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	08/01/2024

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 - 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 physical 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 another resident for one of ten sampled residents (Resident 1). On 7/17/2024 at 5:15 a.m., Resident 2 poured lemon juice on Resident 1's face while Resident 1 was sleeping. This deficient practice resulted in Resident 1 feeling defenseless, hopeless, and verbalized not being able to sleep. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 11/13/2023 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), 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 5/22/2024, indicated the resident's cognitive (problems with a person's ability to think, learn, remember, use judgement, and make decisions) skills was intact. The MDS indicated Resident 1 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on roll left to right. The MDS indicated Resident 1 was dependent on facility staff on chair/bed to chair transfers. The MDS indicated Resident 1's sit to stand ability was not attempted because of the resident's medical condition or safety concerns. A review of Resident 1's Fall Risk Evaluation, dated 5/23/2024, indicated the resident had a total score of 12. A total score above 10 represented high risk for falls. (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 - Actual harm Residents Affected - Few	A review of Resident 1's psychiatric (related to the study of mental illness) evaluation, dated 6/18/2024, indicated the resident had a diagnosis that included major depressive disorder. The Medications section indicated Resident 1 had doxepin (a medication used to treat depression and anxiety) 6 milligrams (mg - unit of measurement) at bedtime for depression and difficulty falling asleep and trazadone (a medication used for treating major depressive disorder) 150 mg at bedtime for depression and inability to fall asleep. A review of Resident 1's COC Form, dated 7/17/2024, indicated that on 7/17/2024 at 5:15 a.m., Resident 1 received physical aggression from Resident 2. The COC indicated Resident 2 poured lemon juice on Resident 1's face that resulted to an eye irritation. A review of Resident 2's Admission Record indicated the facility admitted the resident on 7/16/2024 with diagnoses including encephalopathy (damage or disease that affects the brain), schizophrenia (mental disorder in which people interpret reality abnormally), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). A review of Resident 2's History and Physical (H&P), dated 7/19/2024, indicated the resident had the capacity to make decisions. A review of Resident 2's Progress Notes, dated 7/22/2024, indicated the resident went out on pass (a request by the resident to leave the facility for a period and then come back to continue treatment or stay after clinical assessment). Resident did not return to the facility. During an interview on 7/30/2024 at 12:54 p.m., Resident 1 stated the Admission Director (AD) was informed that Resident 1 was uncomfortable with Resident 2 as the roommate. Resident 1 stated that a bottle of lemon juice was on top of the Resident 1's table. Resident 1 stated on 7/17/2024 early morning, Resident 2 poured the lemon juice on Resident 1's face and chest which went to Resident 1's eyes. Resident 1 stated the lemon juice prevented the resident's eyes to open. Resident 1 pulled the bedside table in front of Resident 2 to prevent the resident from hitting Resident 1. Resident 1 stated that he was not able to fight back because he required assistance on standing up or moving. Resident 1 stated he felt defenseless and was not able to sleep for three days even with his regular sleeping medications. Resident 1 stated that he did not feel safe in the facility and had requested to be discharged sooner. (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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview and concurrent record review on 7/31/2024 at 9:53 a.m., Resident 1's Progress Notes, dated 7/18/2024 at 3:58 p.m., were reviewed with the Social Service Director (SSD) indicated SSD met with Resident 1 and performed a psychosocial wellbeing (the state of mental, emotional, and social health of an individual) visits as follow up on the altercation that happened on 7/17/2024. The Progress Notes indicated Resident 1 stated Mentally, I just don't feel okay. He, referring to Resident 2, really caught me off guard and I couldn't sleep last night. The SSD Progress Notes indicated Resident 1 felt hopeless and defenseless. The SSD stated Resident 1 refused a psychologist (a person that specializes in helping treat people's cognitive, emotional, and social process and behaviors) and psychiatrist (a medical doctor that specializes in the field of psychiatry [field of medicine focused on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders]) evaluation. The SSD was not able to provide documented evidence that Resident 1 refused the psychologist and psychiatrist evaluations. The SSD stated that Resident 1's inability to sleep after the altercation with Resident 2 was not reported to the nursing staff. The SSD stated that the altercation had a negative effect on Resident 1's care. The SSD stated that if the effects of the resident-to-resident altercation