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	06/20/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46445 Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology) by staff. On 6/9/2024 at 1:30 p.m. , the Admissions Coordinator (AC) stated the Facility [NAME] yelled at Resident 1 to shut up. This deficient practice resulted in Resident 1 feeling humiliated and verbalizing not feeling safe in the facility. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 4/26/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), major depressive disorder (mental health condition that causes a persistently low or sad mood and a loss of interest in activities that once brought joy), and anxiety disorder (persistent and excessive worry that interferes with daily activities). A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 5/8/2024, indicated the resident's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The Mood section indicated Resident 1 was feeling down, depressed, or hopeless during the lookback period (time frame for assessment). A review of Resident 1's Care Plan on behavior, dated 6/6/2024, indicated the resident had a behavior of throwing the dinner tray at the kitchen. The Care Plan intervention included to anticipate and meet Resident 1's needs. A review of Resident 1's Change of Condition (COC) form, dated 6/9/2024, indicated the resident went to the kitchen and spoke to the FC about the resident's diet slip (a list of foods served to the resident based on the resident's diet order). The COC form indicated facility staff separated the FC from Resident 1 when the FC started to argue with the resident. The COC form indicated Resident 1 felt safe if the FC was not there. The attending physician was notified at 2 p.m. on 6/9/2024. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Progress Notes, dated 6/9/2024 timed at 2:27 p.m., indicated Social Service Coordinator 1 (SSC 1) heard a commotion outside the social service office. The Progress Notes indicated SSC 1 and the facility nursing staff stood in between the FC and Resident 1. A review of Resident 1's Progress Notes, dated 6/9/2024 timed at 3:28 p.m. as a late entry, indicated SSC 1 was notified about the alleged verbal abuse between the FC and Resident 1. The Progress Notes indicated Resident 1 showed the diet slip to the FC to address some concerns the resident had on the food received. The Progress Notes indicated the KC stated he did not care for Resident 1, he did not respect the resident, and that the KC could read the diet slip. The Progress Notes indicated Resident 1 did not feel safe in the facility with the FC. The resident was informed that FC was no longer in the facility. A review of the facility provided investigation interviews, dated 6/9/2024, indicated the AC witnessed the verbal altercation between the KC and Resident 1. The documented interview indicated the KC stated to AC that Resident 1 was rude, and he could not work with the resident anymore. The documented interview indicated that the altercation escalated, and the KC told Resident 1 to shut up. A review of Resident 1's psychiatric (related to the study of mental illness) evaluation, dated 6/18/2024, indicated the resident had a history of bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) intermittent anger outbursts and bouts of poor judgment. The Assessment / Plan section indicated Resident 1 to continue psychiatric medication regimen for psychiatric stabilization. A review of the facility employee files indicated the KC did not have a background check in his file. The facility was not able to provide the KC's background check document. On 6/20/2024 at 9:52 a.m., during an interview, Resident 1 stated the KC came out of the kitchen and spoke to the AC about Resident 1 while the resident was within hearing distance. Resident 1 stated that the KC was pointing his finger at him and stating in a loud voice that he does not like, and respect Resident 1 and he could not work with the resident. Resident 1 stated that the KC answered him in an arrogant tone when he asked the KC to read the diet slip. Resident 1 stated that the KC clenched his fist like he was going to hit him and yelled at him to shut up. Resident 1 stated that the KC was a big man while he is a resident on a wheelchair that required the use of an oxygen. Resident 1 stated that he was humiliated and agitated by the KC's actions towards him. Resident 1 stated that he did not feel safe in the facility knowing that the KC could come back and hurt him. Resident 1 stated that he felt safe after the facility informed him that the KC was fired. On 6/20/2024 at 10:33 a.m., during an interview, AC stated that Resident 1 approached her for help on the diet slip. AC stated that they went to the kitchen. The KC started to talk to AC about Resident 1, who was within hearing distance, while the KC was pointing his finger at the resident. AC stated the KC called Resident 1 rude and stated that he could not work with the resident. AC stated that Resident 1 was calm, but the KC stated some harsh words which agitated the resident. AC stated that the KC's voice was loud and sounded irritated as he yelled at Resident 1 to shut up. AC stated there were facility staff and residents in the hallway during the incident. AC stated that she led the KC outside the facility and asked him to go home. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/20/2024 at 11:55 a.m., during an interview, Social Service Coordinator 1 (SSC 1) stated she went out of her office because she heard a loud commotion. SSC 1 stated the KC and Resident 1 were cursing at each other at the hallway in front of the kitchen. SSC 1 stated that Resident 1 was brought to the social service office to calm the resident down and to get the resident's statement about the incident. SSC 1 stated that Resident 1 did not feel safe with the KC in the facility. SSC 1 stated she told Resident 1 that the KC was no longer in the facility. SSC 1 defined abuse as an incident where a resident felt unsafe or there was a threat to the resident's safety whether verbal or physical in nature. SSC 1 stated that the verbal altercation between the LC and Resident 2 was an abuse because the resident felt unsafe at that time. On 6/20/2024 at 2:46 p.m., during a concurrent interview and record review, the Administrator stated that he is the facility's abuse prevention coordinator. The facility-provided investigation interview report, dated 6/9/2024, was reviewed with the ADM and the report indicated the KC stated to the AC that Resident 1 was rude, and KC could not work with the resident anymore. The report indicated the KC told Resident 1 to shut up. The ADM stated the KC's behavior was inappropriate and did not cater to customer service and professionalism. The ADM stated that the incident had the potential for residents to be scared to bring up similar events in the future. The ADM stated that the facility failed to ensure the residents were treated with respect and free from potential abuse. A review of the facility's policy and procedure titled, Abuse Prohibition and Prevention Program, dated 10/26/2023, indicated the purpose to provide staff guidelines to ensure protection for the health, welfare, and rights of each resident residing in the facility and to ensure the facility was doing all that is within its control to prevent occurrence of abuse. The Screening section of the policy indicated the facility check with the appropriate licensing board and registries prior to hire and annually thereafter. The Prevention section of the policy indicated the facility strived to provide an environment which prohibits and prevents abuse, neglect, and exploitation of residents through identification, correction, and intervention in situations in which abuse, neglect, and/or misappropriation of resident property was more likely to occur. A review of the facility's policy and procedure titled, Resident Rights, dated 10/26/2023, indicated residents in long term care facilities have rights guaranteed to them under Federal and State law including the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The policy indicated employees shall treat residents with kindness, dignity, and respect.