| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055076 | A. Building<br>B. Wing | 03/05/2026 |

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| Spring Valley Post Acute LLC | 14973 Hesperia Rd<br>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.

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that Discharge Minimum Data Set (MDS-computerized assessment instrument) assessments were initiated, completed and submitted within the required 14ˆday timeframe following resident discharge, in accordance with Centers for Medicare & Medicaid Services (CMS) requirements, for three of three sampled residents reviewed for resident assessments (Residents 35, 78, and 104).This failure had the potential to result in incomplete resident assessment discharge status information, which may affect continuity of care, followˆup services, and compliance with federal reporting requirements.Findings:1. During a review of Resident 35's admission Record (a document that contains demographic and clinical information), Resident 35 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD - a group of airway diseases that restrict breathing).A review of Resident 35's physician's order, dated October 6, 2025, indicated, May D/C [discharge] home on [DATE] [October 9, 2025].A review of Resident 35's MDS was conducted on March 4, 2026, and it indicated Resident 35's Discharge MDS assessment had not been initiated, completed and submitted for four months and 24 days. 2. During a review of Resident 78's admission Record, Resident 78 was admitted to the facility on [DATE], with diagnoses which included chronic kidney disease stage 3A (mild-to-moderate loss of function).A review of Resident 78's physician's order, dated September19, 2025, indicated, May go to [Named of hospital].A review of Resident 78's MDS was conducted on March 4, 2026, and it indicated Resident 78's Discharge MDS assessment had not been initiated, completed and submitted for five months and 14 days. 3. During a review of Resident 104's admission Record, Resident 104 was admitted to the facility October 4, 2025, with diagnoses which included COPD.A review of Resident 104's physician's order for Resident 104, dated December 12, 2025, indicated, D/C [discharged ] to acute [hospital].A review of Resident 104's MDS was conducted on March 4, 2026, and it indicated Resident 104's Discharge MDS assessment had not been initiated, completed and submitted for two months and 21 days.During an interview on March 4, 2026, at 2:40 PM, with the MDS Nurse, the MDS Nurse confirmed Residents 35, 78, and 104's Discharge MDS assessments had not been completed. The MDS Nurse stated that the assessments should have been completed but was unsure of the required timeframe.During an interview on March 5, 2026, at 3:00 PM, with the Director of Nursing (DON), the DON stated that the facility follows the CMS RAI manual (Resident Assessment Instrument- provides guidelines and definitions for completing MDS assessment) that the required Discharge MDS assessment should have been completed within 14 days after Residents 35, 78 and 104's discharge from the facility.During a concurrent interview and record review on March 5, 2026, at 3:10 PM, with MDS Nurse and the DON, the MDS Nurse and the DON reviewed the facility's policy and procedures titled Resident Assessment, revised November 2019, which indicated, Policy Statement A comprehensive assessment of every resident's needs is made at intervals designated by OBRA [is a federal law that establishes regulations for nursing facilities] . Policy Interpretation and Implementation. 1. The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews according<br>(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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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | to the following requirements: a. OBRA required assessments - conducted for all residents in the facility: . (5) Discharge Assessment - Conducted when a resident is discharged from the facility. The Interdisciplinary Team uses the MDS form currently mandated by Federal and State regulation to conduct the resident assessment . The DON stated that the facility did not follow the policy.During a review of CMS RAI manual dated October 2025, it indicated, . 09. Discharge Assessment-Return Not Anticipated (A0310F = 10) Must be completed when the resident is discharged from the facility . Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on observation, record review, and interview, the facility failed to ensure that pressure injury (the type wound [open sore on the skin] caused by sitting or lying in one position too long) treatment and services were consistent with the residents' current wound conditions and with the facility's own treatment protocol for one out of three sampled residents (Resident 3) reviewed for pressure injury care. This failure resulted in delays in appropriate treatment, slowed the healing process, and increased the risk of further deterioration of Resident 3's right ischium (the lower, back part of the hip bone) pressure injury. Findings:During a review of Resident 3's admission Record (a document that contains demographic and clinical information), Resident 3 was admitted to the facility on initially on December 12, 2010, with diagnoses including hemiplegia and hemiparesis following cerebral infraction effected right dominant side (a condition means that a stroke (brain attack) has damaged the left side of the brain, that controls the right side of the body) , anemia (low levels of healthy red blood cells), and hypertension (blood pressure that