

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 03/13/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 1) was free of any significant medication errors (administration of medications which was not in accordance with accepted professional standards and principles), when Resident 1 was given medications that belongs to another resident.</p> <p>These failures had the potential to jeopardize the health and well-being of medically compromised Resident 1.</p> <p>Findings:</p> <p>During a phone interview on March 12, 2025, with Resident 1, Resident 1 reported that at 8:47 AM on February 26, 2025, a nurse gave her a medication cup labeled 52 B containing 6 different types of medication. She claimed that she did not take the medication because she is aware that it is not hers.</p> <p>A review of Resident 1 Face Sheet (contain resident demographic), the Face Sheet indicated, Resident 1 was admitted on [DATE], with a diagnosis that included Chronic Obstructive Pulmonary Disease (COPD - is a group of lung diseases that make it hard to breath).</p> <p>During a review of Resident 1 ' s Minimum Data Set (facility assessment tool), dated October 19, 2024, under Section C, it indicated her Brief Interview for Mental Status (BIMS) score was 15. (A BIMS score of 13 to 15 suggests the patient is cognitively intact).</p> <p>A review of Resident 1 ' s Medication Administration Record (MAR) for the Month of February 2025, indicated on February 26, 2025, resident 1 received the following medications: Lidoderm Patch 5%, Gabapentin capsule 300 mg, Allopurinol oral table 300 mg, Ergo Cal oral capsule 1.25 mg, Folic Acid tablet 1 mg, Isosorbide Mononitrate Oral Tablet 20 mg, Levothyroxine Sodium oral table 125 mcg, Apixaban oral tablet 5 mg, Magnesium oral table 200 mg, Nifedipine ER oral tablet 60 mg, Pantoprazole sodium tablet 40 mg.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on March 13, 2025, at 11:14 AM with the Director of Nursing (DON 1), the DON 1 stated on February 28, 2025, a Registered Nurse (RN 1) notified her that Resident 1 claimed a Licensed Vocational Nurse (LVN 1) provided her with 5 tablets of medication in a cup labeled 52B. Resident 1 asserted she did not consume it because she identified it was not hers. The RN recorded a photo of the medication and communicated it with her. She indicated that she verifies it with the pharmacy consultant, and it was concluded that the medications were: Levetiracetam oral tablet 1000mg, Montelukast Sodium oral tablet 10 mg, Zolofl oral tablet 50 mg, Finasteride oral tablet 5 mg. She noted that none of those medications were linked to Resident 1. She also mentioned that upon reviewing the medications, the four pills that Resident 1 identified belonged to Resident 5, but because Resident 5 had been admitted to the hospital on February 26, 2025, it remains uncertain how Resident 1 acquired the medication.</p> <p>During concurrent record review and interview on March 13, 2025, at 11:23 AM with the DON 1, incident report dated February 28, 2025, was reviewed. DON acknowledged that Incident report indicated the incident of medication error took place however, unable to identify which Nursing staff member committed the error, the exact date and time it happened was unknown.</p> <p>During an interview on March 13, 2025, at 12:04 PM with the Administrator (Admin 1), the admin 1 stated that he thinks if the nursing staff are doing the job properly it shouldn ' t happen.</p> <p>During an interview on March 13, 2025, at 12:10 PM with LVN 1, LVN1 stated that the incorrect medications are those given in the morning, and since she is the night nurse, it was not her who administered the medication.</p> <p>A review of the facility policy and procedure (P&P) titled, Medication and Treatment Administration dated October 2014, indicated, .9. Residents shall be identified before administration of a drug or treatment .</p>		