

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Apple Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11959 Apple Valley Rd Apple Valley, CA 92308	
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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that call light was accessible for two of the three sampled residents (Resident 2 and 3), when Resident 2's call light was observed to be placed on the side of the bed, above the pillow, and beyond Resident 2's reach, while Resident 3's call light was found to be wrapped around the right bedrail, which was also out of Resident 3's reach. This failure had the potential to hinder Residents 2 and 3 from seeking help, when necessary, thereby elevating the risk of unaddressed care requirements and potential harm. During a review of Resident 2's face sheet (contains demographic and medical information) indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included fracture of unspecified part of neck of right femur (thigh bone), difficulty in walking. During a review of Resident 3's face sheet (contains demographic and medical information) indicated Resident 3 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis (Hemiplegia is the complete paralysis of one side of the body, while hemiparesis is a milder weakness on one side) following cerebral infarction (a stroke) affecting right dominant side. During a concurrent observation and interview on November 18, 2025, at 11:47 AM, with Resident 2 in her room, when asked about the location of her call light, she indicated that she was unsure of where it was. It was noted that the call light was situated on the side of the bed, above her pillow, and was beyond her reach. During an interview on November 18, 2025, at 11:50 AM, with the Licensed Vocational Nurse (LVN 1), in Resident 2's room, LVN 1 indicated that Resident 2 is not under her care and verified that the call light is out of Resident 2's reach. She then placed the call light in Resident 2's hand and instructed Resident 2 to press the button on the call light whenever assistance is required. During a concurrent observation and interview on November 18, 2025, at 11:53 AM, with the Certified Nursing Assistant (CNA 1), in Resident 2's room, CNA 1 reported the last time she checked on Resident 2 was 30 minutes prior to her lunch break. However, she did not verify whether the call light was within Resident 2's reach. She stated that according to facility policy, she is required to check Resident 2's call light each time she enters the room, and to ensure the call light is accessible. During a concurrent observation and interview on November 18, 2025, at 12:00 PM, with Resident 3 in her room, Resident 3 was sitting on the right side of the bed close to the edge. Resident 3 stated she does not know where her call light is. During a concurrent observation and interview on November 18, 2025, at 12:03 PM, with CNA 1, in Resident 3's room, CNA 1 stated she is also responsible for Resident 3 and the last time she checked on Resident 3 was 30 minutes prior to her break. She further mentioned she did not verify the location of Resident 3's call light during her last check because she believed it had been removed by maintenance. Subsequently, CNA 1 searched for the call light and discovered it was wrapped around the right bedrail. The bed was lowered, causing the call light to hang down and touch the floor, making it unreachable for Resident 3. CNA 1 acknowledged she was not adhering to the policy by failing to ensure the call light was accessible to Resident 3. During an interview on November 18, 2025, at 12:08 PM, with the Maintenance (M1), in Resident 3's room, M1 indicated that the call light should not be encircled around the bedrail. M1 further stated the nursing staff must ensure the call light is accessible to Resident 3. He also mentioned that if a clip is required to secure the call light, the nursing staff should inform him. During an interview on November 18, 2025, at 12:41 PM, with the Minimum Data Set Nurse (MDS 1), in the conference room, MDS 1 stated that the policy requires the call light to be within reach. The call light is clipped onto the resident's gown, particularly for residents who exhibit weakness on either side. In this instance, Resident 3 has weakness on the right side, and the call light was secured around the right rail, rendering it out of Resident 3's reach. During a concurrent record review and interview on November 11, 2025, at 1:37 PM, with MDS 1, the facility's policy and procedure (P&P) titled, Call light dated September 2022, the P&P indicated, .5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathroom facility and from the floor. MDS 1 confirmed that this is indeed their policy.		