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 09/16/2024
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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on interview and record review, the facility failed to prevent verbal abuse for two of four sampled residents (Resident 1 and Resident 2) when on 8/24/2024 Resident 2 had an exchange of verbal profanity with Resident 1. Resident 1 and Resident 2, who were roommates, were not separated until 9/6/2024. This deficient practice had the potential for further abuse for Resident 1 and Resident 2. Findings: a. A review of Resident 1's Admission Record indicated the facility admitted the resident on 6/9/2024 and was readmitted on [DATE] with diagnoses including major depressive disorder (a serious mental health condition that causes a persistent low mood or loss of interest in activities, which interferes with daily life), muscle weakness, and acute (very serious, extreme, or severe) respiratory failure (a serious condition that makes it difficult to breathe on your own). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-planning tool), dated 7/9/2024, indicated Resident 1 could understand and be understood. The MDS indicated Resident 1 was dependent (helper does all the effort) with toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene, and needed moderate assistance (helper does less than half the effort) with oral hygiene. A review of Resident 1's Activity Progress Notes, dated 9/2/2024 at 3:20 p.m., written by the Activities Director (AD), indicated that on Tuesday, 8/24/2024, Resident 1 was showing aggressive behavior towards her roommate Resident 1. Resident 2 was calling Resident 1 a demon and stated she (Resident 1) is a horrible person. The Progress Notes indicated Resident 2 stated that Resident 1 has a lot of evil inside her, so stay away from me you evil (used verbal profanity). A review of Resident 1's Situational-Background-Assessment-Recommendation (SBAR, communication form between members of the health care team caring for a resident about his / her condition) Change of Condition (COC, a sudden clinically important deviation from a patient's baseline status), dated 9/6/2024 at 12:35 p.m., indicated Resident 1 was allegedly involved in a verbal altercation. The Assessment details indicated Resident 1 was allegedly involved in a verbal altercation and Resident 1 was assessed for signs of injury and emotional distress. The physician was notified on 9/6/2024 at 12:40 p.m. (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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(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	A review of Resident 1's Care plan, developed on 9/6/2024, indicated Resident 1's alleged involvement in a verbal altercation, indicated to monitor any signs of emotional distress, offer room change to the resident, and to provide emotional support and encourage resident to verbalize feelings. A review of the facilities Action Summary indicated Resident 1 was moved from the room (room [ROOM NUMBER]) Resident 1 and Resident 2 shared to current room (room [ROOM NUMBER]) on 9/6/2024 at 7:05 p.m. During an interview on 9/16/2024 at 10:49 a.m., Resident 1 stated that during an activity's session, cannot recall the exact day, she was moved because of an alleged argument. Resident 1 stated, I don't know what happened. Resident 1 stated she was asked if she could move to a different room, since she had never objected in the past, so they moved her to room [ROOM NUMBER]. b. A review of Resident 2's Admission Record indicated the facility admitted the resident on 7/27/2023 with diagnoses including bipolar disorder (a mental illness that causes extreme mood swings, or shifts in mood, energy, and activity levels), history of transient ischemic attack (TIA- a temporary blockage of blood flow to the brain) and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had the ability to usually understand and is usually understood. The MDS indicated Resident 2 was dependent on personal hygiene, putting on and taking off footwear, showering, and required maximal assistance (helper does more than half the effort) with toileting and requires moderate assistance with upper and lower body dressing. A review of Resident 2's Care plan, developed on 8/2/2023, for risk for mood impairment as evidenced by feeling down, depressed, or hopeless, trouble falling asleep or staying asleep, or sleeping too much, feeling tired or having little energy and trouble concentrating. The interventions included to encourage meaningful socialization, provide emotional support, and to use positive reinforcement. A review of Resident 2's SBAR: COC, dated 9/6/2024 at 12:37 p.m., indicated it was reported that Resident 2 was allegedly being verbally aggressive towards another resident during activity's session. The Assessment details indicated Resident 2 was allegedly verbally aggressive towards another resident (Resident 1). A review of Resident 2's Care plan, developed on 9/6/2024, for allegedly being involved in a verbal altercation, with interventions that included to monitor for any signs of emotional distress, offer room change, and to encourage resident to verbalize feelings. A review of Resident 2's Care plan, developed on 9/7/2024, the for potential to demonstrate verbal abusive behaviors related to ineffective coping skills, mental, emotional illness, poor impulse control, with interventions that included when agitated intervene before agitation escalates, guide away from source of distress; engage calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. (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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/16/2024 at 12:31 p.m., the AD stated he had abuse training but feels like he did not get enough training. The AD stated the incident between Resident 1 and Resident 2 occurred on 8/24/2024 and did not document it till 9/2/2024, the AD stated he did not report it but told Certified Nursing Assistant 1 (CNA 1). The AD stated Resident 1 and Resident 2 were roommates and the incident occurred prior to lunch (8/24/2024) during an activity. The AD stated Resident 2 was cussing at the AD and calling the AD verbal profanity. The AD stated he then placed Resident 1 next to Resident 2 and that was when Resident 2 stated, move this (verbal profanity) away from me, she is full of demons. The AD stated Resident 1 looked at Resident 2 but did not respond to Resident 2. The AD stated he was in shock, it was then time for lunch and the AD removed Resident 2 and sent her into her room. The AD denied any physical altercation between Resident 1 and Resident 2. The AD stated he went to get Resident 1 asked if she was okay and Resident 1 stated her stomach hurt bad. The AD stated Resident 2 was directing her comments to Resident 1. The AD stated he made a progress note on 9/2/2024 and did not report it to anyone at that point. The AD stated it was not until there was an abuse in-service and he then told the Director of Nursing (DON) that there had been an abuse incident. The AD stated he was educated that they must report abuse to keep residents safe. The AD stated if abuse is not reported, it can be a big issue. The AD stated if residents involved stay in same room, it can be a risk for more abuse to occur. During an interview on 9/16/2024 at 1:36 p.m., CNA 1 stated the AD never reported any abuse allegation between Resident 1 and Resident 2 to her. During an interview on 9/16/2024 at 2:35 p.m., the Social Service Director (SSD) stated being notified about the incident between Resident 1 and Resident 2 on 9/6/2024 during a meeting as mentioned by the AD. The SSD stated the AD mentioned that Resident 1 and Resident 2 had an incident and was not too sure what abuse was and the AD was not sure if he should have reported it. The SSD stated the AD mentioned Resident 2 was making comments about Resident 1 being evil. The SSD stated for Resident 1 and Resident 2 situation it should have been reported and documented immediately because it was not brought up till a week later. The SSD stated no changes in Resident 1 and Resident 2 and neither one can recall incident. The SSD stated not reporting in a timely manner can be a risk for further abuse because Resident 1 and Resident 2 were roommates. During an interview on 9/16/2024 at 3 p.m., the DON stated the incident with Resident 1 and Resident 2 occurred on 8/24/2024 and was told by the AD. The DON stated that during the weekly meeting on 9/6/2024, the AD stated he documented abuse on 9/2/2024. The DON stated the AD should have immediately separated residents and then inform the nurse so that they can start abuse protocol right away. The DON stated room change for Resident 1 and Resident 2 was done when we found out on 9/6/2024. The DON stated there is a risk for not reporting and no monitoring was done to ensure the residents were not in distress. The DON stated that delayed room separation can be a risk for abuse to occur again. During an interview on 9/16/2024 at 3:33 p.m., the Administrator stated the AD stated should have reported the alleged abuse within two hours if the AD thought it was abuse. The Adm stated Resident 1 and Resident 2 were separated, but if the nursing department was aware of the incident, the room change could have been done earlier. The Adm stated the risk for not separating the involved residents and not providing a room change immediately after the alleged abuse can escalate to further abuse. (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 - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedures titled, Reporting of Alleged Violations, last revised on 2/2024, indicated the facility prohibits the use of verbal, mental, sexual, physical abuse, neglect, misappropriation of resident property, exploitation, and or involuntary seclusion, and physical or chemical restraint not required to treat the resident's symptoms. Verbal abuse: the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Employees, facility consultants and or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Administrator or Director of Nursing Services. The facility shall ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknow source and misappropriation of resident property are reported immediately, but no later than 2 hours after the allegation is made.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on interview and record review, the facility failed to implement its abuse prevention policy by failing to report the alleged abuse to the State Survey Agency no later than 2 hours after the allegation occurred for two of four sample residents (Resident 1 and Resident 2) when on 8/24/2024 Resident 2 had an exchange of verbal profanity with Resident 1. This deficient practice had the potential to result in unidentified abuse and placed Residents 1 and 2 at risk for further abuse. Findings: a. A review of Resident 1's Admission Record indicated the facility admitted the resident on 6/9/2024 and was readmitted on [DATE] with diagnoses including major depressive disorder (a serious mental health condition that causes a persistent low mood or loss of interest in activities, which interferes with daily life), muscle weakness, and acute (very serious, extreme, or severe) respiratory failure (a serious condition that makes it difficult to breathe on your own). