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	06/30/2026

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. Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity by failing to ensure the resident's oxygen concentrator was inventoried in the Resident's Clothing and Possessions. This deficient practice had the potential to result in loss, misplacement, and replacement challenges. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 6/3/2026 with diagnoses including heart failure (a heart disorder which causes the heart to not pump the blood efficiently), obstructive sleep apnea (a disorder where breathing repeatedly stops and starts during sleep when the throat muscles relax and cause the airway to collapse and block airflow), and atrial fibrillation (an irregular and often very rapid heart rhythm). During a review of Resident 1's History and Physical (H&P), dated 6/14/2026, the H&P indicated the resident has the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 6/19/2026, the MDS indicated the resident makes self-understood and has the ability to understand others. The MDS indicated the resident was dependent on staff in rolling left and right while in bed, sitting to lying, and lying to sitting on the side of the bed and respiratory treatments including oxygen therapy were not performed. During a review of Resident 1's Care Plan (CP) focused on Congestive Heart Failure (CHF), created on 6/22/2026, the CP indicated the resident with goals of reduced risk adverse consequences from signs and symptoms of fluid and electrolyte imbalance with interventions which included Oxygen therapy as ordered. During a concurrent observation and interview on 6/30/2026 at 9:23 a.m., inside Resident 1's room, Resident 1 was observed lying in bed, awake. Resident 1 stated he has heart issues and sometimes when he overexerts himself, he gets short of breath, and he puts on his oxygen. Resident 1 stated he has an oxygen concentrator that he brought from home. Resident 1 stated he asked if it was okay for him to bring it in, but he has been using his oxygen concentrator for a long time at home. Resident 1 stated right now he does not need it, so he does not have it on. Resident 1 stated when he needs it, he lowers his bed to get closer to the oxygen concentrator, puts on the nasal cannula tubing and turns on the concentrator and adjusts the concentration as he needs it. Resident 1 stated he would call for help with his concentrator when it is too far for him to reach, besides that he puts it on and turns it on by himself. The oxygen concentrator was observed turned off at Resident 1's right side of bed with nasal cannula tubing connected. During a concurrent interview and record review on 6/30/2026 at 12:44 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's physician orders, Weights and Vitals Summary, nursing progress notes from 6/3/2026 to 6/30/2026, and Resident's Clothing and Possessions, dated 6/3/2026 were reviewed. LVN 1 stated there was no order for oxygen therapy administration and no monitoring. LVN 1 stated there should be an order and monitoring when the resident is receiving oxygen including vital signs. The Weights and Vitals Summary indicated the following:6/6/2026 at 8:21 a.m. 96 percent (% - one per hundred) oxygen via nasal cannula (NC)6/7/2026 at 1:29 a.m. 96% oxygen via NC6/18/2026 at 10:18 p.m. 97% oxygen via NC6/19/2026 at 8:44 p.m. 97% oxygen via NCLVN 1 stated when its documented oxygen given via NC means the oxygen was administered. LVN 1 stated there was no mention about the resident's oxygen concentrator. LVN 1 stated it would either (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be documented in the progress notes or on the Resident's Clothing and Possessions, but there was no mention. During a concurrent observation and interview on 6/30/2026 at 12:51 p.m. with LVN 1, inside Resident 1's room, LVN 1 stated Resident 1 has an oxygen concentrator with nasal cannula tubing attached. Resident 1 stated he brought this from home and was delivered sometime last week. Resident 1 stated when he came back from the hospital no one had come to update his personal belongings to include his oxygen concentrator. Resident 1 stated he does not recall the exact date. LVN 1 stated it was mentioned to her that the resident asked if it was okay to bring in his oxygen concentrator from home awhile back. LVN 1 stated this is the one that was delivered here. LVN 1 stated she does not know when this was brought in. During an interview on 6/30/2026 at 2:10 p.m. with the Director of Nursing (DON), the DON stated she reviewed all the nursing notes and Resident 1's inventory and there was no mention of the resident's oxygen concentrator. The DON stated the Resident's Clothing and Possessions form should be updated on the same day of admission or after admission. The DON stated usually it's updated by the receptionist, who monitors what comes into the building. The DON stated the visitor informs the receptionist about adding items on to the resident's inventory. The DON stated that for the oxygen concentrator it would go through either the desk nurse or charge nurse. The DON stated it is to ensure that if the residents were to be discharged , they would go home with the same belongings and respect their rights for their property. The DON stated that when the resident's items are not inventoried and becomes missing, they would not be replaced by the facility for the resident. The DON stated the residents' rights would not be followed. The DON stated updating the resident's personal belongings inventory is also protection from misappropriation of property. During a review of the facility's policy and procedure (P&P) titled, Respect and Dignity to Have Personal Property, last reviewed and approved on 10/23/2025, the P&P indicated that the Residents are permitted to retain and use personal possessions and appropriate clothing, as space permits . 4. The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished . 7. In the event the resident is physically or cognitively unable to mark their personal inventory items, and he or she does not have authorized resident representative, facility personnel may assist with inventorying personal items

