STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055307	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Canyon Post Acute, LLC	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42311 Based on interview and record review, the facility failed to develop a comprehensive care plan for one of three sampled resident (Resident 1) to address the following: 1. Resident 1 refused lactulose (medication used to constipation [when your bowel movements become less frequent, and stools become difficult to pass]) nine times from 5/4/2024 to 5/9/2024. 2. Resident 1 refused shower twice in a week from 5/3/2024 to 5/9/2024. These deficient practices had the potential for delayed provision of necessary care and services. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 5/3/2024 with diagnoses that included other cirrhosis of liver (is permanent scarring that damages your liver and interferes with its functioning that can lead to liver failure), other ascites (a condition in which fluid collects in spaces within your abdomen) and essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition). A review of Resident 1's Admission Assessment indicated the resident was alert and oriented to person, place, time, and situation. a. A review of Resident 1's Medication Review Report dated 5/4/2024 indicated an order for lactulose (medication used to constipation [when your bowel movements become less frequent, and stools become difficult to pass]), 10 grams (unit of measurement) per 15 milliliter (ml- unit of measurement) and give 30 ml by mouth three times a day for liver cirrhosis. A review of Resident 1's Medication Administration Record (MAR), dated 5/2024, indicated the resident refused lactulose nine times from 5/4/2024 to 5/9/2024. During a concurrent interview and record review on 5/13/2024 at 10:04 a.m., with the ADON, Resident 1's MAR dated 5/2024 and Care Plans was reviewed. The ADON stated Resident 1 had multiple refusal for lactulose. The ADON stated there was no care plan develop on the medication refusal. The ADON stated staff should develop a care plan for any refusal to address Resident 1's refusal of care or medication and to notify the doctor. (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A review of the facility's Shower List for 7 a.m. to 3 p.m. shift indicated Resident 1 was scheduled for shower on Thursdays and Sundays. During a concurrent interview and record review on 5/11/2024 at 9:05 a.m., with the Infection Preventionist (IP), Resident 1's Activities of Daily Living (ADL) - bed bath, dated 5/2024, and Care Plans were reviewed. The ADL- bed bath had a check mark on 5/7/2024 and 5/9/2024. The IP stated Resident 1 had a bed bath on 5/7/2024 and 5/9/2024. The IP stated no shower was provided from 5/3/2024 to 5/9/2024. The IP stated staff should offer shower first and if refused then provide the bed bath and notify the nurses. The IP stated there was no care plan developed to addressed resident refusal of shower. During an interview on 5/13/2024 at 8:53 a.m., Certified Nursing Assistant 2 (CNA 2) stated she offered shower on 5/7/2024 and 5/9/2024 but Resident 1 refused and stated she was cold. CNA 2 stated she gave bed bath on both days. CNA 2 stated bed bath provided did not include washing the hair. CNA 2 stated she did not report to the nurses of Resident 1's refusal to shower. During an interview on 5/13/2024 at 10:04 a.m., the Assistant Director of Nursing (ADON) stated CNAs should notify nurses for any refusal so care plan could be developed. The ADON stated they do not have a policy for showering residents. A review of facility's policy and procedure titled, Develop-Implement Comprehensive Care Plans, dated 2/2018 and revised on 2/2023, indicated The facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preference and goals, and address the resident's medical, physical, mental, and psychosocial needs. The Comprehensive care plan describes: a. The services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. b. Any services that are not provided due to the resident's exercise of right to refuse treatment . Based on interview and record review, the facility failed to develop a comprehensive care plan for one of three sampled resident (Resident 1) to address the following: 1. Resident 1 refused lactulose (medication used to constipation [when your bowel movements become less frequent, and stools become difficult to pass]) nine times from 5/4/2024 to 5/9/2024. 2. Resident 1 refused shower twice in a week from 5/3/2024 to 5/9/2024. These deficient practices had the potential for delayed provision of necessary care and services. Findings: (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's Admission Record indicated the facility admitted the resident on 5/3/2024 with diagnoses that included other cirrhosis of liver (is permanent scarring that damages your liver and interferes with its functioning that can lead to liver failure), other ascites (a condition in which fluid collects in spaces within your abdomen) and essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition). A review of Resident 1's Admission Assessment indicated the resident was alert and oriented to person, place, time, and situation. a. A review of Resident 1's Medication Review Report dated 5/4/2024 indicated an order for lactulose (medication used to constipation [when your bowel movements become less frequent, and stools become difficult to pass]), 10 grams (unit of measurement) per 15 milliliter (ml- unit of measurement) and give 30 ml by mouth three times a day for liver cirrhosis. A review of Resident 1's Medication Administration Record (MAR), dated 5/2024, indicated the resident refused lactulose nine times from 5/4/2024 to 5/9/2024. During a concurrent interview and record review on 5/13/2024 at 10:04 a.m., with the ADON, Resident 1's MAR dated 5/2024 and Care Plans was reviewed. The ADON stated Resident 1 had multiple refusal for lactulose. The ADON stated there was no care plan develop on the medication refusal. The ADON stated staff should develop a care plan for any refusal to address Resident 1's refusal of care or medication and to notify the doctor. b. A review of the facility's Shower List for 7 a.m. to 3 p.m. shift indicated Resident 1 was scheduled for shower on Thursdays and Sundays. During