| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555476 | A. Building<br>B. Wing | 03/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Apple Valley Care Center | 11959 Apple Valley Rd<br>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 0675<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor each resident's preferences, choices, values and beliefs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of the three sampled residents (Resident 1) received timely incontinence care to maintain dignity and comfort when on February 17, 2026, Resident 1 was left in a soiled brief for more than 40 minutes while being served lunch. This failure resulted in Resident 1's dignity and comfort being diminished. Furthermore, Resident 1 experienced a reduction in her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.Findings: A review of Resident 1's Face Sheet (a facility document containing demographics) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which include Left Femur Fracture (break in a bone causing pain, swelling, bruising, and inability to move the affected area), Gout (a common, painful form of inflammatory arthritis that causes sudden, intense attacks of redness, swelling, and pain in joints, most frequently the big toe), Chronic Obstructive Pulmonary Disease (a progressive lung disease that makes it difficult to breathe), Hypertension (high blood pressure), and History of falling. During a concurrent observation and interview on February 17, 2026, at 11:41 AM, Resident 1 was observed in bed, stating that she had put her call light on at 11:00 AM because she needed a diaper change. Resident 1 stated a Certified Nursing Assistant (CNA) brought her lunch at 11:30 AM and refused to assist Resident 1 with a diaper change. During an observation on February 17, 2026, at 11:43 AM, Resident 1 activated her call light while this surveyor was in the room at her bedside. In less than a minute, CNA 1 entered the room without knocking or announcing her entrance. CNA 1 turned off the call light from the wall switch located above Resident 1's bed, ignored Resident 1 entirely, walked over and checked on the roommate, and was about to leave the room. Resident 1, visibly distressed, asked CNA 1 to assist with a diaper change so she could eat her lunch, which was getting cold on the table. CNA 1 stated, I can't change your diaper because your roommate is eating right now. Resident 1 stated, I never felt so disrespected and frustrated. I will not eat while still soiled. During an interview with CNA 1 on February 17, 2026, at 11:52 AM, CNA 1 explained that she had been on her lunch break from 10:40 AM to 11:20 AM and claimed that someone else had answered the call light earlier and should have changed Resident 1's diaper. CNA 1 stated that no one had informed her of Resident 1's needs when she returned from her break. CNA 1 further stated, The DSD (Director of Staff Development) had instructed us not to provide peri-care if someone in the room was eating. I even asked my Charge Nurse if I was allowed to do it, and she said NO.During an interview with the Charge Nurse (CN 1) on February 17, 2026, at 11:58 AM, CN 1 stated that she instructed CNA 1 to pull the privacy curtain around the bed and assist Resident 1 with the diaper change. CN 1 denied instructing CNA 1 not to change Resident 1's diaper because the roommate was eating.During an interview with the Director of Staff Development (DSD) on February 17, 2026, at 12:09 PM, DSD stated she never instructed staff to hold or delay resident's care because someone in the room was eating. DSD further added that her expectations are that staff follow facility's policies and procedures and attend to residents' needs immediately without delay. DSD stated CNA 1 should have pulled the privacy curtain and change the resident's diaper before serving her lunch. Furthermore, DSD stated the proper procedure for all staff is to stop current tasks and respond to residents' needs immediately. DSD denied the existence of a<br>(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 0675<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | policy preventing changing residents while roommates are eating and insisted that proper protocol requires using privacy curtains when providing personal care.During a concurrent record review and phone interview with Director of Nurses (DON) on March 2, 2026, at 11:42 AM, the facility's Policy and Procedure (P&P) titled, Dignity, revised on February 2021, was reviewed. The P&P stated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . 1. Residents are treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facilities stay . 5. When assisting with care, residents are supported in exercising their rights . 7. Staff are expected to knock and request permission before entering residents' rooms . 8. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis or care needs . 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures, 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents . promptly responding to a resident request for toileting assistance. The DON indicated the facility's P&P was not followed when staff members did not provide necessary personal care and left Resident 1 in a soiled diaper for more than 40 minutes. The DON acknowledged this is a violation of the facility's standards of care and the federal requirements as outlined in the Centers for Medicare & Medicaid Services (CMS) regulations, which mandate that residents must receive proper hygiene and personal care to maintain their dignity and well-being. |