

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 02/02/2026
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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was discharged in a safe and orderly manner for one of three sampled residents (Resident 1), by failing to: 1. Ensure Resident 1's post-discharge destination could meet Resident 1's needs prior to the discharge on [DATE].2. Involve Resident 1's Representative in the development of the discharge plan and informed of the final discharge plan. These deficient practices had the potential for Resident 1 not to receive necessary care and services and negatively affecting Resident 1's well-being. Findings: During a review of Resident 1's admission Record, the admission record indicated the facility admitted Resident 1 on 5/14/2025 with diagnoses including heart failure (a progressive condition where the heart muscle is too weak or stiff to pump enough oxygen-rich blood to meet the body's needs), encounter for palliative care (specialized medical care for people with serious illnesses, focusing on relieving symptoms, pain, and stress to improve quality of life), and dementia (a progressive state of decline in mental abilities), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2025, the MDS indicated Resident 1's cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks) was severely impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) from the facility staff with oral hygiene, toileting hygiene, upper and lower body dressing, and personal hygiene. During a review of Resident 1's Order Summary Report, the report indicated the following physician's order:-5/15/2025 at 6:49 p.m.: Transfer resident to Board and Care 1 (a small residential home providing 24-hour non-nursing care, meals, and supervision to residents). During an interview on 2/2/2026 at 1 p.m. with the Director of Nursing (DON), the DON stated there was no documented evidence to indicate the facility staff had evaluated Board the Board and Care Facility and communicated with them (Board and Care 1) prior to Resident 1's discharge on [DATE]. The DON stated the facility staff failed to verify and ensure Resident 1 was discharged to a facility that met the required standards and would be able to ensure provision of care to Resident 1. The DON stated the facility staff relied on the information provided by the palliative care provider and did not complete proper assessment and evaluation. The DON stated Resident 1 was inappropriately discharged. The DON stated Resident 1 was placed at risk of not receiving necessary care to have his (Resident 1) needs met. The DON stated there was a potential for Resident 1 not to receive correct medications, pain assessment and management, negatively affecting Resident 1's well-being. During an interview on 2/2/2026 at 1:17 p.m. with Resident 1's Power of Attorney (POA-legally authorized person to make financial, legal, or medical decisions on behalf of the resident), POA stated that on 5/15/2026, the facility's previous Administrator (Administrator 1) had contacted him (POA) to inform that Resident 1 would be transferred back to the previous Skilled Nursing Facility (SNF) 1. The POA stated that the</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555456
		If continuation sheet Page 1 of 2

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>facility did not contact him (POA) to inform that the discharge plans had changed and that Resident 1 was discharged to a different facility. The POA stated that Resident 1 was discharged without POA's consent and knowledge. The POA stated that two days after Resident 1's discharge, he (POA) contacted Administrator 1 and was informed that Resident 1 was discharged on 5/16/2025 to Board and Care 1. The POA stated after multiple attempts he (POA) was able to contact the Board and Care 1 and request transfer of Resident 1 to a General Acute Care Hospital (GACH). During a concurrent interview and record review on 2/2/2026 at 2:10 p.m. with the DON, Resident 1's Notice of Transfer or Discharge form, dated 5/15/2025, and Discharge Summary, dated 5/15/2025 were reviewed. The Notice of Transfer or Discharge form indicated Resident 1 was unable to sign the form to indicate that he (Resident 1) had received the form. The Discharge Summary indicated Resident 1 was unable to sign the form to indicate that he (Resident 1) had received the discharge summary. The DON stated there was no documented evidence to indicate that Resident 1's POA was provided the Notice of Transfer or Discharge form and the Discharge Summary. The DON stated Resident 1 could not make decisions and the risks and benefits of discharge plan should have been discussed with Resident 1's POA. The DON stated the facility staff failed to follow Resident 1's rights and placed Resident 1 at risk to be placed in a facility without Resident 1's representative's knowledge. The DON stated Resident 1's POA should have been involved in the discharge process to make sure Resident 1's wishes were followed. The DON stated there was a potential for Resident 1 to be transferred to a facility that was not appropriate for Resident 1's care. During a review of the facility's policy and procedure (P&P) titled, Discharge, last revised on 5/30/2025, was reviewed, the P&P indicated, 1. When the facility anticipates a resident's discharge to a private residence, another nursing care facility (i.e., skilled, intermediate care, ICF/IID, etc.), a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his or her new living environment. 4. Every resident will be evaluated for is or her discharge needs and will have an individualized post-discharge plan. 5. The post discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the residents and his or her family and will include: a. Where the individual plans to reside; b. Arrangements that have been made for follow-up care and services; A description of the resident's stated discharge goals; d. The degree of caregiver/support person availability, capacity and capability to perform required care; e. How the IDT will support the resident or representative in the transition to post-discharge care; f. What factors may make the resident vulnerable to preventable readmission, and g. How does factors will be addressed. 7. The resident/representative will be involved in the post-discharge planning process and informed of the post-discharge plan.</p>		