

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2025
NAME OF PROVIDER OR SUPPLIER Antelope Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a topical cream for pain (Diclofenac Sodium- medicated gel to treat pain) was not left at the resident's bedside drawer for one of three sampled residents (Resident 2) and that and Resident 2 was assessed for self-administration of Diclofenac Sodium. This deficient practice had the potential to place other residents at risk to have access to Diclofenac Sodium and misuse the medication. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility initially admitted Resident 2 on 9/27/2024 and readmitted on [DATE] with diagnoses including malignant neoplasm of rectum (cancer that starts as a growth of cells in the rectum {last several inches of the large intestine}) and hypotension (low blood pressure). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 2 was intact with thought process and required supervision assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 2's Physician's Orders, dated 6/27/2025, the Physician's Order indicated to apply Diclofenac Sodium topically to coccyx (tailbone) every four hours as needed for pain management. During a review of the Medication Administration Record of Resident 2, dated 7/14/2025, the Medication Administration Record indicated that diclofenac sodium was given at 7/14/2025 at 4:43 a.m. to apply at coccyx area of Resident 2. During a concurrent observation and interview on 7/14/2025 at 12:41 p.m. inside Resident 2's room with Certified Nursing Assistant (CNA) 3, CNA 3 stated that there were two medication cups containing a white-colored cream above Resident 2's bedside drawer. CNA 3 stated did not know who gave the medication to Resident 2. During a concurrent observation, interview and record review on 7/14/2025 at 12:46 p.m. inside Resident 2's room with Treatment Nurse (TN), the TN observed and stated there were two medication cups with white-colored cream on the top of Resident 2's drawer. The TN stated the two medication cups with white-colored cream were Resident 2's diclofenac sodium and it was given as needed to manage Resident 2's pain. The TN stated that medication should not be at the bedside because other residents could just easily grab the medication and administer it and the residents could have an adverse effect (unexpected side effect) from it. During a concurrent interview and record review on 7/14/2025 at 1:00 p.m. with License Vocational Nurse (LVN) 2, Resident 2's assessment dated [DATE] to 9/27/2025 reviewed. LVN 2 stated there was no assessment found for Resident 2 to self-administer her medication. LVN 2 stated that it was important to assess Resident 2 before self-administering her medication to make sure that Resident 2 knows how to apply it properly. During an interview on 7/15/2025 at 9:54 a.m. with the Director of Nursing (DON), the DON stated it was important to do an assessment for self-administration to Resident 2 to make sure that Resident 2 was capable of self-administration of her own medication. The DON stated that she found out that it was last given at 4 a.m. by one of the charge nurses and left the medication at the bedside. The DON stated that she already spoke to the charge nurse and charge nurse stated that it was a lesson learned for him that he should not leave a medication at the residents' bedside. The DON stated that it was a safety issue for any residents. The other two roommates of resident 2 could just easily grab it and use it. During a review of the facility policy and procedure titled, Self-Administration of Medications, last review date 5/30/2025, the policy and procedure indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the interdisciplinary team assesses each resident's cognitive and physical abilities to determine whether self-administering medications are safe and clinically appropriate for the resident.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the call light of one of three sampled residents (Resident 1) was within reach. This deficient practice had the potential for Resident 1's needs to be not met when Resident 1 calls for help. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility initially admitted Resident 1 on 10/29/2024 and readmitted on [DATE] with a diagnosis of hypertensive (high blood pressure) and history of falling. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/22/2025, the MDS indicated Resident 1 was severely impaired with thought process and required substantial assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a record review of Resident 1's Care Plan titled actual fall, dated 6/27/2025, the Care Plan intervention indicated keep call light within reach. During a concurrent observation and interview on 7/14/2025 at 12:23 p.m. with Director of Staff Development (DSD) inside Resident 1 room. DSD observed and stated that Resident 1 call light was on the floor by Resident 1 top of the bed. DSD stated the call light must within reach all the time to make sure Resident 1 could call for assistance if needed. DSD stated that Resident 1 possibly will not receive her pain medication in a timely manner if Resident 1 does not have her call light within reach, Resident 1 could possibly get upset if Resident 1 was not receiving assistance in a timely manner and Resident 1 could possibly fall because Resident 1 could just get up without assistance. During an interview on 7/15/2025 at 9:54 a.m. with the Director of Nursing (DON), the DON stated that it was important to make sure that the call light was within reach all the time because residents are prone to accidents, and from falling, if the residents need something and will not be able to call for help. During a review of the facility policy and procedure titled, Answering the Call Light, last review date 5/30/2025, the policy and procedure indicated, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.</p>