STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055076	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Valley Post Acute LLC	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)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055076	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Valley Post Acute LLC	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)
F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its own policy and procedure concerning the use of physical restraints when three of three Justice-Involved Residents (residents under the care of law enforcement, community supervision, in custody, held involuntarily through operation of law enforcement authorities [Residents 1, 2, and 3]) did not receive respectful and dignified treatment. This includes the right to be free from physical restraints, which was not necessary to address residents' medical conditions. The facility, instead, placed sole responsibility on the correctional officers for the application, removal, and monitoring of potential complications associated with the use of restraints.These failures had the potential to place clinically compromised residents (Resident 1, 2, and 3) at risk of serious physical injuries, including skin damage, pressure ulcers, nerve damage, and prolonged immobility. Additionally, it can also lead to serious psychological effects, such as loss of dignity, which may lead to anxiety, depression, and suicidal thoughts resulting from lack of monitoring by a trained staff, physician order, care plan, nursing assessments, and proper documentation related to the use of restraints.Findings:During an observation in Resident 1's room on September 24, 2025, at 12:10 PM, Resident 1 was observed lying on bed, restrained with metal shackles on both ankles, which were attached to the end of the bed frame. Resident 1 appeared alert and calm during the observation. The skin around the shackles was assessed and found to be intact, with no evidence of redness, blistering, discoloration, or any other skin issues that possibly are associated with the use of shackles. During this observation, two correctional officers were present at the bedside, monitoring Resident 1. During a review of Resident 1's admission Record (general demographics) on September 24, 2025, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (paralysis on one side of the body) and hemiparesis (partial paralysis on one side of the body), heart failure (heart is not pumping blood as well as it should), and hypotension (low blood pressure).During an observation in Resident 2's room on September 24, 2025, at 12:15 PM, Resident 2 was observed on bed in the same room as Resident 1. Resident 2 was restrained with metal shackles on both ankles, which were attached to the end of the bed frame. Additionally, a metal shackle was observed on his left wrist and was attached to one of the side rails of the bed, while two correctional officers were on bedside monitoring Resident 1 and 2.During a review of Resident 2's admission Record (general demographics) on September 24, 2025, the admission Record indicated Resident 2 was admitted on [DATE], with a diagnoses that included peripheral autonomic neuropathy (condition that affects the nerves that control involuntary body functions, such as heart rate, blood pressure, and sweating), acute kidney failure (kidney suddenly stops working properly), and fracture of the left hand (break in one or more bones in the left hand).During an observation in Resident 3's room on September 24, 2025, at 12:26 PM, Resident 3 was observed on bed, restrained with metal shackles on both ankles that were attached to the end of the bed frame. Additionally, a metal shackle was also observed on his left wrist and was attached to one of the side rails of the bed, while two correctional officers were watching him.During a review of Resident 3's admission Record (general demographics) on September 24, 2025, the admission Record indicated Resident 3 was admitted to the facility on [DATE], with a diagnoses that included cellulitis (bacterial infection that gets into the deeper layer of the skin) of the right lower limb, neuropathy (damaged nerves), and hypertension (high blood pressure). During an interview on September 24, 2025, at 1:20 PM, with a Certified Nursing Assistant (CNA 1), CNA 1 stated, the shackles were removed when the patients [residents] are taken to the restrooms and receive a bath. When asked how she repositions the residents while they are in shackles, she stated, I request the correctional officer to remove the shackles. however, she noted the shackles are not usually removed because there is enough slack for the residents to move their legs around.During an interview on September 24, 2025, at 1: 31 PM, with Certified Nursing Assistant (CNA) 2. CNA 2 confirmed that she is assigned to the three residents who are in shackles. CNA 2 stated she requested the correctional officers to remove the shackles for Resident 1 and Resident 2 when they went to the toilet and when they took a shower. For Resident 3, CNA 2 stated she did not release the shackles throughout her shift, as he had not gone to the bathroom yet. When CNA 2 was asked if she had checked the wrists and ankles of Resident 1, Resident 2, and Resident 3 for bruises, CNA 2 mentioned she only observed briefly while she performed activities of daily living (ADL - basic tasks that residents perform to maintain their personal care).During an interview on September 24, 2025, at 1:50 PM, with the Activity Director (Director), Director stated , The inmates do not