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Form Approved OMB
No. 0938-0391

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 03/13/2026

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 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. 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) by failing to develop a care plan to address Resident 1's nutrition related to early dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) schedule.This failure had the potential for delays in the delivery of necessary care, services and could potentially result in hypoglycemia (low blood sugar) to Resident 1. Cross reference F684. Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 2/25/2026, with diagnoses that included metabolic encephalopathy (a change in how your brain works due to an underlying condition), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and end stage renal disease (ESRD-irreversible kidney failure) with dependence on renal dialysis. During a review of Resident 1's Care Plan, dated 2/25/2026 on activities of daily living (ADL-activities such as bathing, dressing and toileting a person performs daily), the Care Plan indicated Resident 1 was dependent on staff for eating.During a review of Resident 1's Care Plan, dated 2/25/2026, on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), the Care Plan indicated dietary consultation for meal planning as indicated.During a review of Resident 1's Order Recapitulation Report, dated 2/25/2026, the Order Recapitulation Report indicated dialysis schedule every Monday, Wednesday and Friday at 8:45 a.m., with pick up time from Skilled Nursing Facility (SNF) at 8 a.m.During a review of Resident 1's Care Plan, dated 2/26/2026, on risk of malnutrition (a condition caused by an imbalance between the nutrients your body needs to function and the nutrients it receives), the Care Plan indicated the following interventions:Allow adequate time for meal consumption.Assists with meals/fluids as neededMonitor meal intakeProvide diet as orderedDuring a review of Resident 1's Order Recapitulation Report, dated 2/26/2026, the Order Recapitulation Report indicated feeding assistance.During a review of Resident 1's Pre-Hemodialysis Communication Observation/ Assessment, dated 2/27/2026, the Pre-Hemodialysis Communication Observation/Assessment indicated Resident 1 was picked up at 7:50 a.m., and time of last meal was left blank.During a review of Resident 1's Progress Notes, dated 2/27/2026, timed at 8:30 a.m., the Progress Notes indicated the transportation picked up Resident 1 who had not yet have her (Resident 1) breakfast. The Progress Notes indicated that the Dietary Supervisor (DS) was informed, made sack lunch (a portable meal prepared and packed into a paper or plastic bag to be eaten later), sent to dialysis center and provided to the resident.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 3/4/2026, 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 all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily).During an interview on 3/13/2026, at 8:58 a.m., with the DS, the DS stated transportation picked up Resident 1 to go to dialysis center with no sack lunch provided. The DS stated they made a sack lunch and had it delivered to the dialysis center, (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but it was late. The DS stated that late meal intake can affect Resident 1's mood and health.During a concurrent interview, and record review on 3/13/2026, at 10:27 a.m., with the Assistant Director of Nursing (ADON), Resident 1's Care Plans were reviewed. The ADON stated there was no care plan developed to address Resident 1's breakfast intake in relation to early dialysis schedule. The ADON stated the facility did not implement the care plan intervention for malnutrition on allowing adequate time for meal consumption, assists with meals/fluids as needed, and provide diet as ordered. The ADON stated Resident 1 should have been fed by the outgoing shift (11 p.m., to 7 a.m.) before Resident 1's gets picked up for dialysis at 8 a.m. on 2/27/2026. The ADON stated Resident 1 should have a sack lunch with her (Resident 1) to take to the dialysis center. The ADON stated care plan should have been developed to address Resident 1's meal intake (breakfast) related to early dialysis schedule so Resident 1 could be fed early and have a sack lunch before leaving the facility. The ADON stated that without breakfast and sack lunch Resident 1 could have developed hypoglycemia in the dialysis center. During a review of facility's policy and procedure (P&P) titled, Nutritional Assessment and Care Planning, dated 3/2026 was reviewed. The P&P indicated, As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition.7. Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address or minimize to the extent possible the resident's risks for nutritional complications. Such interventions will be developed within the context of the residents' prognosis and per?sonal preferences.8. Individualized care plans shall address to the extent possible:a. The identified causes of impaired nutrition;b. The resident's personal preferences;c. Goals and benchmarks for improvement; andd. Time frames and parameters for monitoring and reassessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure a resident received care consistent with professional standards of practice for one of three sampled residents (Resident 1) by failing to ensure Resident 1 was fed, had breakfast and was provided with a sack lunch (a lunch which is prepared before arriving at the place where it is to be eaten) before getting picked up by transportation to go to the dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) center on 2/27/2026.This failure had the potential to place Resident 1 at risk of hypoglycemia (low blood sugar). Cross reference F656. Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 2/25/2026, with diagnoses that included metabolic encephalopathy (a change in how your brain works due to an underlying condition), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and end stage renal disease (ESRD-irreversible kidney failure) with dependence on renal dialysis. During a review of Resident 1's Order Recapitulation Report, dated 2/25/2026, the Order Recapitulation Report indicated dialysis schedule every Monday, Wednesday and Friday at 8:45 a.m., with pick up time from Skilled Nursing Facility (SNF) at 8 a.m.During a review of Resident 1's Order Recapitulation Report, dated 2/26/2026, the Order Recapitulation Report indicated feeding assistance.During a review of Resident 1's Progress Notes, dated 2/27/2026, timed at 8:30 a.m., the Progress Notes indicated the transportation picked up Resident 1 who had not yet had her breakfast. The Progress Notes indicated that the Dietary Supervisor (DS) was informed, made sack lunch, sent to dialysis center and provided to the resident.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 3/4/2026, 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 all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily).During an interview on 3/13/2026, at 8:58 a.m., with the DS, the DS stated transportation picked up Resident 1 to go to dialysis center with no sack lunch provided. The DS stated they made a sack lunch, and had it delivered to the dialysis center on 2/27/2026, but it was late. The DS stated the facility's process was upon admission, nursing staff will inform the Kitchen Staff of the dialysis schedule. The DS stated residents who go to dialysis early in the morning will be provided early breakfast and the sack lunch will be provided in a thermal bag delivered to the nursing station the night before the scheduled dialysis so the nurse can give it to the resident before leaving the facility for dialysis. The DS stated that late meal intake can affect Resident 1's mood and health. The DS stated he (DS) cannot recall how late the sack lunch was prepared.During an interview on 3/13/2026, at 9:17 a.m., with Registered Nurse 1 (RN 1), RN 1 stated Resident 1 had necrotic (dead or dying tissue, often appearing black, leathery, or gray with potential foul-smelling drainage, usually caused by severe infection, trauma, or lack of blood flow) hands and needs to be fed. RN 1 stated on 2/27/2026, Certified Nursing Assistant 1 (CNA 1) reported that transportation was at the facility at 7:30 a.m., to pick up Resident 1 to go to the dialysis center but CNA 1 had not yet fed Resident 1 her (Resident 1) breakfast. RN 1 stated when she (RN 1) went into Resident 1's room, Resident 1 was already picked up. RN 1 stated CNA 1 reported that Resident 1 was upset so she (RN 1) had reported to the DON and notified Family Member 1 (FM 1) and FM 1 also got upset. RN 1 stated she (RN 1) understood why Resident 1 and FM 1 got upset. RN 1 stated Resident 1 who had an early dialysis schedule should have had an early breakfast and have a sack lunch, and CNA 1 should have fed Resident 1 prior to the pick-up time. RN 1 stated the facility failed to communicate Resident 1's early pick up schedule for dialysis to the kitchen staff. RN 1 stated the incident could have been prevented. RN 1 stated the admission nurse should have notified the Dietary/Kitchen Staff of Resident 1's early dialysis schedule.During an interview on 3/13/2026, at 10:27 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 should have been fed by the outgoing CNA before 8 a.m., (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pick up time for dialysis and should have been provided sack lunch to take to dialysis center. The ADON stated the facility failed to inform the kitchen staff of the early dialysis schedule. The ADON stated the kitchen should have prepared Resident 1's early breakfast and sack lunch should have been prepared ahead of the dialysis pick up time.During an interview on 3/13/2026, at 10:15 a.m. with the Assistant Dietary Supervisor (ADS), the ADS stated the kitchen opens at 5 a.m., daily. The ADS stated the nurses did not communicate to the kitchen Resident 1's early dialysis pick up schedule. The ADS stated the incident could have been prevented.During an interview on 3/13/2026, at 10:27 a.m., with the ADON, the ADON stated without eating breakfast and without sack lunch, Resident 1 could have experience hypoglycemia (low blood sugar) in the dialysis center.During a review of facility's policy and procedure (P&P), titled, Nutritional Assessment and Care Planning, dated 3/2026, was reviewed. The P&P indicated, 1. The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition.3. The nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the following components: a. Nursing: . 5. Current clinical conditions and recent events that may have affected a resident's nutritional status and risk factors; . 9. Usual meal and snack patterns;During a review of facility's P&P, titled, Care of a Resident with End Stage Renal Disease, dated 9/2010, the P&P indicated, Resident with ESRD will be cared for according to currently recognized standards of care.1. Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents.2. Education and training of staff includes, specifically: a. The nature and clinical management of ESRD (including infection prevention and nutritional needs).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain accurate and complete medical record for one of three sampled residents (Resident 1) by failing to ensure Registered Nurse 1 (RN 1) documented interventions provided to Resident 1 when Resident 1 was picked up by transportation to go to the dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) center on 2/27/2026, without breakfast and without sack lunch (a lunch which is prepared before arriving at the place where it is to be eaten). This failure had the potential to result in confusion in Resident 1's care and Resident 1's medical records containing inaccurate documentation.Based on interview and record review, the facility failed to maintain accurate and complete medical record for one of three sampled residents (Resident 1) by failing to ensure Registered Nurse 1 (RN 1) documented interventions provided to Resident 1 when Resident 1 was picked up by transportation to go to the dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) center on 2/27/2026, without breakfast and without sack lunch (a lunch which is prepared before arriving at the place where it is to be eaten). This failure had the potential to result in confusion in care and the medical records containing inaccurate documentation.Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 2/25/2026, with diagnoses that included metabolic encephalopathy (a change in how your brain works due to an underlying condition), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and end stage renal disease (ESRD-irreversible kidney failure) with dependence on renal dialysis. During a review of Resident 1's Order Recapitulation Report, dated 2/25/2026, the Order Recapitulation Report indicated dialysis schedule every Monday, Wednesday and Friday at 8:45 a.m., with pick up time from Skilled Nursing Facility (SNF) at 8 a.m.During a review of Resident 1's Order Recapitulation Report, dated 2/26/2026, the Order Recapitulation Report indicated feeding assistance.During a review of Resident 1's Progress Notes, dated 2/27/2026, timed at 8:30 a.m., the Progress Notes indicated the transportation picked up Resident 1 who had not yet have her (Resident 1) breakfast. The Progress Notes indicated that the Dietary Supervisor (DS) was informed, made sack lunch, sent to dialysis center and provided to the resident.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 3/4/2026, 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 all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily).During an interview on 3/13/2026, at 8:58 a.m., with the DS, the DS stated transportation picked up Resident 1 to go to dialysis center with no sack lunch provided. The DS stated they made a sack lunch and had it delivered to the dialysis center on 2/27/2026, but it was late. The DS stated that late meal intake can affect Resident 1's mood and health.During an interview on 3/13/2026 at 9:17 a.m., with RN 1, RN 1 stated Resident 1 had necrotic (dead or dying tissue, often appearing black, leathery, or gray with potential foul-smelling drainage, usually caused by severe infection, trauma, or lack of blood flow) hands and needs to be fed. RN 1 stated on 2/27/2026, Certified Nursing Assistant 1 (CNA 1) reported that transportation was at the facility at 7:30 a.m., to pick up Resident 1 to go to the dialysis center but CNA 1 had not yet fed Resident 1 her (Resident 1) breakfast. RN 1 stated when she (RN 1) went into Resident 1's room, Resident 1 was already picked up. RN 1 stated CNA 1 reported that Resident 1 was upset so she (RN 1) had reported to the DON and notified Family Member 1 (FM 1) and FM 1 also got upset. RN 1 stated she (RN 1) understood why Resident 1 and FM 1 got upset. RN 1 stated Resident 1 who had an early dialysis schedule should have had an early breakfast and have a sack lunch, and CNA 1 should have fed Resident 1 prior to the pick-up time. RN 1 stated she (RN 1) did not document what happened on 2/27/2026 and did not document her (RN 1) notification to FM 1 and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON. RN 1 stated the facility failed to communicate Resident 1's early pick up schedule for dialysis to the kitchen staff. RN 1 stated she (RN 1) failed to document her interventions to Resident 1 on 2/27/2026.During a concurrent interview, and record review on 3/13/2026, at 10:27 a.m., with the Assistant Director of Nursing (ADON), Resident 1's Progress Notes dated 2/27/2026, were reviewed. The ADON stated there was no documentation from RN 1 on 2/27/2026. The ADON stated RN 1 should have documented especially when she (RN 1) had notified FM 1 and DON. The ADON stated that without breakfast and sack lunch Resident 1 could have developed hypoglycemia in the dialysis center. The ADON stated Resident 1's medical record was not complete.During a review of facility's policy and procedure (P&P) titled, Charting and Documentation, dated 5/2024, was reviewed. The P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.2. The following information is to be documented in the resident medical record:a. Objective observations;b. Medications administered;c. Treatments or services performed;d. Changes in the resident's condition;e. Events, incidents or accidents involving the resident; andf. Progress toward or changes in the care plan goals and objectives.3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.