STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555476	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Valley Care Center	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure their policy and procedure for Changes in Residents Condition (COC) or Status was implemented for one of three sampled residents (Resident 1) when: 1. Resident 1 was assessed with discoloration on his lower back. 2. Resident 1 refused to receive Physical Therapy (a healthcare service that helps people restore movement, manage pain, and improve physical function after injury, surgery or treatments due to a condition. This failure had the potential for Resident 1's overall medical condition to decline and go undetected by the facility. Findings: 1.During a review of Residents 1's admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (a disease in which there is too much sugar in the blood and the body is not able to control the sugar), difficulty in walking (unusual change in the normal walking pattern often due to problems with the brain nerves, leading to unsteadiness, limping, or other abnormal movements that affect mobility and coordination), muscle weakness (reduction in muscle strength).During a review of Resident 1's admission Skin Assessment, dated October 29, 2025, at 7:30 AM, documented by the Wound Care Nurse (WCN), it indicated Resident had Discolorations on Lower Back.During a review of Resident 1's clinical records, there was no documented evidence to indicate the discolorations on Client 1's lower back were addressed by the facility.During a concurrent interview and review of Resident 1's clinical records with the WCN, on December 29, 2025, at 11:25 AM, the WCN stated that a monitoring of change of condition was not done for the discolorations of his lower back on admission skin. The WCN stated, I did not initiate the care plan as well. The WCN further stated that without the care plan they were not able to monitor the discoloration, nor assess or document the skin condition prior to Resident 1 transferring out of the facility. During an interview with the Director of Nursing (DON) on December 29, 2025, at 1:00 PM, the DON stated, The wound care nurse documented on the admission skin assessment that there is a discoloration on lower back. There should have been a change of condition notification to the primary physician and responsible party on admission. A care plan should have been initiated to monitor the discoloration for 14 days. The DON stated it should have been monitored and documented. 2. During a review of Residents 1's admission Record, the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus, difficulty in walking, and muscle weakness.During a review of Resident 1's admission Physician Orders, dated October 28, 2025, it indicated Resident 1 had an order for Physical Therapy Evaluation and Treatment.During a review of Resident 1's Physical Therapy Treatment Encounter notes from November 11, 2025, through November 16, 2025, it indicated Resident 1 refused to ambulate on four occasions, November 11, 2025, November 12, 2025, November 13, 2025, and November 16, 2025.During a review of Resident 1's clinical records, there was no documented evidence to indicate Resident 1's refusals to ambulate were addressed by the facility.During a concurrent interview and review of 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's Physical therapy initial evaluation and treatment notes, on December 29, 2025, at 12:20 PM, with Physical Therapist (PT), the PT stated that Resident 1 often refused to get out of bed and walk with the walker on more than 2 occasions. The PT stated that she did not notify the licensed nurse and only documented the refusal on her notes.During an interview with the Director of Nursing (DON) on December 29, 2025, at 1:05 PM, the DON stated, Resident 1's refusal to get out of bed should have been communicated with the licensed nurse by the Physical therapist. DON further stated a care plan should have been initiated for refusal of treatment on more than 2 occasions so they can create a goal to minimize any decline in mobility.During an interview and concurrent record review with the DON, on December 29, 2025 at 1:10 PM, the DON reviewed and acknowledged the facility's policy and procedure titled Changes in Residents Condition or Status revised March 2025, which indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representatives of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident right, etc.) . 1.The nurse will notify the resident's attending physician or physician on call when there has been .d. significant change in the resident's physical/emotional /mental condition.f. refusal of treatment or medications two (2) or more consecutive times. 2. c. Requires interdisciplinary review and /or revision to the care plan .3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather pertinent information for the provider. 5. Notifications will be made to the responsible party when a change occurring in the resident's medical/mental condition or status. The DON stated there should have been a COC notification and documentation of discoloration of lower back on admission and a refusal of treatment when Resident 1 refused to ambulate on more than 2 occasions.