

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 09/17/2025
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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</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 0880</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 implement and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure Restorative Nurse Assistant (RNA) 1 implemented proper use of personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) for one of three sampled residents (Resident 2) placed on enhanced barrier precautions (EBP-an infection control strategy that uses gloves and gowns during high-contact resident care to reduce the spread of multidrug resistant organisms {MRDOs}). This deficient practice had potential to result in the spread of MRDOs among residents. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 9/13/2023, and readmitted on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), stage four pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). During a review of Resident 2's Order Summary Report, the report indicated the following physician's order: -6/27/2024: RNA for passive range of motion (PROM-movement of joint through the range of motion {ROM-full movement potential of a joint, where two bones meet} with no effort from the person) exercise bilateral lower extremities as tolerated every week during day shift on Monday, Tuesday, Wednesday, Thursday, and Friday. -4/11/2025: EBP to be utilized every shift during high contact resident care activities secondary to chronic wound (a long-lasting, non-healing injury that fails to proceed through the normal stages of healing in a timely manner) and indwelling catheter (a tube left in the bladder to drain urine for an extended period). During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 8/1/2025, the MDS indicated Resident 2 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) from facility staff with upper and lower body dressing. The MDS indicated Resident 2 was dependent (helper does all the effort) with toileting hygiene and transferring from chair to bed. During a review of Resident 2's Care Plan, last revised on 8/12/2025, the Care Plan indicated Resident 2 required enhanced barrier precautions during high-contact resident care activities due to the presence of chronic pressure wound (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and indwelling catheter. During an observation on 9/17/2025 at 8:46 a.m. in Room A (Resident 2's room), RNA 1, who was not wearing an isolation gown, was observed assisting Resident 2 with ROM exercise of bilateral legs. During an interview on 9/17/2025 at 9:05 a.m. with RNA 1, RNA 1 stated Resident 2 was placed on EBP because of the presence of a wound and an indwelling catheter. RNA 1 stated he (RNA 1) did not wear a gown while assisting Resident 2 with ROM exercise. RNA 1 stated gown should have been used when providing wound care or indwelling catheter care to Resident 2, and not during restorative care. During an interview on 9/17/2025 at 11:18 a.m. with Infection Preventionist (IP), the IP stated RNA 1 failed to utilize PPE indicated for providing care to residents on EBP. The IP stated that RNA 1 should have worn a gown while assisting Resident 2 with PROM exercise to prevent the spread of infection to other residents. During an interview on 9/17/2025 at 11:30 a.m. with the Director of Nursing (DON), the DON stated EBP are utilized during high-contact activities such as restorative care. The DON stated the EBP are utilized for residents who have wounds or indwelling catheters and are designed to prevent the spread of infection to other residents in the facility. The DON stated RNA 1 failed to follow EBP guidelines which had the potential to spread infection among residents. During a record review of the facility-provided policy and procedure titled, Enhanced Barrier Precautions, last reviewed on 5/30/2025, the policy and procedure indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi drug-resistant organisms (MRDOs) to residents. 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MRDOs) during high contact resident care activities. 2. Enhanced barrier precautions apply when: .b. A resident is NOT known to be infected or colonized with any MDRO, has a wound, or indwelling medical devices, and does not have secretions or extractions that are unable to be covered or contained 7 FRPs employ targeted gown and glove use in</p>		