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	04/25/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 48142 Based on observation, interview, and record review, the facility failed to provide dignity to one of five sample residents (Resident 4) by not fully covering Resident 4 and exposing his incontinence brief while walking with physical therapist in the hallway. This deficient practice could lead Resident 4 to feel uncomfortable, lose dignity, and lose modesty. Findings: During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted Resident 4 on 4/10/2025 with a diagnosis of hypotension (having abnormally low blood pressure {the force of your blood pushing against the walls of your arteries as your heart pumps blood throughout your body}). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 4/9/2025, the MDS indicated Resident 4's thought process was intact and required substantial assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a concurrent observation and interview on 4/24/2024 at 9:32 a.m., with Physical Therapist Student (PTS), PTS stated while holding Resident 4's waist belt the gown was being pulled upward and caused exposing Resident 4's incontinence brief while walking in the hallway. PTS further stated it was important to cover Resident 4 the whole time so that Resident 4 will not feel bad that his incontinent brief was exposed in the hallway and might feel uncomfortable, and also to protect Resident 4's dignity and modesty. During an interview on 4/25/2025 at 11:08 a.m., with the Director of Nursing (DON), the DON stated staff must cover Resident 4 the whole time while walking in the hallway and nothing should be exposed for Resident 4's dignity. During a review of the current facility-provided policy and procedure titled, Dignity and Respect, last review date of 10/30/2024, the policy and procedure indicated, Residents shall be treated with dignity and respect at all the times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48142 Based on observation, interview, and record review the facility failed to provide a written notice indicating the reason for room changes for three of three sample residents (Resident 1, Resident 2, and Resident 3). This deficient practice resulted to Residents 1, 2, and 3 feeling violated their right to refuse for room changes. Cross reference F837. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility initially admitted Resident 1 on 11/7/2022 and readmitted on [DATE] with diagnosis that included type 2 diabetes mellitus (body doesn't produce enough insulin [acts like a key that unlocks your body's cells so they can use sugar]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/3/2025, the MDS indicated Resident 1's thought process was intact and required set-up assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During an interview on 4/24/2025 at 11:35 a.m., with Resident 1, Resident 1 stated that she was in her previous room for over a year and was moved recently in her current room. Resident 1 stated the facility informed her that she needed to move because they will turn her room as an isolation (apart from others) room. Resident 1 further stated that the facility did not orient her in her new room and Resident 1 was having a hard time to maneuver in the bathroom, room, and keep bumping to her extra dresser because her closet was too small compared to her previous room and she was blind. Resident 1 further stated that she feels that the facility did not care about her by putting her in the farthest room in the very far back of the building because staff know that she was blind. Resident 1 stated she was upset about this room change. Resident 1 stated the room was too small for her and her roommate. During a review of Resident 2's Admission Record, the Admission Record indicated the facility initially admitted Resident 2 on 2/2/2024 and readmitted on [DATE] with a diagnosis of cerebral infarction (blood flow to the brain is interrupted). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was intact with thought process and required dependent assistance from staff to complete activities of daily living. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2025 at 12:03 p.m., with Resident 2, Resident 2 stated that for her it was straight forward they came in our room and telling us that they are moving us and did not even ask me anything. Resident 2 stated it made her feel horrible and felt like they (staff) just threw us in the other room like a garbage. Resident 2 further stated that the facility did not read any document for the room change to her and did not receive any document indicating the reason why she had a room change. Resident 2 further stated that she did not practice her right to make a decision for herself. During a review of Resident 3's Admission Record, the Admission Record indicated the facility initially admitted Resident 3 on 1/12/2025 and readmitted on [DATE], with a diagnosis of urinary tract infection (infection of the urinary system, which includes the kidneys {cleans your blood}, ureters {carries urine from kidney to bladder}, bladder {stores urine}, and urethra {tube through which urine leaves the body}). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was intact with thought process and required substantial assistance from staff to complete activities of daily living. During an interview on 4/24/2025 at 11:17 a.m., with Resident 3, Resident 3 stated she complained about her roommate being loud during the night and her (Resident 3) family member called the facility to inform them about her roommate. Resident 3 stated staff just came in her room and informed Resident 3 that whoever is the complainant they are the one who needs to be moved. Resident 3 stated staff did not orient Resident 3 in her new room and roommate. Resident 3 stated she felt she was forced to moved and felt it was unfair and left her with no choice. During a concurrent interview and record review on 4/24/2025 at 1:19 p.m., the facility's policy and procedure titled, Room or Roommate Change, was reviewed with the Social Service Director (SSD). The SSD stated the notice of a change in room or roommate assignment will be in writing and will include the reasons for such change and the facility may use SS-12 Form A Notification of Room Change to notify the resident of the room change. The SSD stated that SSD did not provide any written notification indicating the reason of the room change to the residents or responsible party. During a review of the facility policy and procedure titled, Room or Roommate Change, last review date of 10/30/2024, the policy and procedure indicated, The notice of a change in room or roommate assignment will be in writing and will include the reason for such change. The facility may use SS-12 Form A Notification of Room Change to notify the resident of the room change. Social services staff will assist in orienting the resident to his or her new room and roommate and will provide the resident the opportunity to see the new location, meet the new roommate, and ask questions about the move.