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-planning tool), dated 7/9/2024, indicated Resident 1 could understand and be understood. The MDS indicated Resident 1 was dependent (helper does all the effort) with toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene, and needed moderate assistance (helper does less than half the effort) with oral hygiene. A review of Resident 1's Activity Progress Notes, dated 9/2/2024 at 3:20 p.m., written by the Activities Director (AD), indicated that on Tuesday, 8/24/2024, Resident 1 was showing aggressive behavior towards her roommate Resident 1. Resident 2 was calling Resident 1 a demon and stated she (Resident 1) is a horrible person. The Progress Notes indicated Resident 2 stated that Resident 1 has a lot of evil inside her, so stay away from me you evil (used verbal profanity). A review of Resident 1's Situational-Background-Assessment-Recommendation (SBAR, communication form between members of the health care team caring for a resident about his / her condition) Change of Condition (COC, a sudden clinically important deviation from a patient's baseline status), dated 9/6/2024 at 12:35 p.m., indicated Resident 1 was allegedly involved in a verbal altercation. The Assessment details indicated Resident 1 was allegedly involved in a verbal altercation and Resident 1 was assessed for signs of injury and emotional distress. The physician was notified on 9/6/2024 at 12:40 p.m. A review of Resident 1's Care plan, developed on 9/6/2024, indicated Resident 1's alleged involvement in a verbal altercation, indicated to monitor any signs of emotional distress, offer room change to the resident, and to provide emotional support and encourage resident to verbalize feelings. A review of the facilities Action Summary indicated Resident 1 was moved from the room (room [ROOM NUMBER]) Resident 1 and Resident 2 shared to current room (room [ROOM NUMBER]) on 9/6/2024 at 7:05 p.m. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/16/2024 at 10:49 a.m., Resident 1 stated that during an activity's session, cannot recall the exact day, she was moved because of an alleged argument. Resident 1 stated, I don't know what happened. Resident 1 stated she was asked if she could move to a different room, since she had never objected in the past, so they moved her to room [ROOM NUMBER]. b. A review of Resident 2's Admission Record indicated the facility admitted the resident on 7/27/2023 with diagnoses including bipolar disorder (a mental illness that causes extreme mood swings, or shifts in mood, energy, and activity levels), history of transient ischemic attack (TIA- a temporary blockage of blood flow to the brain) and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had the ability to usually understand and is usually understood. The MDS indicated Resident 2 was dependent on personal hygiene, putting on and taking off footwear, showering, and required maximal assistance (helper does more than half the effort) with toileting and requires moderate assistance with upper and lower body dressing. A review of Resident 2's Care plan, developed on 8/2/2023, for risk for mood impairment as evidenced by feeling down, depressed, or hopeless, trouble falling asleep or staying asleep, or sleeping too much, feeling tired or having little energy and trouble concentrating. The interventions included to encourage meaningful socialization, provide emotional support, and to use positive reinforcement. A review of Resident 2's SBAR: COC, dated 9/6/2024 at 12:37 p.m., indicated it was reported that Resident 2 was allegedly being verbally aggressive towards another resident during activity's session. The Assessment details indicated Resident 2 was allegedly verbally aggressive towards another resident (Resident 1). A review of Resident 2's Care plan, developed on 9/6/2024, for allegedly being involved in a verbal altercation, with interventions that included to monitor for any signs of emotional distress, offer room change, and to encourage resident to verbalize feelings. A review of Resident 2's Care plan, developed on 9/7/2024, the for potential to demonstrate verbal abusive behaviors related to ineffective coping skills, mental, emotional illness, poor impulse control, with interventions that included when agitated intervene before agitation escalates, guide away from source of distress; engage calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. (continued on next page)

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Desert Canyon Post Acute, LLC	1642 West Avenue J Lancaster, CA 93534

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedures titled, Reporting of Alleged Violations, last revised on 2/2024, indicated the facility prohibits the use of verbal, mental, sexual, physical abuse, neglect, misappropriation of resident property, exploitation, and or involuntary seclusion, and physical or chemical restraint not required to treat the resident's symptoms. Verbal abuse: the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Employees, facility consultants and or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Administrator or Director of Nursing Services. The facility shall ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknow source and misappropriation of resident property are reported immediately, but no later than 2 hours after the allegation is made.