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	11/13/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) was within reach for one of three sampled residents (Resident 1). This deficient practice had the potential to result in a delay of care and services and possible injury to Resident 1 when unable to call for assistance.Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident on 10/30/2025, with diagnoses including sepsis (a life-threatening blood infection), schizoaffective disorder bipolar type (a mental illness that can affect thoughts, mood, and behavior characterized by mood swings that range from the lows of depression to elevated periods of emotional highs), dementia (a progressive state of decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's History and Physical (H&P) dated 11/2/2025, the H&P indicated Resident 2 was represented and unable to make decision. During a review of Resident 2's Minimum Data Set, dated [DATE], the MDS indicated Resident 2 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was unable to understand others and make his needs known. The MDS further indicated Resident 2 required partial/moderate assistance with eating; total assistance from staff with toileting and bathing; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 2's fall risk assessment dated [DATE], the fall risk assessment indicated Resident 2 was at a high risk for falls. During a review of Resident 2's care plan (CP) on risk for falls or injury initiated on 11/6/2025, the CP indicated to keep call light within easy reach and encourage resident to use it for assistance as one of the interventions to minimize the risk from falls.During a concurrent observation and interview on 11/13/2025 at 9:07 a.m., inside Resident 2's room with Certified Nursing Assistant (CNA) 1, observed Resident 2 lying in bed asleep. CNA 1 stated Resident 2's call light was on the floor at the foot part of the bed and not within the resident's reach as Resident 2's head of bed was positioned by the window. CNA 1 stated she just finished providing ADL care to Resident 2. CNA 1 stated after providing care to the residents, the staff have to ensure the residents' call light, and all frequently used items are within the residents' reach at all times prior to leaving the room regardless of their cognitive status. CNA 1 stated she should have placed Resident 2's call light within reach so Resident 2 can call for assistance when needed as it placed Resident 2 at risk for his needs not being attended to and met timely and the resident can fall and get injured. During an interview on 11/13/2025 at 12:30 p.m. with the Assistant Director of Nursing (ADON), the ADON stated staff are supposed to ensure that the call lights are placed within the residents' reach after providing care and prior to leaving the room. The ADON stated Resident 2's call light should have been placed within reach and not left on the floor, especially after providing ADL care as Resident 2 was at a high risk for falls. The ADON stated if the call light was not within Resident 2s reach, the resident would not be able to call for assistance when needed and there could be a delay in providing assistance and meeting Resident 2's needs and lead to falls and/or injury.During an interview with the Director of Nursing (DON) on 11/13/2025 at 4:03 p.m., the DON stated all call lights should be within the resident's reach. The DON stated the CNAs are supposed to ensure the call light and frequently used items are within the resident's reach prior to leaving the room after providing care. The DON stated CNA 1 should have ensured that Resident 2's call light was clipped to the fitted sheet and within reach so Resident 2 can call for assistance when needed which could lead to a delay in the care the resident needs and if the call light was not answered timely, Resident 2 may try to get up unassisted and fall. During a review of the facility's policy and procedure (P&P) titled, Resident Call System, last reviewed on 10/21/2025, the P&P indicated a purpose to provide staff with a method to respond to the resident's requests and needs. The P&P further indicated that the resident call system shall be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for two (2) of three (3) sampled residents (Residents 1 and 2) reviewed for physical restraints during a random observation by:1. Failing to complete a restraint assessment quarterly for the continued use of the restraint bed against the wall according to the facility policy and procedure for Resident 1.2. Failing to ensure Resident 2 did not have pillows tucked under the fitted sheet on the right side of the bed.These deficient practices had the potential to result in the restriction of Resident 1 and Resident 2's freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment, and death of residents.Findings:a. During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted the resident on 12/7/2020 and readmitted in the facility on 5/18/2020, with diagnoses including schizoaffective disorder bipolar type (a mental illness that can affect thoughts, mood, and behavior characterized by mood swings that range from the lows of depression to elevated periods of emotional highs), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 1's History and Physical (H&P) dated 6/24/2025, the H&P indicated Resident 1 was alert and verbally responsive and did not indicate the resident's capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/12/2025, the MDS indicated Resident 1 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make her needs known and Resident 1 required set up or clean up assistance with eating and substantial or maximal to total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated that Resident 1 had impairment on the upper extremity.During a review of Resident 1's Order Summary Report dated 11/13/2025, the Order Summary Report indicated a physician's order dated 7/18/2025 for a high/low bed against the wall to prevent potential injury when Resident 1 rolls out of bed.During a review of Resident 1's fall risk assessments dated 3/26/2025, 5/19/2025, 6/23/2025, and 9/12/2025, the fall risk assessments indicated Resident 2 was at a high risk for falls. During a review of Resident 2's care plan (CP) titled, Use of device/s: Bed against the wall for safety., initiated on 6/14/2024 and last revised on 11/4/2025, the CP indicated interventions that included the following:- Discuss and record with the resident/family/caregivers the risks and benefits of the device.- Evaluate and record continuing risks and benefits of device, alternatives to device, need for ongoing use, and reason for device use.- Discussion by the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) on the risks, benefits, and effect of device with resident or resident representative at a minimum if quarterly or as resident's condition necessitates and IDT review of possible device discontinuation of use as appropriate.During a concurrent observation and interview on 11/13/2025 at 8:39 a.m., inside Resident 1's room with Certified Nursing Assistant (CNA) 2, observed Resident 1 lying in bed with the head of bed in upright position and the bed placed against the wall on the left side. CNA 2 stated Resident 1's bed was placed against the wall to prevent resident falls.During a concurrent observation and interview on 11/13/2025 at 8:42 a.m. inside Resident 1's room with Registered Nurse (RN) 1, RN 1 stated that Resident 1's bed was placed against the wall on the left side to prevent falls as the resident was at a high risk for falls and had the tendency to roll out of bed.During a concurrent interview and record review on 11/13/2025 at 12:33 p.m., reviewed Resident 1's Order Summary Report, CP on use of bed against the wall, fall risk assessments, and Device/Physical Restraint Reassessment/Reevaluation dated 3/10/2024, 4/24/2024, 7/24/2025, 10/20/2024, 11/25/2025, 5/19/2025, 6/23/2025, and 9/12/2025 with the Assistant Director of Nursing (ADON). The Device/Physical Restraint Reassessment/Reevaluation form did not indicate the use of bed against the wall. The ADON stated the audit trail for the physician's order for bed against the wall did not indicate the original order date. The ADON stated the only restraint assessment for the use of bed against the wall was on 2/22/2024. The ADON stated restraint assessments are supposed to be done quarterly and as needed