

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Desert Canyon Post Acute, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1642 West Avenue J Lancaster, CA 93534	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>45958</p> <p>Based on interviews and record reviews, the facility failed to notify the Power of Attorney (POA-a person legally or non-legally appointed to make decisions on behalf of a patient who lacks capacity) of one of three sampled residents (Resident 1) regarding the progression of an abrasion (the surface layers of the epidermis [skin] has been broken) over Resident 1 ' s coccyx (the small bone at the end of the spine tailbone). As a result, Family Member 1 was not provided information to request additional care interventions.</p> <p>This deficient practice violated the resident ' s rights and/or the representative ' s right to be fully informed of Resident 1 ' s change of condition.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the facility initially admitted the resident on 7/28/2023 and readmitted the resident on 1/24/2024 with diagnoses including dementia (a set of symptoms that over time can affect memory, problem-solving, language and behavior), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it.), bipolar disorder (is a mental illness that causes unusual shifts in a person ' s mood, energy, activity levels, and concentration), and morbid obesity (weight is more than 80 to 100 pounds above their ideal body weight). A review of the face sheet indicated the daughter was the resident representative.</p> <p>A review of Resident 1 ' s Advance Health Care Directive Form, dated, 5/11/2016, indicated Resident 1 ' s POA was his Family Member 1 (FM 1). The form indicated Resident 1 designated her daughter as her agent to make health decisions for her.</p> <p>A review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and screening tool), dated 2/8/2024, indicated Resident 1 was severely impaired with thought process and decision-making tasks. The MDS indicated Resident 1 required total dependence from staff for dressing, toilet use (how resident uses toilet room, cleansing after elimination), and shower/bathe self.</p> <p>(continued on next page)</p>

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: 055307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Desert Canyon Post Acute, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1642 West Avenue J Lancaster, CA 93534	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s change in condition (COC), dated 3/20/2024, at 6:53 a.m., indicated Licensed Vocational Nurse 1 (LVN 1) received report that Resident 1 has abrasion and upon assessment Resident 1 has abrasion on her coccyx and noted redness on the site. The COC indicated Resident 1 has no complaint of pain or discomfort. The Medical Doctor was made aware, and Treatment Nurse initiated treatment per facility protocol. The COC indicated LVN 1 attempted to contact Resident 1 ' s Responsible Party (RP), unable to leave message, voicemail was full.</p> <p>On 4/10/2024, at 9:48 a.m., during a telephone interview with Family Member 1 (FM 1), FM 1 stated on 4/4/2024, she took her mother (Resident 1) to a doctor ' s appointment and checked her back and noticed she had a pressure ulcer on her bottom area. FM 1 stated the facility never notified her that the resident had a wound, and she is the resident's POA. FM 1 stated when she went back to the facility, the staff told her, the resident's wound happened on 3/20/2024 and they tried to call her, and her voicemail was full. FM 1 stated that she goes to the facility two to three times a week, and no one told her about the resident's wound and further stated her voicemail is not full.</p> <p>On 4/10/2024 at 1:16 p.m., during an interview with the Director of Nursing (DON), the DON stated the facility should have communicated with FM 1 and tried to reach out to her again or tried another number.</p> <p>On 4/10/2024 at 2:57 p.m., during a concurrent interview and record review with Registered Nurse Supervisor (RNS), Resident 1's medical records including COC from 3/20/2024 were reviewed. The RNS stated that she was informed by LVN 1 of Resident 1 ' s abrasion to the coccyx area and to follow up with Resident 1 ' s FM 1 (Responsible Party). The RNS stated that she did call FM 1, but the call went straight to voicemail and the voicemail messages were full and she could not leave a message. The RNS stated that she forgot to document that she called FM 1 and she forgot to relay to the next shift to follow up and call FM 1 again to notify her of the resident's abrasion. The RNS stated it is important for the facility to notify a resident ' s responsible party of any change of condition because they need to know what is going on and know what interventions the resident is receiving.</p> <p>On 4/10/2024 at 3:13 p.m., during a telephone interview with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated on the morning of 3/20/2024, the Certified Nursing Assistant (CNA) notified her that Resident 1 had a change of condition on her coccyx area. LVN 1 stated that she checked the resident's abrasion to her coccyx area. LVN 1 stated she reported the COC to the medical doctor (MD) and the treatment Nurse 1 (TN 1). LVN 1 stated she called Resident 1 ' s FM 1 (Responsible Party), but no one answered the phone and she endorsed RNS to follow up with FM 1.</p> <p>A review of the facility ' s policy and procedure titled Notification of Changes, revised on 3/2023, indicated, the facility notifies the physician and resident representative of: An accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). The policy further indicated, designated resident representative or family, as appropriate, should be notified of significant changes in the resident health status. Facility staff shall contact the designated resident representative, consistent with his or her authority, to make any required decisions when the resident is not capable of making decisions.</p>		