting on his bed. Resident 1 stated he is very unhappy here in the facility and wants to be released. Resident 1 further stated, They are supposed to be finding me a place to live. A review of Resident 1's, Resident Personal Inventory form, dated February 2, 2020, from his admission was blank indicating it was not completed upon admission. During an interview with Minimum Data Set/ Licensed Vocational Nurse 1 (MDS/LVN 1) on March 3, 2020, at 1:00 PM, MDS/LVN 1 she confirmed there was no Resident Personal Inventory Form completed of Resident 1's personal affects when he was admitted . When asked, MDS/LVNS 1 confirmed this form is supposed to be completed when any resident is admitted to the facility and the admitting nurse is to complete it upon admission. During an interview with the Administrator (ADM) on March 3, 2020, at 4:20 PM, the ADM confirmed Resident 1's Resident Personal Inventory form was not completed. The ADM stated the process for completing this form should be completed for resident's upon on admission and contains a list of personal belongings for the residents. The ADM further stated the form is important especially if a resident's personal belongings go missing. During an interview with SSD on March 4, 2020, at 10:00 AM, the SSD confirmed Resident 1's, Resident Personal Inventory form was not completed. The SSD stated she attempted to complete the form but, Resident 1 was angry at her and kicked her out of his room. A review of the facility policy and procedure titled, Personal Property', dated November 2011, indicated . The resident's personal belongings and clothing shall be inventoried and documented upon admission and such items are replenished.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete an initial comprehensive and accurate assessment (CA- based on resident's needs, strengths, goals, life history, and preferences) within 14 calendar days for one of three sampled residents' (Resident 1). This failure had the potential to result in Resident 1 not being provided accurate care by nursing staff which could affect his health, safety and functional capacity. Findings: A review of the clinical record for Resident 1, the admission record (a document that includes resident identification and a brief medical history) indicated being admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. During an observation/interview with Resident 1 on March 3, 2020 at 3:30 PM, Resident 1 was dressed in his own clothes, sitting on his bed. Resident 1 stated he is very unhappy here in the facility and wants to be released. Resident 1 further stated, They are supposed to be finding me a place to live. A review of Resident 1's admission Minimum Data Set (MDS-process for clinical assessment of all residents') dated January 7, 2020, indicated the following sections were not completed: a. Section A-Identification Information b. Section G-Functional Status c. Section GG-Functional Abilities and Goals d. Section H-Bladder and Bowel e. Section I-Active [DIAGNOSES REDACTED]. Section K-Swallowing/Nutrition Status h. Section M-Skin Conditions i. Section N-Medications j. Section O-Special Treatments, Procedures, and Programs k. Section P-Restraints m. Section X-Correction Request with RN Assessment Signature indicating accurate completion of MDS. During an interview with the MDS/ Licensed Vocational Nurse 1 (MDS/LVN 1) on March 4, 2020 at 2:30 PM, the MDS/LVN 1 stated the timeframe to complete an admission MDS for a resident is within 14 days. The MDS/LVN 1 confirmed only sections B, C, D, E, F, and Q were completed for Resident 1's admission MDS and it was never signed by a Registered Nurse (RN). The MDS/LVN 1 further stated the MDS drives the care for the residents and if the MDS is late it can affect the care being provided to the resident because the care plans (C/P's) are initiated from their MDS. A review of the facility policy and procedure titled, MDS Completion and Submission Time-frames Property, undated, indicated .Our facility will conduct and submit resident assessments with current in accordance with federal and state submissions time-frames. A review of the facility policy and procedure titled, Resident Assessment Instrument, undated, indicated . A comprehensive assessment of a Resident's needs shall be made within fourteen (14) days of the resident's admission. The Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and review within fourteen days of the resident's admission to the facility.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy to initiate and implement a resident centered care plan on admission for one of three residents (Resident 1). This failure has potential to affect Resident 1 a clinically compromised resident overall health and wellbeing. Findings: A review of the clinical record for Resident 1, the admission record (a document that includes resident identification and a brief medical history) indicated being admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. During an observation/interview with Resident 1 on March 3, 2020 at 3:30 PM, Resident 1 was dressed in his own clothes, sitting on his bed. Resident 1 stated he is very unhappy here in the facility and wants to be released. Resident 1 further stated, They are supposed to be finding me a place to live. A review of Resident 1's medical record indicated a baseline care plan had not been developed or imitated. A psychological evaluation dated January 1, 2020, was completed by the Social Services Director (SSW) and contains discharge planning. There were no team meeting notes. During an interview with Director of Nurses (DON) on March 4, 2020, at 1:00 PM, the DON confirmed Resident 1 did not have a base line care plan completed within 48 hours of admission. The DON stated he was just hired and is unsure of the facilities policy and procedure but, I normally believe an admission Interdisciplinary Team Meeting (IDT-group of health care professionals who work in a coordinated effort to manage the physical, psychological, and spiritual needs of the resident) is held with the team within 48 hours. During an interview with the SSD

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 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) in the presence of the DON on March 4, 2020, at 1:30 PM, the SSD stated admission baseline care plans should be completed within 48 hours of a resident's admission by the team. The SSD stated there was no admission IDT meeting. Each team member can talk to the resident individually. The SSD confirmed there was no admission baseline care plan completed by the team for Resident 1 within 48 hours of his admission. A review of the facility policy and procedure titled, Care Plans-Baseline, undated, indicated .A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission. The resident and their representative will be provided a summary of the baseline care plan that includes but not limited to a. initial goals of the residents; b. a summary of the resident's medications and dietary instructions; c. any services or treatment to be administered and d. any undated information based on the plan