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 _____	**03/30/2020**

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 ensure, for two of two sampled residents (Residents 1 and 2), the physician and the residents' representative were notified when Resident 1 fell and injured her hip after being pushed to the floor by Resident 2 and Resident 2 had an adverse behavior, causing injury to Resident 1. This failure had the potential to result in the residents' not receiving appropriate treatments. Findings: During a review of the medical record for Resident 1, it showed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of a Nurse's Note dated February 12, 2020 at 9:49 PM, showed the following: at 2010 (8:10 PM) resident was standing in the doorway of her room when (Resident 2) went to enter room, she punched (Resident 1) in the left check (cheek) and pushed her to the floor. She landed on her right side. Small bump to left check (cheek) noted and small area of bruising to right hip . There was no documentation in the medical record that the resident's physician or the resident's representative was notified of the incident. During a review of the medical record for Resident 2, it showed the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of a Nurse's Note dated February 12, 2020 at 9:59 PM, showed the following: at 2010 resident punched roommate (Resident 1) in the left check (cheek) as she was standing in the doorway of room and then pushed her to the floor. Resident (2) removed from the room. Resident continued to scream at staff and making attempts to enter other rooms . There was no documentation in the medical record that the resident's physician or the resident's representative was notified of the incident. In an interview with the Assistant Administrator on February 20, 2020 at 10:00 AM, she stated there was no documentation in the record that either residents' physician or the resident's representative were notified of the altercation. She acknowledged they should have been notified. A review of a facility policy and procedure titled Resident-to-Resident Altercation, with a revision date of December 2016, showed the following: 2. If two residents are involved in an altercation, staff will: c. Notify each resident's representative and Attending Physician of the incident. A review of a facility policy and procedure titled Change in a Resident's Condition or Status, with a revision date of May 2017, showed the following: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): a. accident or incident involving the resident . 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source;
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 Observation, interview and record review, the facility failed to ensure their policy and procedure for falls was implemented for one of two sampled residents (Resident 1) by not monitoring the resident for complications related to the fall. This failure had the potential for complications from the fall not to be recognized and treated in a timely manner. Findings: During a review of the medical record for Resident 1, it showed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a nurse's note dated February 12, 2020 at 9:49 PM, showed the following: at 2010 (8:10 PM) resident was standing in the doorway of her room when (Resident 2) went to enter room, she punched (Resident 1) in the left check (cheek) and pushed her to the floor. She landed on her right side. Small bump to left check (cheek) noted and small area of bruising to right hip . There was no evidence in the medical record that Resident 1 was monitored after her fall for any complications until the resident was stable. In an interview with the Assistant Administrator on February 20, 2020 at 10:00 AM, she stated the post fall assessments for Resident 1 were not found in her medical record. She acknowledged the resident should have been monitored for complications. A review of a facility policy and procedure titled Falls-Clinical Protocol, with a revision date of March 2018, showed the following: Monitoring and Follow-Up 1. The staff with the physician's guidance will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma (bleeding into the brain) have been ruled out or resolved. a. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematoma or other intracranial bleeding could occur up to several weeks after a fall.

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.