

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2024
NAME OF PROVIDER OR SUPPLIER  Spring Valley Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  14973 Hesperia Road Victorville, CA 92395	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45240</b></p> <p>Based on interview, and record review, the facility failed to notify the resident's designated responsible party for one of three sampled resident (Resident 1) when Resident 1's change of condition when Resident 1 developed redness, irritation to right side of throat and right ear with pain and itching.</p> <p>This failure prohibited Resident 1's representative to be actively involved in participating with Resident 1's comprehensive Plan of care.</p> <p>Findings:</p> <p>During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was re- admitted to the facility on [DATE].2024, with diagnoses to include: Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), peripheral autonomic neuropathy ( a disorder that damages the nerves that control your internal organs), hypertensive heart disease ( condition that develops over many years in people with high blood pressure which occurs when the heart muscle does not pump properly), type 2 diabetes mellitus (condition in which the body has trouble controlling blood sugar), and dementia (loss of thinking, remembering, and reasoning).</p> <p>During a concurrent interview and record review of Change of Condition notification (COC) with LVN 1 on June 18,2024 at 10:30 am. LVN 1 stated that on April 30,2024 at 10:30 am, she did not notify Resident 1's Responsible Party (RP) of redness, irritation to right side of throat and right ear with pain and itching. LVN1 stated that Resident 1 is self-responsible per documentation on Admission Record. During a record review of Resident 1's History and Physical (H&amp;P) with LVN1, Resident 1's Primary Physician (MD), indicated that Resident 1 does not have the capacity to understand and make decisions. When LVN1 was asked if she reviewed the H&amp;P that was written by Resident 1's MD on April 8, 2024, LVN 1 denies reviewing the H&amp;P. She stated that she only read the admission record.</p> <p>During a concurrent record review and interview on June 18,2024 at 11:05 am with Director of Nursing (DON), DON stated that Resident 1's RP on COC form indicated that RP was not notified on April 23,2024 and April 30,2024. DON stated that Resident 1's Admission Record should have been updated to reflect MD's H&amp;P written on April 8, 2024, indicating that Resident 1 does not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy titled, Change of Condition , revised in December,2014, the policy indicated: It is the policy of this facility, except in medical emergencies, to notify the resident, his/her attending physician, and any interested family member or legal representative, of changes in the resident's condition and /or status.</p>