a concurrent interview and record review on 5/11/2024 at 9:05 a.m., with the Infection Preventionist (IP), Resident 1's Activities of Daily Living (ADL) - bed bath, dated 5/2024, and Care Plans were reviewed. The ADL- bed bath had a check mark on 5/7/2024 and 5/9/2024. The IP stated Resident 1 had a bed bath on 5/7/2024 and 5/9/2024. The IP stated no shower was provided from 5/3/2024 to 5/9/2024. The IP stated staff should offer shower first and if refused then provide the bed bath and notify the nurses. The IP stated there was no care plan developed to addressed resident refusal of shower. During an interview on 5/13/2024 at 8:53 a.m., Certified Nursing Assistant 2 (CNA 2) stated she offered shower on 5/7/2024 and 5/9/2024 but Resident 1 refused and stated she was cold. CNA 2 stated she gave bed bath on both days. CNA 2 stated bed bath provided did not include washing the hair. CNA 2 stated she did not report to the nurses of Resident 1's refusal to shower. During an interview on 5/13/2024 at 10:04 a.m., the Assistant Director of Nursing (ADON) stated CNAs should notify nurses for any refusal so care plan could be developed. The ADON stated they do not have a policy for showering residents. A review of facility's policy and procedure titled, Develop-Implement Comprehensive Care Plans , dated 2/2018 and revised on 2/2023, indicated The facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preference and goals, and address the resident's medical, physical, mental, and psychosocial needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055307	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Canyon Post Acute, LLC	1642 West Avenue J Lancaster, CA 93534

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive care plan describes: a. The services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. b. Any services that are not provided due to the resident's exercise of right to refuse treatment .

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42311 Based on observation, interview, and record review, the facility failed to implement infection control measures for one of three sampled residents (Resident 2) by: 1. Failing to ensure Certified Nursing Assistant 1 (CNA 1) wore protective gown during incontinent care (care provided to resident with no bladder and bowel control) and linen change. Residents 2's was on enhanced barrier precaution (expand the use of personal protective equipment and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms [MDRO- are germs that are difficult to treat because they are resistant to many antibiotics]). 2. Failing to ensure Licensed Vocational Nurse 1 (LVN 1) was notified that Resident 2 was on enhanced barrier precaution. These deficient practices had the potential for cross contamination (unintentional transfer of bacteria/germs or other contaminant from one surface to another) of infection among residents. Findings: A review of Resident 2's Admission Record indicated the facility admitted the resident on 1/4/2024 with diagnoses that included cerebral infarction (also known as a stroke - refers to damage tissues in the brain due to a loss of oxygen to the area), encounter for attention to gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food and medications) and dysphagia (swallowing difficulties). A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/13/2024, indicated resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. A review of Resident 2's Care Plan on enhanced barrier precaution (expand the use of personal protective equipment and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms [MDRO- are germs that are difficult to treat because they are resistant to many antibiotics]) related to gastrostomy tube (GT) site, dated 5/1/2024, indicated an intervention that health teaching will be provided to resident, family members and staff about the importance of enhanced barrier precaution including proper hand hygiene and wearing of personal protective equipment (PPE-equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) during high contact resident activities. During an observation on 5/11/2024 at 8:24 a.m., observed Resident 2 in bed with ongoing GT feeding at 40 milliliter (ml- unit of measurement) per hour. A signage was posted that indicated enhanced barrier precaution: providers and staff must also wear gloves and gown for the following high contact resident care activities (dressing, bathing, transferring, changing line, etc.) posted by wall on Resident 2's foot part of the bed. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/11/2024 at 8:24 a.m., Certified Nursing Assistant 1 (CNA 1) stated Resident 2 had GT but not on enhanced barrier precaution. CNA 1 stated he had the resident last Sunday, 5/5/2024 and there was no enhanced barrier precaution signage in the room. CNA 1 stated he did not receive a report that Resident 2 was on enhanced barrier precaution. CNA 1 admitted providing incontinent care (care provided to resident with no bladder and bowel control) and changed Resident 2's linen without wearing a gown. During an interview on 5/11/2024 at 8:33 a.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 2 was not on enhanced barrier precaution and LVN 1 did not receive a report from outgoing shift that Resident 2 is on enhanced barrier precaution. LVN 1 stated it is important to endorse that resident was on enhanced barrier precaution to stop the spread of infection. During an interview on 5/11/2024 at 8:39 a.m., Registered Nurse 1 (RN 1) stated Resident 2 was on enhanced barrier precaution because of the GT. RN 1 stated it is important to notify staff to use gown and gloves when providing care to prevent the spread of infection. During an interview on 5/11/2024 at 9:05 a.m., the Infection Preventionist (IP) stated staff were in-serviced that any resident with tubings, catheter, or wound will be on enhanced barrier precaution. The IP stated resident on enhanced barrier precaution had the signage posted in the room and wears an orange bracelet. The IP stated staff should wear gown and gloves when giving direct care to prevent the spread of infection. A review of facility's policy and procedure titled, Enhanced Barrier Precautions, dated 4/1/2024, indicated, I. Enhanced barrier precaution is used in conjunction with standard precautions and expand the use of PPE to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms (MDRO- are germs that are difficult to treat because they are resistant to many antibiotics) to staff hands and clothing. II. EBP are indicated for residents with any of the following: B. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized (germs are on the body but do not make you sick. People who are colonized will have no signs or symptoms) with a MDRO. IV. IV. Indwelling medical device examples include central lines (lines that goes all the way up to a vein near the heart or just inside the heart), urinary catheters (a flexible tube used to empty the bladder and collect urine in a drainage bag), feeding tubes (allows you to receive nutrition directly through your stomach), and tracheostomies (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck). Based on observation, interview, and record review, the facility failed to implement infection control measures for one of three sampled residents (Resident 2) by: (continued on next page)

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 05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Canyon Post Acute, LLC	1642 West Avenue J Lancaster, CA 93534

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Failing to ensure Certified Nursing Assistant 1 (CNA 1) wore protective gown during incontinent care (care provided to resident with no bladder and bowel control) and linen change. Residents 2's was on enhanced barrier precaution (expand the use of personal protective equipment and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms [MDRO- are germs that are difficult to treat because they are resistant to many antibiotics]). 2. Failing to ensure Licensed Vocational Nurse 1 (LVN 1) was notified that Resident 2 was on enhanced barrier precaution. These deficient practices had the potential for cross contamination (unintentional transfer of bacteria/germs or other contaminant from one surface to another) of infection among residents. Findings: A review of Resident 2's Admission Record indicated the facility admitted the resident on 1/4/2024 with diagnoses that included cerebral infarction (also known as a stroke - refers to damage tissues in the brain due to a loss of oxygen to the area), encounter for attention to gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food and medications) and dysphagia (swallowing difficulties). A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/13/2024, indicated resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. A review of Resident 2's Care Plan on enhanced barrier precaution (expand the use of personal protective equipment and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms [MDRO- are germs that are difficult to treat because they are resistant to many antibiotics]) related to gastrostomy tube (GT) site, dated 5/1/2024, indicated an intervention that health teaching will be provided to resident, family members and staff about the importance of enhanced barrier precaution including proper hand hygiene and wearing of personal protective equipment (PPE-equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) during high contact resident activities. During an observation on 5/11/2024 at 8:24 a.m., observed Resident 2 in bed with ongoing GT feeding at 40 milliliter (ml- unit of measurement) per hour. A signage was posted that indicated enhanced barrier precaution: providers and staff must also wear gloves and gown for the following high contact resident care activities (dressing, bathing, transferring, changing line, etc.) posted by wall on Resident 2's foot part of the bed. During a concurrent observation and interview on 5/11/2024 at 8:24 a.m., Certified Nursing Assistant 1 (CNA 1) stated Resident 2 had GT but not on enhanced barrier precaution. CNA 1 stated he had the resident last Sunday, 5/5/2024 and there was no enhanced barrier precaution signage in the room. CNA 1 stated he did not receive a report that Resident 2 was on enhanced barrier precaution. CNA 1 admitted providing incontinent care (care provided to resident with no bladder and bowel control) and changed Resident 2's linen without wearing a gown. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/11/2024 at 8:33 a.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 2 was not on enhanced barrier precaution and LVN 1 did not receive a report from outgoing shift that Resident 2 is on enhanced barrier precaution. LVN 1 stated it is important to endorse that resident was on enhanced barrier precaution to stop the spread of infection. During an interview on 5/11/2024 at 8:39 a.m., Registered Nurse 1 (RN 1) stated Resident 2 was on enhanced barrier precaution because of the GT. RN 1 stated it is important to notify staff to use gown and gloves when providing care to prevent the spread of infection. During an interview on 5/11/2024 at 9:05 a.m., the Infection Preventionist (IP) stated staff were in-serviced that any resident with tubings, catheter, or wound will be on enhanced barrier precaution. The IP stated resident on enhanced barrier precaution had the signage posted in the room and wears an orange bracelet. The IP stated staff should wear gown and gloves when giving direct care to prevent the spread of infection. A review of facility's policy and procedure titled, Enhanced Barrier Precautions, dated 4/1/2024, indicated, I. Enhanced barrier precaution is used in conjunction with standard precautions and expand the use of PPE to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms (MDRO- are germs that are difficult to treat because they are resistant to many antibiotics) to staff hands and clothing. II. EBP are indicated for residents with any of the following: B. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized (germs are on the body but do not make you sick. People who are colonized will have no signs or symptoms) with a MDRO. IV. IV. Indwelling medical device examples include central lines (lines that goes all the way up to a vein near the heart or just inside the heart), urinary catheters (a flexible tube used to empty the bladder and collect urine in a drainage bag), feeding tubes (allows you to receive nutrition directly through your stomach), and tracheostomies (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck).