

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/18/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper and safe infection control practices were followed when: 1. Resident 41, Resident 54, and Resident 139's nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) tubing (a thin plastic hose that delivers pressurized air from the nebulizer's air compressor machine to the medicine cup) was found unlabeled and not stored in plastic bags in accordance with the facility's policy and procedure (P&P). 2. Resident 139's portable oxygen tank (a lightweight, mobile container that stores oxygen) nasal cannula tubing (a small flexible plastic tube that connects to an oxygen source) was found unlabeled in Resident 139's room. 3. Licensed Vocational Nurse 3 (LVN 3) was observed entering Resident 51 and Resident 151's room on novel respiratory precaution without the required face shield or goggles in accordance with facility's policy and procedure (P&P). 4. Resident 51, Resident 95, and Resident 160's nasal cannula (a lightweight, clear tube with two prongs that fit into the nostrils to deliver supplemental oxygen or increased airflow for respiratory support) was found undated and unlabeled in accordance with facility's policy and procedure (P&P). These failures had the potential to spread infectious disease (disease caused by bacteria, viruses, fungi or parasite) to 87 medically compromised residents and staff in the facility. Findings: 1.a. During a review of Resident 41's admission Record (contains medical and demographic information), the admission Record indicated Resident 41 was admitted to the facility on [DATE] with the diagnoses which included chronic respiratory failure with hypoxia (The lungs have a long-term problem keeping enough oxygen in your blood, leading to low oxygen levels), Chronic Obstructive Pulmonary Disease (COPD- a progressive lung disease that blocks airflow, making it hard to breathe) and Asthma (a chronic lung condition where airways become inflamed, swollen, and narrow, making it hard to breathe). During a review of Resident 41's Physician Order dated February 26, 2025, the Physician Order indicated, . Change handheld nebulizer and put in new bag weekly. Initial and date HHN (handheld nebulizer) and bag every day shift every Thursday. During a concurrent observation and interview, with Licensed Vocational Nurse 2 (LVN 2) on February 15, 2025, at 10:50 AM, in Resident 41's room, LVN 2 confirmed Resident 41's nebulizer tubing was not in use and not stored in a plastic bag, she further confirmed the nebulizer tubing was not labeled per policy. 1b. During a review of Resident 54's admission Record, the admission Record indicated Resident 54 was admitted to the facility on [DATE] with the diagnoses which included, Chronic Obstructive Pulmonary Disease (COPD- a progressive lung disease that blocks airflow, making it hard to breathe) and Lobar Pneumonia (a lung infection that inflames the air sacs causing them to fill with fluid or pus making it hard to breathe), and Syncope and Collapse (a temporary loss of consciousness [fainting]) (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and sudden fall). During a review of Resident 54's Physician Order dated December 8, 2025, the Physician Order indicated, . Change handheld nebulizer and put in new bag weekly. Initial and date HHN and bag every day shift every Thursday. During a concurrent observation and interview on December 15, 2025, at 11:40 AM with the Interim Infection Preventionist (IIP), in Resident 54's room, observed Resident 54's nebulizer tubing not in use on resident nightstand unlabeled and not stored in a plastic bag. IIP states it's the facility's policy for nebulizer tubing to be labeled and stored in a plastic bag when not in use. 1c. During a review of Resident 139's admission Record, the admission Record indicated Resident 139 was admitted to the facility on [DATE] with the diagnoses which included chronic respiratory failure with hypoxia (The lungs have a long-term problem keeping enough oxygen in your blood, leading to low oxygen levels), Chronic Obstructive Pulmonary Disease(COPD- a progressive lung disease that blocks airflow, making it hard to breathe) and Dependence on supplemental oxygen (extra oxygen supplied through a device to maintain enough oxygen in their bloodstream for their body to function properly). During a review of Resident 139's Physician Order dated December 8, 2025, the Physician Order indicated, . Change handheld nebulizer and put in new bag weekly. Initial and date HHN and bag every day shift every Thursday. During a concurrent observation and interview, on February 15, 2025, at 11:49 AM with IIP in Resident 139's room, observed Resident's 139's nebulizer tubing not in use, on Resident 139's nightstand unlabeled, and not stored in a plastic bag. IIP confirmed nebulizer should be stored in a plastic bag when not in use and it should be labeled. IIP further stated policy was not followed. During a concurrent interview and record review on December 17, 2025, at 2:00 PM, with the Director of Nursing (DON) in the DON's office, the facility's policy and procedure (P&P) titled, Respiratory Therapy-Prevention of Infection, dated 2001 was reviewed. The P&P indicated, . Steps in the Procedure. Infection Control Considerations Related to Medication Nebulizer/Continuous Aerosol .8. Label the nebulizer tubing and plastic bag with the date. Replace these items every (7) days or sooner if needed. Discard the administration set up every (7) days. The DON stated the P&P was not followed for Resident 41, Resident 54 and Resident 139 and should have been to prevent possible cross contamination. 2. During a review of Resident 139's admission Record, the admission Record indicated Resident 139 was admitted to the facility on [DATE] with the diagnoses which included chronic respiratory failure with hypoxia (The lungs have a long-term problem keeping enough oxygen in your blood, leading to low oxygen levels), Chronic Obstructive Pulmonary Disease(COPD- a progressive lung disease that blocks airflow, making it hard to breathe) and Dependence on supplemental oxygen (extra oxygen supplied through a device to maintain enough oxygen in their bloodstream for their body to function properly). During a review of Resident 139's Physician Order dated February 26, 2025, it indicated, .give (3) Liters/Minutes (L/M&mdash;a unit of measurement) oxygen per Nasal Canula every shift for COPD related to acute and chronic respiratory failure with hypoxia, COPD and dependence on supplemental oxygen. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 139's Physician Order dated February 26, 2025, the Physician Order indicated, .Change O2 (oxygen) cannula/mask tubing Q(Every)7 days or PRN (as needed) soilage every day shift every Thursday. During a concurrent observation and interview, on February 15, 2025, at 11:53 AM with IIP in Resident 139's room, the IIP confirmed there was no date on Resident 139's portable oxygen tank NC. IIP stated the facility's expectation is that all NC tubing should be labeled with the date, so staff know how old the tubing is and when to change it. During a concurrent interview and record review on December 17, 2025, at 2:13 PM, with the Director of Nursing (DON) in the DON's office, the facility's policy and procedure (P&P) titled, Respiratory Therapy-Prevention of Infection, dated 2001 was reviewed. The P&P indicated, . Steps in the Procedure. Infection Control Considerations Related to Oxygen Administration .5. Label the oxygen cannula, tubing and plastic bag every (7) days, or as needed.6. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use. The DON stated the P&P was not followed and should have been for infection control prevention. 3a. During a review of Resident 51's admission Record, it indicated Resident 51 was admitted to the facility on [DATE], with diagnoses of Contracture of Muscle left lower leg (a permanent tightening and shortening of muscles, tendons, or skin, restricting joint movement and causing stiffness), Peripheral Vascular Disease (a circulation problem where narrowed or blocked blood vessels), and Dependence of Supplemental Oxygen (extra oxygen supplied through a device to maintain enough oxygen in their bloodstream for their body to function properly). During a review of Resident 51's Physician Order dated December 12, 2025, the Physician Order indicated, Novel Respiratory Isolation [strict infection control measures often use for unknown or highly contagious respiratory pathogens] times 10 days for COVID 19 [respiratory pathogen that causes difficulties in breathing] infection. During a review of Resident 151's admission Record, the admission Record indicated Resident 51 was admitted to the facility on [DATE], with diagnoses of Encephalopathy (a disease of the brain caused by toxins, or infection which causes altered mental status), Transient cerebral ischemic attack (a temporary blockage of blood flow to the brain, often from a blood clot traveling from another part of the body), and muscle weakness (a reduction in muscles' strength). During a review of Resident 151's Physician Order dated December 9, 2025, the Physician Order indicated, Novel Respiratory Isolation times 10 days for COVID 19 infection. During an observation on December 17, 2025, at 7:24 AM outside room [number of the room] (Resident 51 and Resident 151's room) observed novel respiratory precautions sign outside the door of room [number], COVID positive room. During an observation on December 17, 2025, at 7:27 AM outside room [number of the room] (Resident 51 and Resident 151's room) observed Licensed Vocational Nurse 3 (LVN 3) donning personal protective equipment (PPE), mask, gown and gloves prior to entering room. LVN 3 entered room without the required face shield or goggles. During an interview on December 17, 2025, at 7:35 AM with LVN 3, LVN 3 acknowledged that she did not adhere to the novel respiratory precaution requirements when entering room [number], a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	COVID-19 positive room, as she was not wearing the required face shield or protective goggles. During a concurrent interview and record review on December 17, 2025, at 12:45 PM, with the Director of Nursing (DON) in the DON's office, the facility's policy and procedure (P&P) titled, COVID-19, Prevention and Control, dated June 17, 2025, was reviewed. The P&P indicated, .F. Personal Protective Equipment.D. Eye Protection.a. Eye protection (which can be goggles or face shields) is no longer required for all direct resident care, including aerosol generate except: when caring for residents in the COVID care cohort or COVID isolation areas. The DON stated the P&P was not followed and it's important for staff to follow to prevent the spread of COVID-19 in the facility. 