STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555331	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valencia Gardens Health Care Center	4301 Caroline Court Riverside, CA 92506

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on interview and record review, the facility failed to ensure the interventions provided to Resident 1 when she had a low blood sugar level of 37 (hypoglycemia), was documented in the medical record. This failure had the potential to affect Resident' 1's health and make it harder for nursing staff to communicate effectively and provide proper care. Findings: A review of Resident 1's admission record indicated she was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (high blood sugar level). A review of Resident 1's History and Physical dated December 19, 2024, indicated she had the capacity to understand and make decisions. A review of Resident 1's Medication Administration Record (MAR) for the month of January 2025 indicated she had a blood sugar level of 37 at 6:30 a.m. on January 1, 2025. A review of Resident 1's SBAR (Situation Background Assessment Recommendation- a standardized communication tool) Communication Form and progress note . written by Licensed Vocationa Nurse (LVN) 1, indicated Resident 1 had hypoglycemia on January 1, 2025, at 6:15 a.m. and the physician was notified. There was no other documented evidence that interventions were provided to manage Resident 1's hypoglycemia on January 1, 2025. In addition there was no documented evidence Resident 1 physician responded to the notification. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 24, 2025, at 1:48 p.m. during a concurrent interview with LVN 1 and record review of Resident 1's medical record, LVN 1 stated she was notified that Resident 1 had a low blood sugar level, she notified the physician and initiated an SBAR. LVN 1 stated there were no new orders from Resident 1's physician. LVN 1 stated for residents with a blood sugar level of 70 and below, the orange juice or glucagon is provided to the resident and the physician would be notified. LVN 1 stated there was no documentation in Resident 1's medical record that interventions were provided to manage Resident 1's low blood sugar level. LVN 1 stated when orange juice or glucagon was given, it should be documented in Resident 1's medical record. On March 24, 2025, at 2:54 p.m., during a telephone interview with LVN 2, she stated she was familiar with Resident 1 and that she was the charge nurse when Resident 1 had a low blood sugar level. LVN 2 stated Resident 1 was confused so she checked her blood sugar, and it was low. LVN 2 stated Resident 1 was still awake, she gave her orange juice and rechecked her blood sugar level. LVN 2 stated she could not recall what the result of the recheck was. LVN 2 stated she did not document that she provided orange juice and rechecked Resident 1's blood sugar level and she should have documented it. On March 24, 2025, at 4:17 p.m. during an interview with the Administrator and Director of Nursing (DON), the DON stated she expected the licensed nurses to document everything they do. The DON stated if LVN 2 provided interventions to manage Resident 1's blood sugar then she should have documented it. A review of the facility's policy and procedure titled Acute Condition Changes - Clinical Protocol dated March 2018 indicated .Monitoring and Follow-up .The staff will monitor and document the resident/patient's progress and responses to treatment .