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	12/16/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to notify the Physician of resident's refusal of buspirone hydrochloride (medication used to treat generalized anxiety disorder [GAD - excessive, persistent worry that interferes with daily life, not just normal stress]) for one of three sampled residents (Resident 1). This failure had potential for Resident 1's delays in the delivery of necessary care and services and had the potential to increase Resident 1's level of anxiety.Findings: During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 11/19/2025, with diagnoses that included recurrent (reappears repeatedly over time) enterocolitis (when both your small intestine and large intestine get inflamed [swollen and irritated]) due to clostridium difficile (C. diff - a highly contagious bacteria that causes severe diarrhea), generalized muscle weakness and essential hypertension (high blood pressure that is not due to another medical condition).During a review of Resident 1's Order Summary Report, dated 11/20/2025, the Order Summary Report indicated buspirone hydrochloride oral tablet five milligrams (mg - metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth every eight hours for anxiety manifested by repetitive verbalization about health.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 was dependent on staff for showering and toileting. The MDS indicated Resident 1 had anxiety disorder and was on antianxiety medications (medication that help calm the nervous system and the brain to reduce strong feelings of fear, worry, and panic).During a review of Resident 1's Medication Administration Record (MAR - flowsheet that indicates medications given to a resident), dated 12/2025, the MAR indicated Resident 1 had been refusing buspirone from 12/5/2025 to 12/11/2025, until it was discontinued on 12/11/2025.During a concurrent interview and record review on 12/16/2025 at 10:58 a.m. with the Assistant Director of Nursing (ADON), Resident 1's Physician Order, dated 11/20/2025, and MAR, dated 12/2025, were reviewed. The MAR indicated Resident 1 refused buspirone on 12/8/2025 to 12/11/2025 at 6 a.m. (four times), on 12/5/2025 to 12/9/2025 (five times), and on 12/11/2025 at 2 p.m. (total of 10 times). The ADON stated Resident 1's Physician should have been notified of Resident 1's refusal of buspirone. The ADON stated the facility did not have documented evidence that Resident 1's Physician was notified. The ADON stated the nurses should have completed a Change in Condition Evaluation (COC form - used to document any changes in a resident health status), notify the Physician and monitor Resident 1. The ADON stated the Physician should have been notified of the refusal so the Physician could have made changes with the medication order.During an interview on 12/16/2025 at 11:12 a.m. with the Director of Nursing (DON), the DON stated the nurses should have completed the Change in Condition Evaluation form to address Residents 1's refusal of medication, notify the Physician to obtain an order for a change of medication or change of medication dose. The DON stated Resident 1's anxiety level could increase without the therapeutic effect (positive result of a treatment) of the antianxiety medication.During an interview on 12/16/2025 at 11:25 a.m. with Resident 1, Resident 1 stated she (Resident 1) had been refusing buspirone because it was never effective. Resident 1 stated she (Resident 1) had notified the nurses that it was not effective, but the nurses kept on offering the medication.During a review of facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2001, and last reviewed on 5/2024, the P&P indicated, 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): .f. refusal of treatment or medications two (2) or more consecutive times); .8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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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	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 1) to address Resident 1's refusal of medication. This failure had potential for Resident 1's delays in the delivery of necessary care and services.Findings: During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 11/19/2025, with diagnoses that included recurrent (reappears repeatedly over time) enterocolitis (when both your small intestine and large intestine get inflamed [swollen and irritated]) due to clostridium difficile (C. diff- a highly contagious bacteria that causes severe diarrhea), generalized muscle weakness and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 1's Order Summary Report, dated 11/20/2025, the Order Summary Report indicated buspirone hydrochloride (medication used to treat generalized anxiety disorder [GAD-excessive, persistent worry that interferes with daily life, not just normal stress]) oral tablet five milligram (mg - metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth every eight hours for anxiety manifested by repetitive verbalization about health.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 was dependent on staff for showering and toileting. The MDS indicated Resident 1 had anxiety disorder and was on antianxiety medications (medication that helps calm the nervous system and the brain to reduce strong feelings of fear, worry, and panic).During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 12/2025, the MAR indicated Resident 1 had been refusing buspirone from 12/5/2025 to 12/11/2025, until it was discontinued on 12/11/2025.During a concurrent interview and record review on 12/16/2025 at 10:58 a. m. with the Assistant Director of Nursing (ADON), Resident 1's Physician Order, dated 11/20/2025, MAR, dated 12/2025, and Care Plans were reviewed. The MAR indicated Resident 1 refused buspirone on 12/8/2025 to 12/11/2025 at 6 a.m. (four times), on 12/5/2025 to 12/9/2025, (five times), and on 12/11/2025 at 2 p.m. (total of 10 times). The ADON stated there was no care plan developed on Resident 1's refusal of buspirone. The ADON stated there should be a care plan developed to ensure facility was following up on Resident 1's refusal, to inform the Physician and to do a psychiatry consult (when a medical doctor asks a psychiatrist [a mental health physician] to evaluate a resident's mental health to provide an expert opinion and recommend a treatment plan) on Resident 1 behavior of refusal. The ADON stated the care plan guides the nurses on what care to provide Resident 1. The ADON stated buspirone is an antianxiety medication and if not administered could increase Resident 1's behavior of anxiety. The ADON stated without a care plan for refusal of medication care could not be provided.During an interview on 12/16/2025 at 11:12 a.m. with the Director of Nursing (DON), the DON stated the nurses should have developed a care plan on Resident 1's refusal of medication. The DON stated the care plan is part of Resident 1's care and provides intervention on how to address the problem of Resident 1's refusal. The DON stated Resident 1's anxiety level could increase without the therapeutic effect (positive result of a treatment) of the antianxiety medication.During an interview on 12/16/2025 at 11:25 a.m. with Resident 1, Resident 1 stated she (Resident 1) had been refusing buspirone because it was never effective. Resident 1 stated she (Resident 1) had notified the nurses that it was not effective, but the nurses kept on offering the medication.During a review of facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Plans, dated 12/2016 and last reviewed on 5/2024, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial (the connection between your mind/feelings [psycho] and your social life/environment [social]) and functional needs is developed and implemented for each resident.8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; . g. Incorporate identified problem areas;