4. During a review of Resident 51's admission Record (contains medical and demographic information), it indicated Resident 51 was admitted to the facility on [DATE], with diagnoses of Contracture of Muscle left lower leg (a permanent tightening and shortening of muscles, tendons, or skin, restricting joint movement and causing stiffness), Peripheral Vascular Disease (a circulation problem where narrowed or blocked blood vessels), and Dependence of Supplemental Oxygen (extra oxygen supplied through a device to maintain enough oxygen in thier bloodstream for their body to function properly). During an observation on December 15, 2025, at 12:52PM, inside Resident 51's room, Resident 51 was observed receiving oxygen therapy via nasal cannula connected to an oxygen concentrator. The oxygen tubing was unlabeled and undated During an interview on December 15, 2025, at 12:54PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 acknowledged Resident 51 was on oxygen via nasal cannula unlabeled and undated, and should have been labeled and dated, but was not. During a review of Resident 51's Order Summary Report dated September 30, 2025, it indicated, .give (2) Liters/Minutes oxygen per Nasal Canula (a lightweight, clear tube with two prongs that fit into the nostrils to deliver supplemental oxygen or increased airflow, connecting to an oxygen source) every shift for SOB related to dependence on supplemental oxygen. During a review of Resident 95's admission Record (contains medical and demographic information), it indicated Resident 95 was admitted to the facility on [DATE], with diagnoses of Acute and Chronic Respiratory Failure (a sudden worsening of breathing in someone with a pre-existing lung condition, like COPD, where the lungs can't get enough oxygen), and pneumonia (a lung infection that inflames the air sacs causing them to fill with fluid or pus, making it hard to breathe and get oxygen, and can be caused by bacteria, viruses, or fungi). During an observation on December 15, 2025, at 12:44 PM, inside Resident 95's room, Resident 95 was observed receiving oxygen therapy via nasal cannula connected to an oxygen concentrator. The oxygen tubing was unlabeled and undated During an interview on December 15, 2025, at 12:44 PM, with LVN 1, LVN 1 acknowledged Resident 95 was on oxygen via nasal cannula unlabeled and undated, and should have been labeled and dated, but was not. During a review of Resident 95's Order Summary Report dated June 20, 2025, it indicated, .Administer oxygen at (2) Liters/Minutes via Nasal Canula as needed. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 160's admission Record (contains medical and demographic information), it indicated Resident 160 was admitted to the facility on [DATE], with diagnoses of Paroxysmal Atrial Fibrillation (a type of irregular heartbeat where episodes start and stop on their own, typically resolving within seven days, though sometimes requiring treatment), and hydronephrosis with renal and ureteral calculous obstruction (kidney swelling caused by a kidney stone stuck in the ureter, blocking urine flow from the kidney down to the bladder, leading to urine backup, pain, potential infection). During an observation on December 15, 2025, at 11:28 AM, inside Resident 160's room, Resident 160 was observed receiving oxygen therapy via nasal cannula connected to an oxygen concentrator (a medical device that pulls in ambient air, filters out nitrogen and impurities, and delivers concentrated, purified oxygen (around 90-95%) to individuals needing supplemental oxygen for respiratory issues like COPD, via a nasal cannula or mask, providing a continuous supply for better breathing.) During an interview on December 15, 2025, at 11:33 AM, with LVN 1, LVN 1 acknowledged Resident 160 was on oxygen via nasal cannula unlabeled and undated, and should have been labeled and dated, but was not. During an interview and record review on December 16, 2025, at 4:13 PM with Interim Infection Preventionist (IIP), IIP acknowledged that Residents 51, 95, and 160 were on oxygen therapy via nasal cannula that are undated and unlabeled, and facility policy was not followed and should have been. During a review of Resident 160's Order Summary Report dated December 11, 2025, it indicated, .Administer oxygen at (2) Liters/Minutes via Nasal Canula continuously for diagnosis: shortness of breath (SOB) every shift. During a concurrent interview and record review on December 16, 2025, at 4:35 PM, with the Director of Nursing (DON), in the facility's conference room. the facility's policy and procedure (P&P) titled, Respiratory Therapy & Prevention of Infection revised 2001 was reviewed. The P&P indicated .Infection Control Consideration Related to Oxygen Administration. 5. Label the oxygen cannula, tubing and plastic bag every seven (7) days, or as need . The DON stated the P&P was not followed and should have been.		