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 _____	**05/22/2020**

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their policy and procedure on investigation and reporting abuse for one of three sampled residents (Resident 1). This failure had the potential to result in the abuse of vulnerable residents. Findings: During a review of Resident 1's Medical Records from the Emergency Department Physician Summary and radiology results, dated October 13, 2019, the ED Physician Summary and radiology results indicated, that resident 1's chief complaint was mass right side chest with an onset of two weeks. The context and associated signs and symptoms state resident had a fall that occurred 2 weeks prior to arrival and staff at facility did not notice mass until today. The physical exam shows there was ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising) that extends from the left anterior (front) chest wall to the right anterior chest wall and ecchymosis on the humeral region (upper arm). The CT of the chest shows right anterior chest wall hematoma (a solid swelling of clotted blood within the tissues) and right posterior (rear) lateral (side) [MEDICAL CONDITION] (excess of watery fluid collecting in the cavities or tissues) or hemorrhage (bleeding) presumably on a traumatic basis. During an observation on April 28, 2019, at 11:52 AM, Resident 1 was in Geri chair and she was non-verbal when attempting to interview her. During an interview on April 28, 2020, at 12:09 PM, with Certified Nurse Assistant (CNA1), CNA1 stated, He saw bruising to Resident 1 and did not know what happened to cause it. He states she was totally dependent on care so she couldn't have moved and fallen off the bed. He states he reported it to his charge nurse but unable to remember who it was. During a review of the Minimum Data Set (MDS- an assessment used by nursing homes to assess residents and plan the care) for Resident 1, dated October 6, 2019, the MDS indicated, under Section C (cognitive) that resident is rarely/never understood and under Section G (functional abilities) she was totally dependent with transferring, eating, bed mobility, dressing and locomotion. During a review of the progress notes for Resident 1, dated October 1, 2019, the progress note written by LVN1 indicated, that a CNA found the area under armpit and right posterior flank was discolored and resident showed signs and symptoms of flinching when turning resident 1. Resident was not able to tell what happened. During an interview on April 28, 2020, at 1:14 PM, with LVN1, LVN1 stated, she isn't sure what happened to Resident 1. She had the bruising on one side under her arm pit but not sure about the other side of her chest. I remember that I wrote a report on it and she was showing signs of pain. LVN1 stated she just lays still and has no history of climbing out of bed. LVN1 stated, she can't move. LVN1 stated, I don't know if facility investigated it later on but I know they did not investigate it at the time it was discovered. LVN1 did not remember who the CNA was when it was found. During a concurrent interview and record review on April 28, 2020, at 1:23 PM, with the MDS Coordinator, the MDS Coordinator stated, she was unable to find the cause of the bruising to Resident 1 in the records. The review of the transfer note, dated October 13, 2019, indicated, Resident 1 was sent to ER for swelling to right upper chest and continues to increase. During an interview on April 28, 2020, at 1:35 PM, with the DON, the DON stated, I am unable to find an investigation done for injury of unknown origin and I am unable to find that it was reported to the State of [ST] Department of Public Health. The DON states that in the case of an injury of unknown origin, he would notify the MD, Ombudsman and Responsible Party, as well as, do an investigation and report to the State with SOC 341. During a review of the facility's policy and procedure titled, Abuse Investigation and Reporting, Revised July 2017, indicated, under Policy Statement, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.

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.