is higher than normal).A review of Resident 3's physician's order, dated February 23, 2026, indicated RT [right] ischium Stage 2 Pressure Injury [a stage that the top layer of skin (epidermis) has broken, and the second layer (dermis) is exposed] : Cleanse with NS [sterile solution]., Pat Dry, Cover with foam dressing [ a medical dressing that super-fast absorbent] Q [every] D [day] and PRN [as needed] .During a wound care observation on March 4, 2026, at 9:48 AM, with the Treatment Nurse (TN), the TN performed wound care to Resident 3. The TN applied treatment to the resident's right ischium pressure injury, full thickness tissue loss in which contained yellow slough (soft tissue) and dark brown eschar (dead tissue) that covered the wound bed and prevented visualization of the base, demonstrating characteristics consistent with an unstageable pressure injury. The TN continued to apply interventions ordered for a Stage 2 pressure injury and did not reassess or modify the treatment based on Resident 3's right ischium pressure injury condition at the time of the observation.During an interview on March 5, 2026, at 1:40 PM, with the TN, the TN asked to describe Resident 3's current right ischium wound condition. The TN stated the wound had some part slough and some part eschar covering the wound bed, making it difficult to see the base of the wound. The TN further stated that when slough or/and eschar is present and still covering the base, therefore the true depth, and stage cannot be determined (unstageable).During a follow up interview on March 5, 2026, at 1:50 PM, with the TN, the TN referred to the woundˆstaging poster kept on the unit and compared the wound's appearance to the pictures on the poster. The TN stated the wound characteristics were consistent with an unstageable pressure injury. The TN further stated she reported that she had notified the wound physician but was unable to provide documentation to show that any notification occurred.During a concurrent record review and interview on March 5, 2026, at 5:20 PM, Resident 3's clinical record was reviewed with the Director of Nurses (DON) which showed that Stage 2 treatment continued through March 5, 2026, with no documented reassessment, no notification to the provider of the change in wound condition, and no updated treatment orders reflecting the unstageable status. The DON stated when wound care is performed, the wound should be assessed at the same times and follow the treatment according to facility's wound protocol.During a concurrent interview and record review on March 5, 2026, at 5:30 PM, with TN and DON, TN and DON reviewed the facility policy and procedures titled Policy and Procedure on Pressure Ulcers dated October 2010, indicated The facility shall ensure that a resident who enters the facility with pressure ulcer and/or develops unavoidable pressure ulcers while being in the facility, must receive treatment and services necessary to promote healing, prevent infection, and prevent new ulcers from developing. Procedures: Licensed charge nurse or treatment nurse shall conduct basic assessment and data collection on the following.progress towards healing (slow response or delayed healing, healing well). 2. Assessment of pressure ulcers shall be done at least once every week or as wound condition changes.3. Document general findings in the weekly skin and wound progress report. The DON stated that staff should have reassessed Resident 3's right ischium pressure injury when the<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | wound condition changed and updated the treatment orders to reflect the wound's Unstageable status to ensure the resident receive appropriate care to promote healing and prevent further decline. The DON further stated that the facility did not follow the policy.During a concurrent record review and interview on March 5, 2026, at 5:55 PM of the facility's pressure injury treatment protocol with the Administrator and DON titled PRESSURE ULCER GUIDELINES revised February 7, 2012, indicated . STAGE II, WITHOUT INFECTION: _____ (area) Stage II Pressure Ulcer - Cleanse w/ [with] NS to surrounding skin, cover w/ Hydrocolloid Dressing [medical dressing for surface open wounds] Q 3 Days & PRN soiling/ displacement until healed; then D/C [discontinue] . UNSTAGEABLE. Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed. _____ ,(area) Unstageable Pressure Ulcer -Cleanse well w/ NS, generously apply Santyl Ointment [a prescription topical medication used to debride (remove) dead tissue from the wound] , . Q Day & PRN, soiling/displacement; until fully debrided, then reevaluate. The DON acknowledged that the treatment provided for Resident 3's right ischium did not follow the correct protocol for either the initial staging (stage 2) or the actual wound condition (unstageable). The DON stated Resident 3's right ischium pressure injury should have been identified as Unstageable and initiated the treatment according to the facility's pressure ulcer guidelines, but the facility protocol was not followed. