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	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Antelope Valley Care Center	44567 North 15th St. West Lancaster, CA 93534

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a person-centered care (CP, a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) for one of four sampled residents (Resident 1) by failing to develop a care plan to address Resident 1's Intravenous Gamma-Globulin (IVGG- a therapy used to treat immune-related disorders by strengthening the immune system) infusion for cervical disc disorder at cervical vertebra (C)5-C6 level with myelopathy (a severe, often progressive condition involving spinal cord dysfunction). This failure had the potential to delay care and negatively affect Resident 1's well-being.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 8/26/2024 and readmitted on [DATE] with diagnoses including cervical disc disorder at C5-C6 level with myelopathy, anemia (a condition where the body does not have enough healthy red blood cells), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and cerebral infarction (-stroke, loss of blood flow to a part of the brain). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 10/5/2024, the H&P indicated, Resident 1 had the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 1 had intact cognitive functioning (resident's mental abilities, impacting their ability to think, learn, remember, reason, and make decisions). The MDS indicated Resident 1 required supervision (helper provides verbal cutes or contact guard assistance) from the facility staff with personal hygiene. The MDS indicated Resident 1 required substantial assistance (helper does more than half the effort) from the facility staff with upper and lower body dressing. During a review of Resident 1's Order Summary Report, the report indicated the following physician's order:-9/16/2025: IVGG for cervical disc disorder at C5-C6 level with myelopathy as ordered by the physician. Weekly supplied by Infusion Company 1. Administered by Infusion Nurse. -3/26/26: Appointment for infusion on 4/6/26. Infusion Company 1 to infuse in-facility. During a concurrent interview and record review on 4/2/2026 at 2:03 p.m. with the Assistant Director of Nursing (ADON), Resident 1's Care Plan was reviewed. The ADON stated Resident 1's Care Plan did not address Resident 1's IVGG infusions for cervical disorder at C5-C6 level with myelopathy. The ADON stated that even though the IVGG infusion was provided by a different company, it was still the facility's responsibility to monitor and implement necessary care for Resident 1. The ADON stated the purpose of the Care Plan was to guide the facility staff to monitor and provide appropriate care for Resident 1. The ADON stated the failure to address Resident 1's diagnoses of cervical disease and IVGG infusion had the potential to delay care for Resident 1. The ADON stated there was a potential for Resident 1 to experience adverse reaction. During a review of the facility-provided policy and procedure titled, Care Plans, Comprehensive Person-Centered last reviewed on 5/30/2025, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan: . b. describes the (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received the intravenous catheter (IV-a flexible plastic tube that is inserted into a vein to deliver fluids and medications) care consistent with professional standards of practice for three of four sampled residents (Resident 1, 2 and 3), by failing to: 1. Ensure Resident 1's IV was assessed and monitored for potential complications.2. Ensure peripherally inserted IV was labeled and dated for Resident 2 and Resident 3.These failures had the potential to delay the provision of necessary care and services for Residents 1,2, and 3 and to negatively affect the residents' well-being. Cross reference F842. Findings: 1a. During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 8/26/2024 and readmitted on [DATE] with diagnoses including cervical disc disorder at C5-C6 level with myelopathy, anemia (a condition where the body does not have enough healthy red blood cells), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and cerebral infarction (-stroke, loss of blood flow to a part of the brain). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 10/5/2024, the H&P indicated, Resident 1 had the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 1 had intact cognitive functioning (resident's mental abilities, impacting their ability to think, learn, remember, reason, and make decisions). The MDS indicated Resident 1 required supervision (helper provides verbal cutes or contact guard assistance) from the facility staff with personal hygiene. The MDS indicated Resident 1 required substantial assistance (helper does more than half the effort) from the facility staff with upper and lower body dressing. During a concurrent observation and interview on 4/2/2026 at 10:30 a.m. with Resident 1 in Resident 1's room, Resident 1 was observed with left wrist double lumen (two separate internal channels) intravenous catheter secured with transparent adhesive dressing and covered with mesh gauze (specialized, low-adherent dressing). Resident 1 stated he (Resident 1) could not recall the exact date the IV catheter was inserted. During a concurrent interview and record review on 4/2/2026 at 2:03 p.m. with the Assistant Director of Nursing (ADON), Resident 1's Progress Notes and Assessment forms, dated 2026, were reviewed. The ADON indicated there was no documented evidence to indicate when and by whom Resident 1's IV catheter was inserted. The ADON stated there was no documented evidence to indicate if Resident 1's IV catheter was a peripheral IV or peripherally inserted central catheter (PICC-a long, flexible, thin tube inserted into a vein and threaded to a large vein near the heart). The ADON stated there was no documented evidence to indicate that Resident 1's IV catheter was assessed and monitored by the facility staff. The ADON stated the facility staff failed to identify, assess, and monitor Resident 1's IV catheter. The ADON stated it was facility's responsibility to monitor Resident 1's IV catheter for potential complications. The ADON stated the failure to assess and monitor Resident 1's IV catheter had the potential for Resident 1 to experience adverse effects without facility staff's knowledge. During a review of the facility-provided policy and procedure titled, Intravenous Therapy, last reviewed on 5/30/2025, the P&P indicated, The facility will adhere to accepted standards of practice regarding infusion practices. 13. IV sites are checked every four (4) hours or as per facility protocol and PRN for signs and symptoms of infection or inflammation. 15. The IV documentation is recorded in the nurses' notes and/or Medication Administration Record. 16. The nurse will notify the practitioner to assess the need for continuation of the catheter if not being used for IV fluids or medications and will discontinue as per the practitioner's order. During a review of the facility-provided policy and procedure titled, Peripheral and Midline IV Dressing Changes, last reviewed on 5/30/2025, the P&P indicated, The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, loosened, or soiled catheter-site dressings. 6. Assess the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	peripheral/midline access device at least every 4 hours (every 1-2 hours for residents with cognitive impairment) . c. Assess the patency of the vascular device. d. Palpate and inspect the skin, dressing, and securement device for signs of complications.During a review of the facility-provided policy and procedure titled, Peripheral IV Catheter Insertion, last reviewed on 5/30/2025, the P&P indicated, The purpose of the procedure is to provide guidelines for the safe and aseptic insertion of a peripheral intravenous catheter for the administration of intravenous fluids and/or medications.Documentation: The following information should be recorded in the resident's medical record: 1. Date and time of the procedure; 2. Number of venipuncture attempts (maximum of two); 3. Type, length, and gauge of catheter; 4. Type of antiseptic agent used; 5. Site of insertion (be specific to name of vein, area of limb);. 9. Condition of the IV site; . 11. Resident's response to procedure; and 12. Signature and title of the person recording the date. 2a. During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 4/5/2024 and readmitted on [DATE] with diagnoses including rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), type two diabetes mellitus (DM II-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's H&P, dated 6/13/2025, the H&P indicated, Resident 2 had the capacity to make decisions. During a review of Resident 2's MDS, dated [DATE] the MDS indicated Resident 2 had intact cognitive functioning (resident's mental abilities, impacting their ability to think, learn, remember, reason, and make decisions). The MDS indicated Resident 2 was dependent (helper does all of the effort) on facility staff for oral hygiene, toilet hygiene, and personal hygiene.During a review of Resident 2's Order Summary Report, the report indicated the following physician's order:-4/2/2026: Assess peripherally inserted IV (PIV) access site every eight hours and document every shift. -4/2/2026: Flush PIV with Normal Saline (a sterile solution of salt in water, used for diluting intravenous medications) 0.9 percent (%-one part of every hundred) five milliliters (ml-unit of measurement) before and after medication use. -3/26/2026: Ceftriaxone Sodium Solution Reconstituted (medication used to treat bacterial infections) one gram (gm-unit of measurement) intravenously in the evening for posterior cervical site abscess (a swollen area within body tissue, containing an accumulation of pus) for 14 days. During a concurrent observation and interview on 4/2/2026 at 11:40 a.m. with Registered Nurse (RN) 1 in Resident 2's room, Resident 2 was observed with right forearm PIV. RN 1 stated there was no label on Resident 2's PIV to indicate the date of the PIV insertion. 