

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 02/21/2025
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878</p> <p>Based on interview and record review, the facility failed to protect the resident ' s right to be free from verbal abuse (at type of abuse that uses language) for two of two sampled residents (Resident 2 and Resident 3), when on 2/11/2025, both Resident 3 and Resident 2 called each other derogatory words (unflattering, unkind, or demeaning).</p> <p>This deficient practice resulted in Resident 2 and Resident 3 being subjected to verbal abuse while under the care of the facility. Residents who are subjected to verbal abuse are at increased risk for low self-esteem (when someone lacks confidence in themselves and their abilities), anxiety (a feeling of fear, dread, and uneasiness), depression (mood disorder that causes a persistent feeling of sadness and loss of interest in activities for long periods of time) and social isolation (when someone has few or no social connections or support, and lacks relationships with others).</p> <p>Findings:</p> <p>a. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 7/2/2024 with diagnoses including muscle weakness (generalized), essential (primary) hypertension (HTN-high blood pressure), and end stage renal disease (ESRD- irreversible kidney failure).</p> <p>During a review of Resident 2 ' s Minimum Data Set (MDS- an assessment and care screening tool), dated 7/10/2024, cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS further indicated that Resident 2 was dependent (helper does all of the effort) with oral hygiene, toileting, showering, and putting on and taking off footwear, and required substantial assistance (helper does more than half the effort) with upper and lower body dressing and personal hygiene.</p> <p>During a review of Resident 2 ' s Situational Background Assessment and Request (SBAR- a communication framework that helps people share information in a structured way), dated 2/11/2025 at 10 a.m. indicated altercation with another resident. The SBAR indicated Resident 2 was involved in a verbal altercation with another resident (Resident 3). As per Resident 2, she was talking to a male resident (name not indicated) when the female resident (Resident 3) started cursing and using inappropriate words.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055307
		If continuation sheet Page 1 of 3

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 1/17/2025 with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a condition that causes excessive fear, worry, and dread that can interfere with daily life), and essential (primary) hypertension (HTN-high blood pressure).</p> <p>During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making were moderately impaired. The MDS further indicated Resident 3 required substantial assistance (helper does more than half the effort) with oral hygiene, showing, lower body dressing, and putting on and taking off footwear and required partial assistance (helper does less than half the effort) with eating, toileting, upper body dressing, and personal hygiene.</p> <p>During a review of Resident 3 ' s SBAR, dated 2/11/2025 at 10 a.m., the SBAR indicated Resident 3 had a verbal disagreement with another resident (Resident 2). The SBAR indicated Resident 3 got interrupted talking to a male resident.</p> <p>During an interview on 2/21/2025 at 10:08 a.m., Resident 2 stated got into a fight with another resident who is no longer in the facility. Resident 2 stated cannot recall date or time but was in the activity room when a male resident called Resident 2 over to his table where Resident 3 was sitting next to the male resident. Resident 2 stated Resident 3 became upset and called Resident 2 a derogatory name and that was when she called Resident 3 a derogatory name.</p> <p>During an interview on 2/21/2025 at 11:39 a.m. with the Infection Preventionist (IP), the IP stated she was in the facility when incident occurred with Resident 2 and Resident 3 but cannot recall the date. The IP stated it happened after breakfast. The IP stated she was in the nurses ' station 1 when she heard yelling coming from the activity room. The IP stated she ran to the activity room and saw Resident 2 with staff behind her and Resident 3 was on the other side of the table with another staff behind Resident 3. The IP stated she heard Resident 2 and Resident 3 calling each other derogatory names. The IP stated based on the situation that occurred with Resident 2 and Resident 3 the IP stated she would consider it abuse because it could affect their residents' emotionally and/or mentally. The IP stated this was emotional abuse because there was a verbal argument and there was cursing, and you are going to feel emotionally damaged by being called those names.</p> <p>During an interview on 2/21/2025 at 12:09 p.m. the Activities Assistants (AA) stated does not recall the date but the time was around 9:30 a.m. to 10 a.m. and both Resident 2 and Resident 3 were in the activity room. The AA stated a male resident who was sitting next to Resident 3 called Resident 2 over and that was when Resident 3 said something under her breath. The AA stated she did not hear what Resident 3 said but Resident 2 became upset. The AA stated Resident 2 began to cuss at Resident 3. The AA stated there was a table between both residents. The AA stated she would consider this verbal abuse and can be emotional abuse. The AA stated this would be abuse because they both used hateful words that were not needed and could develop to emotional distress. The AA state the words were hurtful.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/21/2025 at 1 p.m. with the Social Services Director (SSD), the SSD stated she was by station 2 when she heard yelling so she ran and saw nurses ran to the activity room and observed a nurse separating Resident 2 and Resident 3. The SSD stated she spoke to Resident 2 and Resident 2 stated that both herself and Resident 3 were in the activity room when a male resident called Resident 2 over where Resident 3 was sitting. The SSD stated Resident 2 stated the male resident was asking about lunch when Resident 2 got upset and told the male resident, Then you can go with that (derogatory word). The SSD stated Resident 2 got upset and both Resident 2 and Resident 3 began to cuss at each other. The SSD stated when she spoke to Resident 3, Resident 3 stated Resident 2 made a comment but could not say what Resident 2 said about Resident 3 but stated that they both then began to cuss at each other.</p> <p>During an interview on 2/21/2025 at 3:45 p.m. the Director of Nursing (DON) stated was not in the building when Resident 2 and Resident 3 had an incident. The DON stated residents cursing at each other is a form of abuse and would say it was verbal abuse. The DON stated residents should not be involved in verbal abuse. The DON stated there was a potential for emotional distress and mental distress.</p> <p>During a review of the facility policy and procedures (P&P) titled, Abuse Prevention Agitated or Combative Residents, last reviewed on 10/30/2024, the P&P indicated each resident has the right to be free from mistreatment, neglect, and misappropriation of property.</p> <p>During a review of the facility P&P titled, Abuse Prohibition and Prevention Program, last reviewed on 10/30/2024, the P&P indicated the facility [NAME] to provide an environment which prohibits and prevents abuse, neglect, and exploitation of resident and misappropriation of resident property.</p>		