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure respiratory care provided to residents was consistent with professional standards of practice for one of two sampled residents (Resident 1) reviewed for respiratory care, by failing to ensure there were physician orders for oxygen administration, documentation of when oxygen was administered, and monitored while in use. These deficient practices had the potential to place residents at risk for respiratory complications such as signs and symptoms of tracheal irritation, difficulty breathing, or slow, shallow rate of breathing of oxygen and toxicity (too much oxygen). Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 6/3/2026 with diagnoses including heart failure (a heart disorder which causes the heart to not pump the blood efficiently), obstructive sleep apnea (a disorder where breathing repeatedly stops and starts during sleep when the throat muscles relax and cause the airway to collapse and block airflow), and atrial fibrillation (an irregular and often very rapid heart rhythm). During a review of Resident 1's History and Physical (H&P), dated 6/14/2026, the H&P indicated the resident has the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 6/19/2026, the MDS indicated the resident makes self-understood and has the ability to understand others. The MDS indicated the resident was dependent on staff in rolling left and right while in bed, sitting to lying, and lying to sitting on the side of the bed and respiratory treatments including oxygen therapy were not performed. During a review of Resident 1's Care Plan (CP) focused on Congestive Heart Failure (CHF), created on 6/22/2026, the CP indicated the resident's goals included a reduced risk for adverse consequences from signs and symptoms of fluid and electrolyte imbalance with interventions which included Oxygen therapy as ordered. During a concurrent observation and interview on 6/30/2026 9:23 a.m., inside Resident 1's room, Resident 1 lying in bed, awake. Resident 1 stated he has heart issues and sometimes when he overexerts himself, he gets short of breath, and he puts on his oxygen. Resident 1 stated he has an oxygen concentrator that he brought from home. Resident 1 stated he asked if it was okay for him to bring it in, but he has been using his oxygen concentrator for a long time at home. Resident 1 stated right now he does not need it, so he does not have it on. Resident 1 stated when he needs it, he lowers his bed to get closer to the oxygen concentrator, puts on the nasal cannula tubing and turns on the concentrator and adjusts the concentration as he needs it. Resident 1 stated he would call for help with his concentrator when it is too far for him to reach besides that he puts it on and turns it on by himself. The oxygen concentrator was observed to be turned off at Resident 1's right side of the bed with nasal cannula tubing connected. During a concurrent interview and record review on 6/30/2026 at 12:44 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's physician orders, Weights and Vitals Summary, and nursing progress notes from 6/3/2026 to 6/30/2026 were reviewed. LVN 1 stated there was no order for oxygen therapy administration and no monitoring. LVN 1 stated there should be an order and monitoring when the resident is receiving oxygen including vital signs. The Weights and Vitals Summary indicated the following:6/6/2026 at 8:21 a.m. 96 percent (% - one per hundred) oxygen via nasal cannula (NC).6/7/2026 at 1:29 a.m. 96% oxygen via NC.6/18/2026 at 10:18 p.m. 97% oxygen via NC.6/19/2026 at 8:44 p.m. 97% oxygen via NC.LVN 1 stated when it's documented that oxygen was given via NC, it means the oxygen was administered. During a concurrent observation and interview on 6/30/2026 at 12:51 p.m. with LVN 1, inside Resident 1's room, LVN 1 stated Resident 1 has an oxygen concentrator with nasal cannula tubing attached. Resident 1 stated he brought this from home and it was delivered sometime last week. LVN 1 stated the purpose of the order is to ensure it was approved by the physician. LVN 1 stated the doctor should have been notified before it was administered. LVN 1 stated there should be an order to make sure it is the right treatment for the resident. LVN 1 stated the resident could receive the wrong treatment. During an interview on 6/30/2026 at 1:28 p.m. with the Director of Nursing (DON), the DON stated before oxygen therapy (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiation there needs to be an order and when a resident has a change in condition or asking for oxygen, the resident is to be assessed to determine if it's really needed. The DON stated that when it was assessed that the resident has a low oxygen saturation, then the nurse should initiate a change in condition assessment. The DON stated it is important to obtain oxygen orders and further monitoring orders because the resident has the potential to not received the oxygen that is needed and would not be monitored. The DON stated that when the resident is not assessed, administering oxygen without an order, and not monitoring vital signs and signs or symptoms of respiratory distress, it could potentially affect the resident's respiratory status and cause the resident to not get the appropriate oxygen needed. During a concurrent interview and record review on 6/30/2026 at 2:28 p.m. with the DON, the facility's policy and procedures (P&P) titled, Oxygen Therapy, was reviewed. The DON stated when the resident adjusts the oxygen concentration by himself, he could have too much oxygen. The DON stated their P&P indicated Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: a. signs and symptoms of cyanosis . b. Signs or symptoms of hypoxia . c. Signs or symptoms of oxygen toxicity (i.e. tracheal irritation, difficulty breathing, or slow, shallow rate of breathing). The DON stated it is important that the resident is assessed and monitored when receiving oxygen therapy. During a review of the facility's P&P titled, Oxygen Therapy, last reviewed and approved 10/23/2025, the P&P indicated that the purpose of this P&P is to provide guidelines to the administration of oxygen. The P&P indicated the guidelines:1. Residents receiving oxygen therapy will have a physician order including a. Device. b. Flow Rate or FiO2. c. Frequency/Duration. d. Target Oxygen Saturation. e. Titration Parameters (if applicable). f. Indication. g. Start Date & Time. h. Reassessment or Stop Parameters i. Reassess in X hours/days. j. Discontinue when stable. k. Physician providing order. l. Title and signature of staff receiving order . 9. Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: a. signs and symptoms of cyanosis . b. Signs or symptoms of hypoxia . c. Signs or symptoms of oxygen toxicity (i.e. tracheal irritation, difficulty breathing, or slow, shallow rate of breathing). d. Vital signs. e. Lung sounds. f. Oxygen Saturation . h. Other laboratory results (hemoglobin, hematocrit, and complete blood count), if applicable . 11. Record the following information in the medical record as applicable: a. The date and time that the procedure was performed. b. The rate of oxygen flow, route, and rationale. c. The frequency and duration of the treatment. d. The reason for p.r.n. administration. e. Resident adverse reactions to treatment as applicable; and f. The signature and title of the person recording the data. 12. Only Registered Nurses and Respiratory Therapist or Respiratory Care Practitioners may initiate or titrate oxygen.