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	11/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of practice for three of five sampled residents (Resident 1, Resident 2, and Resident 3) by failing to: 1. Ensure licensed nurses monitored Resident 1's respiratory (organs that are involved in breathing) status after the resident's change of condition (COC) on 11/12/2025.2. Ensure licensed nurses monitored Resident 3's respiratory status after the resident's change of condition (COC) on 11/20/2025.3. Ensure licensed nurses monitored Resident 2's gastrointestinal (stomach and intestines) status after the resident's change of condition (COC) on 11/21/2025. These deficient practices had the potential to place Resident 1, Resident 2, and Resident 3 at risk for undetected and worsening medical conditions which could negatively impact the residents' health and safety.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 12/16/2024 with diagnoses including end stage renal disease (the kidneys cease functioning on a permanent basis), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/13/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was moderately impaired. During a review of Resident 1's Change in Condition Evaluation, dated 11/12/2025 and 11/13/2025, the Change in Condition Evaluation indicated the resident had shortness of breath on both dates. During an interview on 11/24/2025 at 1:55 p.m. and concurrent record review of Resident 1's Progress Notes, dated 11/9/2025 to 11/13/2025, reviewed with Registered Nurse (RN) 1, RN 1 stated on 11/12/2025 at 4:20 a.m., Resident 1 had a COC for shortness of breath. RN 1 stated residents should be monitored for 72 hours after a COC. RN 1 stated Resident 1's Progress Notes indicated there was no documented evidence that monitoring was done on 11/12/2025 (3 p.m. to 11 p.m. and 11 p.m. to 7 a.m.) shifts. RN 1 stated Resident 1's Progress Notes indicated that on 11/13/2025 at 9:04 a.m., the resident had another COC for shortness of breath. RN 1 stated Resident 1 was not monitored every shift after the resident had a COC on 11/12/2025. RN 1 stated Resident 1's respiratory condition had the potential to be missed and worsen. During an interview on 11/24/2025 at 3:38 p.m. and a concurrent record review of Resident 1's Progress Notes, dated 11/9/202/ to 11/13/2025, reviewed with the Interim Director of Nursing (IDON), the IDON stated Resident 1 was not monitored for two shifts (3 p.m. to 11 p.m. and 11 p.m. to 7 a.m.) after the resident's COC on 11/12/2025. The IDON stated resident monitoring after a COC should be done to ensure and assess if the interventions were effective or not. The IDON stated Resident 1's respiratory condition had the potential to worsen. The IDON stated the facility failed to ensure Resident 1 was monitored every shift for 72 hours after the resident's COC. During a review of Resident 3's admission Record (undated), the admission Record indicated the facility admitted the resident on 11/19/2025 with diagnoses including pleural effusion (the buildup of excess fluid between the lungs and the wall lining inside the chest), asthma (a disease that affects the lungs), and chronic respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). During a review of Resident 3's Admission/readmission Evaluation/Assessment, dated 11/19/2025, the Admission/readmission Evaluation/Assessment indicated Resident 3's cognition was intact. During a review of Resident 3's Change in Condition Evaluation, dated 11/20/2025, the Change in Condition Evaluation indicated the resident had shortness of breath. During an interview on 11/24/2025 at 1:55 p.m. and concurrent record review of Resident 3's Progress Notes, dated 11/19/2025 to 11/24/2025, reviewed with RN 1, RN 1 stated on 11/20/2025 at 9:30 a.m., Resident 3 had a COC for shortness of breath. RN 1 stated residents should be monitored for 72 hours after a COC. RN 1 stated Resident 3's Progress Notes indicated there was no documented evidence that monitoring was done on the following days and shifts: a. 11/20/2025 (11 p.m. to 7 a.m. shift),b. 11/22/2025 (11 p.m. to 7 a.m. shift), and c. 11/23/2025 (7 a.m. to 3 p.m. shift).RN 1 stated Resident 3 was not monitored every shift after the resident had a COC on 11/20/2025. RN 1 stated Resident 3's respiratory condition had the potential to be missed and worsen. During an interview on 11/24/2025 at 3:38 p.m. and a concurrent record review of Resident 3's Progress Notes, dated 11/19/2025 to 11/24/2025, reviewed with the IDON, the IDON stated Resident 3 was not monitored every shift after the resident's COC on 11/20/2025. The IDON stated resident monitoring after a COC should be done to ensure and assess if the interventions were effective or not. The

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services for one of three sampled residents (Resident 3) by failing to: 1. Ensure Resident 3's oxygen tubing and oxygen humidifier (a device that adds moisture to the oxygen a person is breathing in during oxygen therapy) was dated when it was changed.2. Ensure Resident 3 had an oxygen supplies bag for the oxygen tubing to be kept inside when not in use. These deficient practices had the potential for Resident 3 to develop respiratory (organs and structures in the body that allow a person to breathe) diseases or infections. Findings: During a review of Resident 3's admission Record (undated), the admission Record indicated the facility admitted the resident on 11/19/2025 with diagnoses including pleural effusion (the buildup of excess fluid between the lungs and the wall lining inside the chest), asthma (a disease that affects the lungs), and chronic respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood). During a review of Resident 3's Admission/readmission Evaluation/Assessment, dated 11/19/2025, the Admission/readmission Evaluation/Assessment indicated Resident 3's cognition was intact. The Admission/readmission Evaluation/Assessment indicated Resident 3 had shortness of breath (SOB) on exertion, at rest, and while laying flat. Resident 1 used oxygen at two liters per minute (Lpm - unit of measurement). During a review of Resident 3's Physician Order, dated 11/19/2025, the Physician Order indicated the use of oxygen at two Lpm via nasal cannula (a device used to deliver supplemental oxygen). During a concurrent observation and interview on 11/24/2025 at 3 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 3 was observed with oxygen via nasal cannula connected to an oxygen concentrator (a device that provides extra oxygen). LVN 1 stated Resident 3's nasal cannula and oxygen humidifier were not dated. LVN 1 stated Resident 3's oxygen mask used for respiratory treatment was on top of the resident's bedside table. LVN 1 stated there were no oxygen supplies bags in Resident 3's room. LVN 1 stated Resident 3's oxygen therapy supplies should be inside a dated and labeled oxygen supplies bag when not in use. LVN 1 stated residents' oxygen therapy supplies should be dated and changed every 7 days. LVN 1 stated Resident 3's oxygen supplies could get dirty and had the potential to cause respiratory infections. During an interview on 11/24/2025 at 3:38 p.m. and concurrent record review of the facility's policy and procedure (PnP) titled Oxygen Administration, last facility-review on 10/30/2025, reviewed with the Interim Director of Nursing (IDON), the IDON stated the PnP indicated .replace oxygen supplies / tubings typically every seven to 14 days or per manufacturer's guidelines. The IDON stated the resident oxygen supplies should indicate the date the supplies were last changed. The IDON stated the facility staff would be unaware how long Resident 3 had used the undated oxygen supplies. The IDON stated Resident 3's oxygen supplies should be in a dated oxygen supplies bag when not in use. The IDON stated not in use oxygen supplies outside the oxygen supplies bag and undated oxygen supplies had the potential to cause residents' respiratory infections. The IDON stated the facility failed to ensure the policy on oxygen administration was followed.