were reported, the nursing staff had the opportunity to provide necessary interventions for Resident 1. During an interview and concurrent record review on 7/31/2024 at 10:34 a.m., Resident 1's Physician Orders were reviewed with the Assistant Director of Nursing (ADON) indicated a psychiatry and psychology evaluation was ordered on 7/24/2024, seven days after Resident 1 and Resident 2's physical altercation. The ADON was not able to provide documented evidence that Resident 1 was offered and refused a psychiatry and psychology evaluation. Resident 1's SSD Progress Notes, dated 7/18/2024 at 3:58 p.m., was reviewed with the ADON indicated SSD documented Resident 1 felt hopeless, defenseless and the inability to sleep. The ADON stated the SSD should report to the licensed nurses the negative impact of the resident-to-resident altercation on Resident 1 that resulted to the resident's feeling of hopelessness, defenseless and inability to sleep. The ADON stated the act of pouring juice on another person was considered a physical abuse because there was contact. The ADON stated Resident 1 had the potential for an increased anxiety and depression. During a follow up interview on 7/31/2024 at 12:44 p.m., the ADON stated the effect of lack of sleep on residents included easily irritated, more emotionally sensitive, grumpy, slow decision-making ability, and slow performance. The ADON stated the facility failed to address the resident-to-resident altercation effect on Resident 1. During an interview on 7/31/2024 at 2:51 p.m. Attending Physician 2 (MD 2) stated people that lack sleep for a couple of days may develop behavior changes such as feeling irritated, not happy, frustrated, or behaviors that required the need for medication or medication adjustment. 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 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. The Protection section of the policy indicated the facility will provide protection of residents from harm during an investigation including but not limited to . c. interventions to calm the situation and support the involved residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46445 Based on interview and record review, the facility failed to ensure residents receive the necessary care based on the assessed individual needs to prevent accidents and minimize injuries forone of ten sampled residents (Resident 3), who was identified as a high fall risk. The facility failed to: 1. Ensure Resident 3 was provided visual supervision while sitting on a Geri-chair (a padded reclining chair that was designed to help older adults with limited mobility) in the hallway. 2. Review and revise Resident 3's care plan interventions that were person-centered and were individualized based on the resident's risks, physical, and mental condition. 3. Implement the facility's policies and procedure on Fall Management Program and Free of Accident Hazards / Supervision / Devices. As a result, on 7/14/2024 at 7:45 p.m., Resident 3 fell out of the Geri-chair in the hallway and sustained a right femur fracture (a break in the thighbone), acute (severe or sudden onset) nondisplaced fracture (the bone cracks or breaks but retains its proper alignment) of the right inferior and superior pubic ramus (pelvic bones), and an acute mildly comminuted (a bone that is broken in at least two pieces) and mildly displaced fracture (the ends of the bone had come out of alignment) of the left inferior pubic ramus. Findings: A review of Resident 3's Admission Record indicated the facility admitted the resident on 4/12/2023 with diagnoses including chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), muscle weakness, and essential hypertension. A review of Resident 3's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 4/16/2024, indicated the resident's cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills was moderately impaired. The MDS indicated Resident 3 required moderate assistance (helper lifts, holds, or supports trunk or limbs but provides less than half the effort) roll left and right. The MDS indicated Resident 3's assessment on lying to sitting, sit to stand, and chair/bed-to-chair transfer were not attempted because of the resident's medical condition or safety concerns. A review of Resident 3's Fall Risk Evaluation, dated 4/18/2024, indicated the resident had a total score of ten. A score of ten or greater represented high risk for falls. The fall risk evaluation indicated a prevention protocol should be initiated immediately and documented on the care plan and reviewed at least quarterly and with COC. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 3's Change of Condition (COC) Form, dated 6/22/2024, indicated the resident had an unwitnessed fall. Resident 1 was seen lying on the floor and sustained a skin tear on the right elbow. The COC indicated Resident 3 was agitated and wanted to throw self off the bed. The COC indicated the family was notified and consents were acquired for pad alarm (a device placed under a high fall risk resident on the bed or on a chair to alert the caregivers), extra mattress on the floor, and to put the resident's bed against the wall. The COC indicated Ativan 0.5 milligrams (mg - unit of measurement) twice a day, as needed was ordered. A review of Resident 3's Fall Risk Evaluation, dated 6/22/2024, indicated the resident had a total score of 12. A score of ten or greater represented high risk for falls. The fall risk evaluation indicated a prevention protocol should be initiated immediately and documented on the care plan and reviewed at least quarterly and with COC. A review of Resident 3's Physician Orders, dated 6/22/2024, indicated an order for a pad alarm on bed. A review of Resident 3's Physician Orders, dated 6/22/2024, indicated an order for lorazepam (a medication used to manage anxiety disorders) 0.5 milligrams (mg - unit of measurement) for verbalization of feeling nervous. A review of Resident 3's Care Plan on actual fall, dated 6/22/2024, indicated the resident had a fall secondary to poor balance. The Care Plan interventions included bed against the wall, mattress on the floor, encourage Resident 3 to use bell to call for assistance, and to keep the call light (a device used to call for assistance from the facility staff) within reach at all times. The Care Plan interventions did not include Resident 3's pad alarm. A review of Resident 3's COC Form, dated 7/14/2024, indicated the resident was found on the floor beside Resident 3's chair. The COC indicated Resident 3 sustained a small bump on the head without bleeding and Emergency Medical Services (EMS) were notified. Resident 3 was transferred to General Acute Care Hospital 1 (GACH 1) for further evaluation. A review of Resident 3's Post Fall Evaluation/Interdisciplinary Team (IDT) Review, dated 7/14/2024, indicated the resident was observed on the floor at 7:45 p.m., beside the resident's Geri-chair. The IDT Review indicated Resident 3 sustained a bump on the head. The IDT Review indicated Resident 3 had hallucination of being killed. A review of Resident 3's GACH 1 History and Physical (H&P) Reports, dated 7/14/2024 at 9:03 p.m., indicated the resident was admitted to the emergency department due to a fall. The Physical Exam section indicated Resident 3 had a deformity of the right leg consistent with fracture. The Assessment / Plan section indicated Resident 3 sustained a fall, blunt head injury (caused by an external force strong enough to move the brain within the skull), and hematoma (an area of blood that collects outside of the larger blood vessels caused of the face). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 3's GACH 1 Discharge Instructions, dated 7/16/2024, indicated the resident's diagnoses included fall, blunt head trauma, and hematoma of the face. The Imaging section indicated a computed tomography (CT - a diagnostic imaging procedure that used a combination of x-ray [the use of electromagnetic energy beams to produce images of internal tissues, bones, and organs] and computer technology to produce images of the inside of the body) scan of the brain/head without contrast (a dye or other substance that helps show abnormal areas inside the body) was done at 8:42 p.m. on 7/14/2024. The CT scan impression indicated Resident 3 had mild to moderate bi-frontoparietal scalp (both forehead and upper back wall of the head bones) hematoma or contusion (an injury that resulted from a direct blow or impact in which the skin is not broken) at the vertex (top of the head). The CT scan of the pelvis without contrast indicated Resident 3 had a right femur fracture, acute nondisplaced fracture of the right inferior and superior pubic ramus, and an acute mildly comminuted and mildly displaced fracture of the left inferior pubic ramus. During an interview and concurrent record review on 7/30/2024 at 11:42 a.m., Registered Nurse 1 (RN 1) stated that Resident 3 was agitated and anxious. RN 1 stated that Resident 3 was unable to walk and had a high risk for falls. Resident 3's Care Plan on risk for falls, initiated on 4/13/2023 and last revised on 2/9/2024, was reviewed with RN 1 and indicated the resident was at risk for falls secondary to gait and balance problems and muscle weakness. The Care Plan had a goal to minimize risk of injury from falls. The Care Plan Interventions included to educate the resident /family/caregivers about safety reminders and what to do if a fall occurs. During a telephone interview on 7/31/2024 at 6:10 p.m., CNA 4 stated she went on her lunch break and informed LVN 2 and CNA 6 that Resident 3 was on a Geri-chair in the hallway across from the resident's room. During a telephone interview on 7/31/2024 at 6:22 p.m., LVN 2 stated CNA 4 went on a lunch break and informed her that Resident 3 was on a Geri-chair in the hallway. LVN 2 stated CNA 6 informed her that she was going to return a food tray to the kitchen. LVN 2 stated she was at nurse station 2 and could not see Resident 3 from the nurse station. CNA 6 returned to the hallway and found Resident 3 on the floor. LVN 2 was made aware and saw Resident 3 lying facing the left side on the floor beside the Geri-chair. LVN 2 stated that Resident 3 complained of pain on the head. LVN 2 stated that EMS was called, and Resident 3 was brought to GACH 1. During an interview on 8/1/2024 at 10:40 a.m., CNA 6 stated she went to the kitchen to return a resident's food tray and informed LVN 2, who weas at nurse station 2, that Resident 3 was on a Geri-chair in the hallway. CNA 6 stated she returned to the hallway and found Resident 3 on the floor with the resident's hand on the head. CNA 6 stated Resident 6 was on a Geri-chair in