STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555456	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Antelope Valley Care Center	44567 North 15th St. West Lancaster, CA 93534

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46445 Based on interview and record review, the facility failed to ensure a comprehensive, person-centered care plan with measurable objectives and interventions for one of three sampled residents (Resident 1) was created and implemented by failing to: 1. Ensure Resident 1 had a care plan that addressed the resident's possession of a vaping device (a battery-powered device that simulates smoking). 2. Ensure Resident 1's care plans were accurately and completely documented. These deficient practices had placed Resident 1 at risk for not receiving the necessary services and assistance that can result in resident injury or serious condition such as worsening of Resident 1's respiratory diseases. Findings: During a review of Resident 1's Admission Record (undated), the Admission Record indicated the facility admitted the resident on 5/15/2025 with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe on your own), asthma (a disease that affects the lungs), and chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow). During a review of Resident 1's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/16/2025, the H&P indicated Resident 1 had the capacity to understand and make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/22/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was intact. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/2025 at 11:25 a.m. with the Quality Assurance Nurse (QAN), the QAN stated Certified Nursing Assistant (CNA) 2 gave her a vaping device found in Resident 1's possession. The QAN stated she gave Resident 1's vaping device to the Social Service Assistant (SSA). The QAN stated she does not remember if she informed Licensed Vocational Nurse (LVN) 1, nurse assigned to Resident 1, about the resident's possession of a vaping device. The QAN stated she did not document that Resident 1 had possession of a vaping device. The QAN stated a care plan should be initiated that addressed Resident 1's risk for potential use of a vaping device. The QAN stated Resident 1's respiratory condition had the potential to worsen. During an interview on 5/28/2025 at 12:17 p.m. with CNA 2, CNA 2 stated Resident 1 was found with a vaping device on the resident's right hand. CNA 2 stated she gave Resident 1's vaping device to a LVN (CNA 2 could not remember the LVN's name). During an interview on 5/28/2025 at 2:40 p.m. and concurrent record review of Resident 1's Care Plan on oxygen use, initiated on 5/16/2025, reviewed with the Assistant Director of Nursing (ADON), the ADON stated the resident's Care Plan Goals indicated oxygen saturation will remain within range of (blank space) percent (% - per one hundred) to (blank space) % (blank space) or above (blank space) % (blank space). Resident 1's Care Plan Interventions indicated to administer oxygen at (blank space) liters (L - unit of measurement) via (blank space). The ADON stated Resident 1 did not have a care plan that addressed the resident's possession of a vaping device. The ADON stated care plans were created based on physician orders, resident's change of condition, and new treatments. The ADON stated care plans should be specific and individualized to the resident's needs. The ADON stated a care plan should have been initiated to address Resident 1's risk for possession of a vaping device. The ADON stated Resident 1's Care Plan on oxygen use should be complete and specific. The ADON stated Resident 1's respiratory needs had the potential to not be addressed. The ADON stated the facility failed to ensure Resident 1's care plans were created and specific to the resident's respiratory needs. During a review of the facility's policy and procedure (PnP) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 2/28/2025, the PnP indicated a comprehensive, person-centered care plan that includes measurable objectives to meet the resident's physical, psychological, and functional needs were developed and implemented for each resident. The care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents were ongoing and care plans were revised as information about the residents and the residents' condition change. During a review of the facility's PnP titled, Charting and Documentation, last reviewed on 3/21/2025, the PnP indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT, a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological and spiritual needs of the patient) regarding the resident's condition and response to care. The PnP indicated documentation in the medical record will be objective, complete, and accurate.

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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	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46445 Based on interview and record review, the facility failed to ensure the medical records of one of three sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure Licensed Nurses documented the level of care provided to Resident 1 after the resident was found in possession of a vaping device (a battery-powered device that simulates smoking). This deficient practice resulted in incomplete information on Resident 1's medical records and had the potential for delayed medical interventions. Findings: During a review of Resident 1's Admission Record (undated), the Admission Record indicated the facility admitted the resident on 5/15/2025 with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe on your own), asthma (a disease that affects the lungs), and chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow). During a review of Resident 1's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/16/2025, the H&P indicated Resident 1 had the capacity to understand and make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/22/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was intact. During an interview on 5/28/2025 at 10:52 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated upon coming back from her lunch break, she was informed that either a medication or an item was found in Resident 1's possession. LVN 1 stated she was not informed and she did not ask what the specific medication or item was found on Resident 1. LVN 1 stated she did not document the information on Resident 1's medical records. LVN 1 she took Resident 1's vital signs (measurements of the body's most basic functions such as body temperature, heart [pulse] rate, respiration rate [rate of breathing], and blood pressure [pressure of circulating blood against the walls of blood vessels]) after she was informed about a medication or item found on the resident. LVN 1 stated she did not document the vital signs in Resident 1's medical records. During an interview on 5/28/2025 at 11:25 a.m. with the Quality Assurance Nurse (QAN), the QAN stated Certified Nursing Assistant (CNA) 2 gave her a vaping device found in Resident 1's possession. The QAN stated she gave Resident 1's vaping device to the Social Service Assistant (SSA). The QAN stated she does not remember if she informed Licensed Vocational Nurse (LVN) 1, nurse assigned to Resident 1, about the resident's possession of a vaping device. The QAN stated she did not document that Resident 1 had possession of a vaping device. (continued on next page)

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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	During an interview on 5/28/2025 at 2:40 p.m. and concurrent record review of Resident 1's medical records, reviewed with the Assistant Director of Nursing (ADON), the ADON stated there were no documented evidence of an assessment and nursing care provided to Resident 1 after a vaping device was found in the resident's possession. The ADON stated she was working on 5/23/2025 and was not made aware of a vaping device found on Resident 1's possession. The ADON stated the incident and Resident 1's vital signs should have been documented to ensure continuity of care for the resident. The ADON stated the facility failed to accurately and completely document in Resident 1's medical records. During a review of the facility's PnP titled, Charting and Documentation, last reviewed on 3/21/2025, the PnP indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT, a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological and spiritual needs of the patient) regarding the resident's condition and response to care. The PnP indicated documentation in the medical record will be objective, complete, and accurate.