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48142 Based on observation, interview, and record review, the facility failed to update the facility's policy and procedure for a room change affecting three of three sampled residents (Residents 1, 2, and 3). This deficient practice resulted to Resident 1, Resident 2, Resident 3 feeling their right to refuse for a room change was violated. Cross reference F559. Finding: During a review of Resident 1's Admission Record, the Admission Record indicated the facility initially admitted Resident 1 on 11/7/2022 and readmitted on [DATE] with diagnosis that included type 2 diabetes mellitus (body doesn't produce enough insulin [acts like a key that unlocks your body's cells so they can use sugar]). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/3/2025, the MDS indicated Resident 1's thought process was intact and required set-up assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During an interview on 4/24/2025 at 11:35 a.m., with Resident 1, Resident 1 stated that she was in her previous room for over a year and was moved recently in her current room. Resident 1 stated the facility informed her that she needed to move because they will turn her room as an isolation (apart from others) room. Resident 1 further stated that the facility did not orient her in her new room and Resident 1 was having a hard time to maneuver in the bathroom, room, and keep bumping to her extra dresser because her closet was too small compared to her previous room and she was blind. Resident 1 further stated that she feels that the facility did not care about her by putting her in the farthest room in the very far back of the building because staff know that she was blind. Resident 1 stated she was upset about this room change. Resident 1 stated the room was too small for her and her roommate. During a review of Resident 2's Admission Record, the Admission Record indicated the facility initially admitted Resident 2 on 2/2/2024 and readmitted on [DATE] with a diagnosis of cerebral infarction (blood flow to the brain is interrupted). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was intact with thought process and required dependent assistance from staff to complete activities of daily living. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2025 at 12:03 p.m., with Resident 2, Resident 2 stated that for her it was straight forward they came in our room and telling us that they are moving us and did not even ask me anything. Resident 2 stated it made her feel horrible and felt like they (staff) just threw us in the other room like a garbage. Resident 2 further stated that the facility did not read any document for the room change to her and did not receive any document indicating the reason why she had a room change. Resident 2 further stated that she did not practice her right to make a decision for herself. During a review of Resident 3's Admission Record, the Admission Record indicated the facility initially admitted Resident 3 on 1/12/2025 and readmitted on [DATE], with a diagnosis of urinary tract infection (infection of the urinary system, which includes the kidneys {cleans your blood}, ureters {carries urine from kidney to bladder}, bladder {stores urine}, and urethra {tube through which urine leaves the body}). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was intact with thought process and required substantial assistance from staff to complete activities of daily living. During an interview on 4/24/2025 at 11:17 a.m., with Resident 3, Resident 3 stated she complained about her roommate being loud during the night and her (Resident 3) family member called the facility to inform them about her roommate. Resident 3 stated staff just came in her room and informed Resident 3 that whoever is the complainant they are the one who needs to be moved. Resident 3 stated staff did not orient Resident 3 in her new room and roommate. Resident 3 stated she felt she was forced to moved and felt it was unfair and left her with no choice. During a concurrent interview and record review on 4/24/2025 at 1:19 p.m., the facility's policy and procedure titled, Room or Roommate Change, was reviewed with the Social Service Director (SSD). The SSD stated the notice of a change in room or roommate assignment will be in writing and will include the reasons for such change and the facility may use SS-12 Form A Notification of Room Change to notify the resident of the room change. The SSD stated that SSD did not provide any written notification indicating the reason of the room change to the residents or responsible party. During a concurrent interview and record review on 4/25/2025 at 12:43 p.m., the facility's policy and procedure titled, Room or Roommate Change, last review date of 10/30/2024, and State Operation Manual were reviewed with the Director of Nursing (DON). The policy and procedured titled, Room or Roommate Change, indicated the notice of a change in room or roommate assignment will be in writing and will include the reasons for such change. The DON read State Operation Manual guidance 483.10(e)(4)-(6) indicated, when a resident is being moved at the request of facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required. The DON stated that the facility's policy and procedures did not indicate that resident must receive an explanation in writing of why the move is required as indicated in the State Operation Manual guidance. The DON stated that the policy and procedure must be reviewed and updated by the governing body according to the regulations. During a review of facility's policy and procedure titled, Governing Body, last review date of 10/30/2024, indicated, The facility has an active, engaged and involved governing body that is responsible for establishing and implementing policies regarding the management of the facility. Individual such as facility owners, Chief Executive Officers, or other individuals who are legally responsible to establish and implement policies regarding the management and operations of the facility.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48142 Based on observation, interview, and record review, the facility failed to ensure the facility's emergency exit was not blocked by a Hoyer lift (a device that helps caregivers safely lift and move people) and wheelchair, and an emergency cart was not parked in both sides of the hallway. These deficient practices had the potential for the delay of care during an emergency. Findings: During a concurrent observation and interview on 4/25/2025 at 8:59 a.m., during a facility tour with License Vocational Nurse 2 (LVN 2), in Station A, observed with LVN 2 that a Hoyer lift was parked in the right side in front and close to emergency exit door, an emergency crash cart was parked on the right side beside the utility room, and two wheelchairs parked in between the right side of the hallway. LVN 2 stated that the Hoyer lift should not be parked in front of the emergency exit. LVN 2 stated wheelchairs and carts should be parked in one side of the hallway. LVN 2 stated they (Hoyer lift, wheelchairs, and carts) are blocking the hallways and exit door and could cause delay in the care of the residents during an emergency. During an interview on 4/25/2025 at 11:09 a.m., with the Director of Nursing (DON), the DON stated the emergency exit should not be blocked because the residents possibly will not be able to go out during an emergency. During a review of facility policy and procedure titled, Safe Environment, last reviewed date of 10/30/2024, indicated, The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely. The physical layout of the facility maximizes resident independence and does not pose a safety risk.