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its smoking safety policy for one of three sampled residents reviewed for smoking safety (Resident 47), when Resident 47 was found to have smoking materials in his possession on March 4, 2026.This failure had the potential to place the residents and others at risk for fire-related injury or other smoking-related accidents.Findings: During a review of Resident 47's admission Record (a document that contains demographic and clinical information), Resident 47 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD - a group of airway diseases that restrict breathing).A review of Resident 47's clinical record of Resident Smoking Assessment dated January 22, 2026, indicated , . A. Does the Resident Smoke? . [marked] 2. Yes. Proceed with assessment .During an observation and concurrent interview on March 3, 2026, at 11:00 AM, in Resident 47's room, Resident 47 removed a pack of cigarettes and a lighter from a jacket pocket. Resident 47 stated I keep these [cigarette and lighter] with me because I am an independent smoker.During a concurrent observation and interview on March 4, 2026, at 2:00 PM, in Resident 47's room, with the Activity Director (AD), Resident 74 pulled a cigarette from his pants' pocket, with a lighter stored inside the cigarette box. The AD verified the finding and stated that an independent smoker may keep their cigarettes but should not keep a lighter.During a concurrent interview and record review on March 5, 2026, at 2:05 PM, with the Administrator (Admin), the Admin reviewed the facility's policy and procedures titled Resident Supervised Smoking Policy effective January 16, 2026, which indicated Policy: It is the policy of the facility to allow residents to exercise their right to smoke in a manner that does not jeopardize other residents, facility property, staff and the resident exercising that right. All resident smoking must be supervised and materials secured. Procedure: . 7. Residents are not permitted to keep smoking materials, lighters, matches or any related materials in their possession. Smoking materials will be labeled with the resident's name and secured in a designated location. Responsible party and/or family members will be asked not to provide smoking materials directly to residents. Smoking materials brought into the facility should be presented to Social Services staff or charge nurses. 8. This facility may check periodically to determine if residents have any smoking articles in violation of this policy. The Administrator stated it was his responsibility to ensure staff were educated on the updated smoking policy. The Administrator acknowledged that according to the updated policy, residents should not keep any smoking materials, including cigarettes or lighters, regardless of smoking independence status, to reduce fire and safety risks. The Admin further stated that the facility did not follow the policy. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their dialysis policy for one resident (Resident 130) when staff did not monitor and complete Resident 130's Post Access Site Assessment (checking the dialysis access site after treatment to make sure it is safe and there are no problems like bleeding, swelling, infection). This failure had potential to cause complications at the access site for Resident 130. Findings: During a review of Resident 130's admission Record (contains patient demographics), the admission Record indicated Resident 130 was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus with hyperglycemia (a condition where body cannot produce enough insulin), dependence of renal dialysis (a person with permanent kidney failure requires regular, life-sustaining, artificial blood filtration (dialysis- to remove waste and excess fluids), and dysphagia (difficult swallowing). During a review of Resident 130's Orders Summary Report (active physician orders), dated March 3, 2026, it indicated Dialysis Days: T-TH- S (Tuesday, Thursday, Saturday) Observe/monitor bruit (abnormal rushing or whooshing sound heard via stethoscope indicating turbulent blood flow)/thrill (palpable, buzzing vibration felt over the same area indicating turbulent blood flow) for (0)absence and (1) =presence. During a concurrent observation and interview on March 3, 2026, at 2:45 PM, in Resident 130's room, Resident 130 was awake in her bed. She had a fistula (connection surgically made that's used for dialysis access) on her left arm. Resident 130 stated she has dialysis on Tuesdays, Thursdays, and Saturdays. During a concurrent interview and record review on March 4, 2026, at 1:30 PM, with the Director of Nursing (DON), the DON reviewed Resident 130's Dialysis Communication Record Post Dialysis Assessment for January 29, 2026, February 7, 2026, February 11, 2026, February 14, 2026, and acknowledged there were no documented evidence to indicate the Post Access Site Assessment were conducted for those days. The DON stated nurses were to monitor and to document after each post dialysis. During a concurrent interview and record review on March 5, 2026, at 8:20 AM, with the DON, the facility's policy and procedures (P&P) titled Dialysis Care revised in October 2019 was reviewed. The P&P indicated, Policy. It is this facility policy to provide standards of care to residents receiving dialysis care.2. After each dialysis treatment, licensed nurse shall evaluate resident and notify physician immediately of any apparent complication from dialysis procedures.5. Licensed nurse shall monitor and document on pre and post dialysis observations such as vital signs, change of condition, bruits, thrill, and dialysis access site for redness, swelling, and drainage . The DON stated her expectation was for nurses to assess the resident and document the assessment after each dialysis. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with the physician's orders and policy for one of six residents reviewed for Medication Administration (Resident 103) when a Licensed Vocational Nurse (LVN 1) administered an anti-hypertensive (used to treat high blood pressure) to Resident 103. This failure had the potential to result in poor blood pressure control and increased risk of hypertension-related complications.<br>Findings: During a record review of Resident 103's admission Record (contains demographic and medical information), it indicated Resident 103 was admitted to the facility on [DATE], with diagnoses which included unspecified dementia (clear signs of such as memory loss, confusion, and behavioral changes), hyperlipidemia (high level of fats) and secondary hypertension (high blood pressure). During review of Resident 103's Order Summary (active physician orders for a resident's care), it indicated Resident 103 had an order to receive Metoprolol Tartrate (used to treat high blood pressure) 25 mg (milligram (used to measure medication dosages)). Give 1 tablet by mouth two times a day for HTN (hypertension) Hold if SBP (top number in a blood pressure reading (maximum force of blood pushing against artery walls when the heart beats and contracts)) < (less than) 110 or HR)( Heart Rate (the number of times your heart beats per minute)) < 60. During a medication administration observation and concurrent interview, with LVN 1, on March 4, 2026, at 8:43 AM, LVN 1 was inside Resident 103's room to check Resident 103's blood pressure and heart rate. The blood pressure reading was 124 /80, while the heart rate was 61. LVN 1 then went to the Medication Cart to prepare Resident 103's due medications, which included Metoprolol Tartrate. LVN 1 searched the Medication Cart and the e-kit (emergency kits (sealed, secured, and regularly audited supply of essential medications and emergency supplies)) but was unable to find Resident 103's Metoprolol Tartrate. LVN 1 stated that a supervisor reached out to the pharmacy and had the medication delivered as soon as possible. During a concurrent interview and record review on March 4, 2026, at 10:45 AM, with the Director of Nursing (DON) and the Administrator, the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019 was reviewed. The P&P indicated .4. Medications are administered in accordance with prescriber orders, including any required time frame. The DON and the Administrator stated the policy was not followed. The DON further stated that the medication should have been given in a timely manner. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a sanitary and safe environment for one of five residents reviewed for infection control when a License Vocational Nurse (LVN 2) entered Resident 130's room, which was a contact isolation precautions resident room ( prevent the spread of infections transmitted through direct or indirect contact with a patient or their environment), without wearing personal protection equipment (PPE-such as gloves and gown). This failure had the potential for cross contamination and infection (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) which can jeopardize the health and safety of residents and staff. Findings: During a review of Resident 130's admission Record (contains patient demographics), the admission Record indicated Resident was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus with hyperglycemia (a condition where body cannot produce enough insulin), dependence of renal dialysis(a person with permanent kidney failure requires regular, life-sustaining, artificial blood filtration (dialysis) to remove waste and excess fluids, and dysphagia (difficult swallowing). During a review of Resident 130's Orders Summary Report (active physician orders), dated March 3, 2026, it indicated Resident 130 was placed on Contact isolation precautions for ESBL (Extended-Spectrum Beta-Lactamase- bacterial infection resistant to common antibiotics).During a concurrent observation and interview on March 3, 2026, at 10:35 AM, with LVN 2, in Resident 130's room, there was a sign posted at the door that indicated Resident 130 was on Contact isolation precautions for ESBL. LVN 2 was inside the room talking to Resident 130 and family. She was not wearing a gown. LVN 2 verified the finding and stated she was not sure about the difference between EBL (Enhanced Barrier precautions-an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes) and contact isolation. During a concurrent interview and record review with Infection Preventionist (IP), on March 3, 2026, at 11:23 AM, the facility's policy and procedure (P&P) titled, Infection Control-Transmission-based Precautions, revised in October 2019 was reviewed. The P&P indicated Contact Precautions, Contact precautions are intended to prevent transmission of infections that are spread by direct(person-to-person) or indirect contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves upon entering the resident's room or cubicle. The PPE should be removed, and hand hygiene performed before leaving the resident's room or cubicle. The IP stated when contact isolation precautions sign is posted at the door, staff need to wear appropriate PPE and wash hands. The IP stated LVN 2 did not follow the policy. During a concurrent interview and record review with the Director of Nursing (DON), on March 5, 2026, at 8:05 AM, the DON reviewed and acknowledged the facility's policy and procedure (P&P) titled, Infection Control-Transmission-based Precautions, revised in October 2019, which indicated Contact precautions are intended to prevent transmission of infections that are spread by direct (person-to-person) or indirect contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves upon entering the resident's room or cubicle. The PPE should be removed, and hand hygiene performed before leaving the resident's room or cubicle The DON stated her expectation was for the staff to wear appropriate PPE. |