the hallway for closer supervision because of the resident's daily attempt to jump out of the bed. CNA 6 stated Resident 3's fall could be prevented if there was someone visually watching the resident. CNA 6 stated Resident 3 was on a Geri-chair without a pad alarm or a mattress on the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/1/2024 at 12:44 p.m., the Assistant Director of Nursing (ADON) stated Resident 3 was a fall risk, had impulsive behavior, and attempted to get out of bed. The ADON stated Resident 3 was placed on a Geri-chair in the hallway for more visual monitoring. The ADON stated the pad alarm and mattress were not provided for Resident 3 while on the Geri-chair. Resident 3's Care Plan on risk for falls, dated 6/22/2024, was reviewed with the ADON indicated the resident did not have the pad alarm and Geri-chair as part of the Care Plan interventions. The ADON stated that care plans should be individualized to meet the resident's need. The ADON stated the facility failed to include the use of Geri-chair, pad alarm, and visual monitoring in Resident 3's Care Plan interventions. Resident 3's facility provided GACH 1 records were reviewed with the ADON and indicated the resident sustained an acute right hip fracture and left pubic fracture. The ADON stated the facility failed to ensure Resident 3 was monitored and visually supervised to prevent resident falls. A review of the facility's policy and procedure titled, Fall Management Program, dated 11/2017 and last reviewed on 10/26/2024, indicated the facility strives to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls and to provide an environment which remains as free from accident hazards as possible. The policy defined fall as unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force. The policy indicated the facility nursing staff and/or the interdisciplinary team shall update the resident's plan of care accordingly to reduce the risk of further occurrences of a fall and/or to reduce the risk for significant injury related to falling. A review of the facility's policy and procedure titled, Free of Accident Hazards / Supervision / Devices, dated 3/2018 and last reviewed on 10/26/2023, indicated the intent to provide guidelines for facility staff to manage residents at risk for avoidable accidents. The System Approach section indicated implementation of individualized, resident centered interventions, including adequate supervision and assistive devices, to reduce individual risks related to hazards in the environment. A review of the facility's policy and procedure titled, Develop - Implement Comprehensive Care Plans, dated 2/2018 and last reviewed on 10/26/2023, indicated the facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed, and implemented to meet the preferences and goals and address the resident's medical, physical, mental, and psychosocial needs. The policy indicated the facility must establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining their highest practicable quality of life.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46445 Based on interview and record review, the facility failed to ensure clinical records were complete and accurately documented for two of ten sampled residents (Resident 1 and Resident 3) by failing to: a. Ensure the Social Service Director (SSD) documented the correct date of Resident 1 and Resident 2's altercation in Resident 1's clinical record. The SSD also failed to document Resident 1's refusal of a psychologist (a person that specializes in helping treat people's cognitive, emotional, and social process and behaviors) and psychiatrist (a medical doctor that specializes in the field of psychiatry [field of medicine focused on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders]) evaluation. b. Ensure the Emergency Medical Services (EMS) time of notification and the time Resident 3 was taken to General Acute Care Hospital 1 (GACH 1) was documented in Resident 3's clinical record. The facility also failed to ensure Resident 3's Attending Physician 1 (MD 1) and Family Member 1 (FM 1) were notified of Resident 3's change of condition (COC) and accurately documented in the resident's clinical records. These deficient practices resulted in inaccurate information on Resident 1 and Resident 3's clinical record and had the potential for delayed medical interventions for Resident 1 and Resident 3. Findings: a. A review of Resident 1's Admission Record indicated the facility admitted the resident on 11/13/2023 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), 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 5/22/2024, indicated the resident's cognitive (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills was intact. The MDS indicated Resident 1 was dependent on facility staff on chair/bed to chair transfers. The MDS indicated Resident 1's sit to stand ability was not attempted because of the resident's medical condition or safety concerns. A review of Resident 1's COC Form, dated 7/17/2024, indicated the on 7/17/2024 at 5:15 a.m., Resident 1 received physical aggression from Resident 2. The COC indicated Resident 2 poured lemon juice on Resident 1's face that resulted to an eye irritation. A review of Resident 2's Admission Record indicated the facility admitted the resident on 7/16/2024 with diagnoses including encephalopathy (damage or disease that affects the brain), schizophrenia (mental disorder in which people interpret reality abnormally), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's History and Physical (H&P), dated 7/19/2024, indicated the resident had the capacity to make decisions. During an interview and concurrent record review on 7/31/2024 at 9:53 a.m., Resident 1's progress notes were reviewed with the SSD. The Progress Notes, dated 7/18/2024, indicated SSD met with Resident 1 and performed a psychosocial wellbeing (the state of mental, emotional, and social health of an individual) visits as follow up on the altercation that happened on 7/17/2024. The SSD progress notes indicated the incident happened on 7/19/2024. The SSD stated Resident 1 refused a psychologist and psychiatrist evaluation. The SSD was not able to provide documented evidence that Resident 1 refused the psychologist and psychiatric evaluations. The SSD stated her documentation of Resident 1 and Resident 2's reported altercation date was inaccurate. The SSD also stated that not documenting Resident 1's refusals indicated that the facility did not offer and provide the resident with interventions after the reported altercation. The SSD stated that interventions not documented were not done. The SSD stated the facility failed to ensure documentation in Resident 1's clinical records were complete and accurate. A review of the facility's policy and procedure titled, Documentation Policy, dated 7/2019 and last reviewed on 10/26/2023, indicated it was the facility's policy to document relevant findings in the clinical record. The policy indicated that 72-hour charting shall be once daily and may be completed more frequently at the nurses' discretion .and if there is a change that requires further physician notification in accordance with charting by exception. The policy indicated to complete the notification of the family/responsible party/legal representative with name, date, and time. A review of the facility's policy and procedure titled, Reporting of Alleged Violations, dated 11/2017 and revised on 2/2024, indicated the Social Service Department or designee will monitor the resident's reactions and psychosocial well-being regarding the incident and provide further support as needed and desired by the resident. b. A review of Resident 3's Admission Record indicated the facility admitted the resident on 4/12/2023 with diagnoses including chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), muscle weakness, and essential hypertension. A review of Resident 3's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 4/16/2024, indicated the resident's cognitive skills was moderately impaired. The MDS indicated Resident 3 required moderate assistance (helper lifts, holds, or supports trunk or limbs but provides less than half the effort) roll left and right. A review of Resident 3's COC form, dated 7/14/2024, indicated the resident was found on the floor beside the resident's chair. The COC indicated the facility called the Emergency Medical Services (EMS) and transferred Resident 3 to GACH 1. The COC form did not indicate the time the EMS was called and the time the EMS took Resident 3 to GACH 1. The COC form indicated Attending Physician 1 (MD 1) was notified at 8 p.m. on 7/14/2023, 1 year before Resident 3's fall. The COC form indicated the Family Member 1 (FM 1) was notified at 8:25 p.m. on 7/14/2023, one year before Resident 3's fall. (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	08/01/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 7/30/2024 at 11:42 a.m., Resident 3's COC form was reviewed with Registered Nurse 1 (RN 1) and the resident's clinical record did not indicate the time EMS was called and the time the resident was taken to GACH 1. The COC indicated MD 1 and FM 1 were notified on 7/14/2023, one year before Resident 3's fall. RN 1 stated that documentation in Resident 3's clinical records should be accurate and complete. RN 1 stated that Resident 3 had the potential to receive delayed services and care. During an interview and concurrent record review on 7/31/2024 at 12:44 p.m., Resident 3's clinical records were reviewed with the Assistant Director of Nursing (ADON). The ADON was not able to provide documented evidence on the time the EMS was called. The ADON was not able to provide documented evidence on the time EMS took Resident 3 to GACH 1. The ADON stated that Resident 3's COC form indicated FM 1 and MD 1 were notified on 7/14/2023, one year before the resident's fall incident. The ADON stated the facility failed to ensure accurate documentation of Resident 3's fall incident that happened on 7/14/2024. A review of the facility's policy and procedure titled, Documentation Policy, dated 7/2019 and last reviewed on 10/26/2023, indicated it was the facility's policy to document relevant findings in the clinical record. The policy indicated to complete the notification of the family/responsible party/legal representative with name, date, and time. A review of the facility's policy and procedure titled, Notification of Changes, dated 11/2017 and last reviewed on 10/26/203, indicated the facility notifies the physician and resident representative on an accident involving the resident which results in injury and had the potential for requiring physician intervention.