2b. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 3/27/2026 with diagnoses including acute kidney failure (the sudden loss of kidney function), type two diabetes mellitus, and heart failure (a heart disorder which causes the heart to not pump the blood efficiently). During a review of Resident 3's Order Summary Report, the report indicated the following physician's order:-4/1/2026: Flush PIV with Normal 0.9 % 10 ml before and after medication use.-4/1/2026: Normal Saline Intravenous Solution 0.9%. Use 500 ml intravenously only for hypotension for one day. Given bolus (a single dose of medication is given all at once). -4/1/2026: Normal Saline Intravenous Solution 0.9%. Use 75 milliliters per hour (ml/hr.-unit of measurement) intravenously every hour for hypotension until 4/3/2026 for total of 2 liters (L-unit of measurement). During a review of Resident 3's Care Plan, initiated on 4/2/2026, the Care Plan indicated Resident 3 required IV hydration related to hypotension (low blood pressure). During a concurrent observation and interview on 4/2/2026 at 11:45 a.m. with RN 1 in Resident 3's room, Resident 3 was observed with left forearm PIV. RN 1 stated there was no label on Resident 3's PIV to indicate the date of the PIV insertion. During an interview on 4/2/2026 at 2:03 p.m. with the ADON, the ADON stated the PIV should be labeled, dated and changed every 72 hours or as needed. The ADON stated the purpose of labeling was to ensure the facility staff were able to identify when the PIV needs to be changed. The ADON stated the failure to label and date the PIV had the potential for Resident 2 and Resident 3 to develop an infection at the PIV site. During a review of the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility-provided policy and procedure titled, Peripheral IV Catheter Insertion, last reviewed on 5/30/2025, the P&P indicated, The purpose of the procedure is to provide guidelines for the safe and aseptic insertion of a peripheral intravenous catheter for the administration of intravenous fluids and/or medications. Steps in the Procedure: . 15. Place label on one side of the catheter (not over insertion site). Include the date and time of catheter insertion, initials, and length and gauge of catheter on the label.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical records for one of four sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure accurate documentation of the peripheral intravenous catheter (peripheral IV-a flexible plastic tube that is inserted into a vein to deliver fluids and medications) insertion for four of four sampled residents (Residents 1, 2, 3, and 4). This deficient practice had the potential for inaccurate medical interventions for Residents 1, 2, 3, and 4. Cross reference F694. Findings:a. During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 8/26/2024 and readmitted on [DATE] with diagnoses including anemia (a condition where the body does not have enough healthy red blood cells), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and cerebral infarction (stroke, loss of blood flow to a part of the brain). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 10/5/2024, the H&P indicated, Resident 1 had the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 1 had intact cognitive functioning (resident's mental abilities, impacting their ability to think, learn, remember, reason, and make decisions). The MDS indicated Resident 1 required supervision (helper provides verbal cutes or contact guard assistance) from the facility staff with personal hygiene. The MDS indicated Resident 1 required substantial assistance (helper does more than half the effort) from the facility staff with upper and lower body dressing. During a review of Resident 1's Order Summary Report, the report indicated the following physician's order:-3/4/2026: Sodium Chloride 0.9 percent (%- one part in every hundred). Use 100 milliliters per hour (ml/hr.