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	01/17/2025

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 - Few	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 residents (Resident 1) by failing to ensure care plan was developed on Resident 1's refusal of medication. This deficient practice had the potential for delayed provision of necessary care and services. Findings: During a record review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 3/15/2024, with diagnoses that included sepsis (a life-threatening blood infection), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and end stage renal disease (ESRD-irreversible kidney failure). During a record review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 11/23/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/13/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 was dependent to staff for toileting, and personal hygiene. During a record review of Resident 1's Medication Administration Record (MAR- record of medication received by the resident) dated 1/2025, the MAR indicated multiple medication refusal was documented as follows: 1. Amlodipine (medication used to treat high blood pressure)- refused on 1/4/2025 and 1/12/2025. 2. Aspirin (medication used to lower risk of heart attack, stroke [occurs when blood flow to the brain is interrupted] or blood clot)- refused on 1/4/2025, 1/8/2025 and 1/12/2025. 3. Atorvastatin (medication used to reduce the amount of cholesterol in the blood)-refused on 1/8/2025, 1/9/2025 and 1/10/2025. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Minoxidil (medication used to treat high blood pressure)-refused on 1/7/2025. 5. Mirtazapine (medication used to treat depression [a mental disorder that involves a prolonged low mood and loss of interest in activities]) refused on 1/8/2025, 1/9/2025, and 1/10/2025. 6. Docusate (medication used to soften the stool, making it easier to have a bowel movement) -refused on 1/8/2025 and 1/9/2025. 7. Protonix (medication used to treat heartburn [occurs when stomach acid backs up into the tube that carries food from your mouth to your stomach]) refused on 1/8/2025 and 1/9/2025. 8. Hydralazine (medication used to treat high blood pressure)- refused on 1/4/2025, 1/12/2025, and 1/7/2025. 9. Sevelamer (medication that prevent increase in phosphates among people who are on dialysis due to chronic kidney disease [CKD-a long-term condition that occurs when the kidneys are damaged and can not filter blood properly])-refused on 1/8/2025, 1/9/2025, and 1/12/2025. 10. Sucralfate (medication that treats stomach ulcers [a sore in the stomach lining])- refused on 1/2/2025, 1/3/2025, 1/8/2025, 1/9/2025, 1/10/2025, 1/11/2025 and 1/12/2025. During a concurrent interview and record review on 1/17/2025 at 11:05 a.m., with the Director of Nursing (DON), Resident 1's Care Plans was reviewed. The DON stated there was no care plan created for medication refusal. The DON stated the care plan ensures the resident was provided with specific intervention to help plan their care. The DON stated care plan is created after refusing the medication three times. The DON stated nurses were in charge of creating care plan. During a record review of facility's policy and procedure (PnP) titled, Comprehensive Care Plans-Timing, dated 3/2023, the PnP indicated, Each resident shall have a person-centered, comprehensive care plan, developed, reviewed, and revised by the facility interdisciplinary team including the resident and resident representative, if applicable. Each resident has the right to participate in choosing or refusing treatment options and must be given the opportunity to participate in the development, review, and revision of his/her care plan.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to provide an ongoing activity program that is resident centered for one of three sampled residents (Resident 2). This deficient practice had the potential to affect Resident 2's sense of self-worth and psychosocial well-being. Findings: During a record review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 12/28/2024, with diagnoses that included unspecified (unconfirmed) fracture of right patellar (break in the bone of the kneecap), unspecified dementia (a progressive state of decline in mental abilities) and history of fall. During a record review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 1/4/2025, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. The MDS indicated Resident 2 was dependent to staff for toileting, and showering. During an interview and record review on 1/17/2025 at 11:05 a.m., with the Director of Nursing (DON), Resident 2's Activity Participation and Attendance for 1/2025 were reviewed. The DON stated Resident 2 was not yet assessed for activity and there was no documented activity provided and attendance. The DON stated Resident 2 was admitted on [DATE] and should have been assessed within three days before 1/1/2025. The DON stated activity staff were assigned to assess and provide activity to residents. The DON stated there were no activity attendance since 12/28/2024. The DON stated upon admission, staff assess and complete Activity Review Assessment then staff needs to activate the task to allow documentation daily. During an interview on 1/17/2025 at 11:29 a.m., with the Activity Director (AD), the AD stated there was a miscommunication on what was needed to complete. The AD stated upon admission, she (AD) talks to resident and family and asks their activity preference. The AD stated she (AD) was not sure why its activity assessment and attendance were not documented. During a record review of facility's policy and procedure (PnP) titled, Activities, dated 3/2023, the PnP indicated, The facility provides an ongoing activities program to support residents in their choices of activities to support their physical, mental, and psychosocial well-being, encouraging both independence and interaction in the community. The facility creates opportunities for each resident to have a meaningful life by supporting his or her domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning). Residents are assessed upon admission and periodically to identify their interests, hobbies, and cultural preferences. 4. Residents with cognitive impairment may benefit from activities related interventions. Resident's individualized activities of interest shall be noted in the assessment, identified in the plan of care, and updated as necessary to reflect changes in the resident's preferences.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 42311 Based on interview and record review, the facility failed to employ a qualified Activity Director (AD) that met the qualifications as per facility's job description for Activity Director for one of two staff. This deficient practice had a potential for residents residing in the facility not being assisted and receiving activity related necessary care to attain highest practicable well-being. Findings: During an interview on 1/17/2025, at 11:05 a.m., with the Director of Nursing (DON), the DON stated AD was hired by the Administrator (ADM). During an interview on 1/17/2025 at 11:25 a.m., with the ADM, the ADM stated the facility provided the training and orientation when AD was hired. During a concurrent interview and record review on 1/17/2025 at 11:29 a.m., with the AD, AD's Job Description was reviewed. The Job Description indicated, The Activities Director plans, oversees and leads the residents' activities in accordance with Federal, State and company requirements. Completes, in writing, a comprehensive assessment of each Resident's past and present leisure interests, physical and mental limitations, and activity-related needs. Completes required documentation in health record in accordance with Federal, State and company requirements. Maintains written records of Residents' attendance at activities, other related lists and inventories. Certificates and Licenses: Current Activities Director certification in long term care specialization. The AD stated she (AD) was hired on 10/2024 as AD. The AD stated did not maintain written record of resident's attendance. The AD stated she (AD) had no certification in long term care specialization. During a concurrent interview and record review on 1/17/2025 at 11:43 a.m., with the ADM, AD's Job Description was reviewed. The ADM stated AD was probably not qualified based on the facility's Job Description.