-unit of measurement) intravenously two (2) liters (L-unit of measurement) for hydration for one day. During a concurrent interview and record review on 4/2/2026 at 11:05 a.m. with the Assistant Director of Nursing (ADON), Resident 1's Progress Notes, dated March 2026, were reviewed. The ADON stated there was no documented evidence to indicate when Resident 1's PIV was inserted. b. During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 4/5/2024 and readmitted on [DATE] with diagnoses including rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), type two diabetes mellitus (DM II-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 6/13/2025, the H&P indicated, Resident 2 had the capacity to make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had intact cognitive functioning. The MDS indicated Resident 2 was dependent (helper does all of the effort) on the facility staff for oral hygiene, toilet hygiene, and personal hygiene. During a review of Resident 2's Order Summary Report, the report indicated the following physician's order:-4/2/2026: Assess PIV access site every eight hours and document every shift. -4/2/2026: Flush PIV with Normal Saline (a sterile solution of salt in water, used for diluting intravenous medications) 0.9 % five milliliters (ml-unit of measurement) before and after medication use. During a concurrent interview and record review on 4/2/2026 at 11:05 a.m. with the Assistant Director of Nursing (ADON), Resident 2's Progress Notes, dated April 2026, were reviewed. The ADON stated there was no documented evidence to indicate when Resident 2's PIV was inserted. c. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 3/27/2026 with diagnoses including acute kidney failure (the sudden loss of kidney function), type two diabetes mellitus, and heart failure (a heart disorder which (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	causes the heart to not pump the blood efficiently). During a review of Resident 3's Order Summary Report, the report indicated the following physician's order:-4/1/2026: Flush PIV with Normal 0.9 % 10 ml before and after medication use.-4/1/2026: Normal Saline Intravenous Solution 0.9%. Use 500 ml intravenously only for hypotension for one day. Given bolus (a single dose of medication is given all at once). -4/1/2026: Normal Saline Intravenous Solution 0.9%. Use 75 milliliters per hour (ml/hr.-unit of measurement) intravenously every hour for hypotension until 4/3/2026 for total of 2 liters (L-unit of measurement). During a review of Resident 3's Care Plan, initiated on 4/2/2026, the Care Plan indicated Resident 3 required IV hydration related to hypotension (low blood pressure). During a concurrent interview and record review on 4/2/2026 at 11:05 a.m. with the Assistant Director of Nursing (ADON), Resident 3's Progress Notes, dated March 2026, were reviewed. The ADON stated there was no documented evidence to indicate when Resident 3's PIV was inserted. d. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 1/7/2026 with diagnoses including cerebral infarction, hemiplegia, and type 2 diabetes mellitus. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had severely impaired cognitive functioning. The MDS indicated Resident 4 was dependent on facility staff for personal hygiene, toileting hygiene, and lower body dressing. During a review of Resident 4's Care Plan, initiated on 3/28/2026, the Care Plan indicated Resident 4 was receiving antibiotic (medication used to treat bacterial infection) for recurrent urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 4's Order Summary Report, the report indicated the following physician's order:-3/28/2026: Zosyn Intravenous Solution 3-0.375 gram(gm)/50ml. Use 3.375gm intravenously every eight hours for UTI for seven days.During a concurrent interview and record review on 4/2/2026 at 11:05 a.m. with the Assistant Director of Nursing (ADON), Resident 4's Progress Notes, dated March 2026, were reviewed. The ADON stated there was no documented evidence to indicate when Resident 4's PIV was inserted. During an interview on 4/2/2026 at 2:03 p.m. with the ADON, the ADON stated the facility staff should document in resident's Progress Notes when the PIV is inserted, where it is inserted, technique used, and reason for the IV therapy. The ADON stated it was important to have complete documentation of the PIV insertion for facility staff to monitor the PIV site and provide care as needed. The ADON stated the failure to document the insertion of the PIV had the potential for Resident 1 to develop infection at the PIV site. During a review of the facility-provided policy and procedure titled, Peripheral IV Catheter Insertion, last reviewed on 5/30/2025, the P&P indicated, The purpose of the procedure is to provide guidelines for the safe and aseptic insertion of a peripheral intravenous catheter for the administration of intravenous fluids and/or medications.Documentation: The following information should be recorded in the resident's medical record: 1. Date and time of the procedure; 2. Number of venipuncture attempts (maximum of two); 3. Type, length, and gauge of catheter; 4. Type of antiseptic agent used; 5. Site of insertion (be specific to name of vein, area of limb);. 9. Condition of the IV site; . 11. Resident's response to procedure; and 12. Signature and title of the person recording the date. During a review of the facility-provided policy and procedure titled, Charting and Documentation, last reviewed on 5/30/2025, 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: . c. Treatments or services performed.