

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056024	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Highland Palms Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7534 Palm Ave Highland, CA 92346	
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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that call light (a device that allows residents to communicate with nursing staff when they need assistance) was within resident's reach for one (1) of the five (5) sampled residents (Resident 1), when Resident 1's call light was found to be wrapped around the bedrail and out of Resident 1's reach. This failure had the potential to result in Residents 1's needs not being addressed when needed help, placing him at risk of injury. During a review of Resident 1's face sheet (contains demographic and medical information), the face sheet indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis (conditions that affect only one side of the body due to damage in the brain or spinal cord) affecting left non-dominant side, muscle wasting, and atrophy (the loss of muscle mass, which causes muscles to shrink and weaken). During a concurrent observation and interview on July 8, 2026, at 10:57 AM, with Resident 1, in his room, Resident 1 was lying in bed, the call light was wrapped around the right bottom of his bed rail, making it inaccessible to reach. Resident 1 stated the staff had not provided him with a call light and he had to, [NAME] for help. During a concurrent observation and interview on July 8, 2026, at 11:03 AM, with Certified Nursing Assistant (CNA 1), in Resident 1's room, CNA 1 confirmed the call light was wrapped around the right side of bed rail, making it inaccessible to the Resident 1 and that was not the appropriate way to position the call light. CNA 1 stated Resident 1's call light should not be positioned out of his reach, as this could prevent Resident 1 from calling for help in case of an emergency or if assistance is needed. During a concurrent observation and interview on July 8, 2026, at 11:09 AM, with the License Vocational Nurse (LVN 1), in Resident 1's room. LVN 1 stated she administered medications to Resident 1 this morning (July 8, 2026), but did not realize the call light was out of reach. LVN 1 stated it was part of her responsibility to ensure the call light is always accessible to the residents. During a concurrent observation and interview on July 8, 2026, with CNA 2, CNA 2 stated she was assigned to Resident 1, she must have forgotten to return the call light to a position within Resident 1's reach after rendering care and that was unacceptable. During a concurrent record review and telephone interview on July 8, 2026, at 12:11 PM, with the Director of Nursing (DON), in the presence of the Administrator (Admin), the facility's policy and procedure (P&P) titled, Answering the Call Light, dated September 2022, was reviewed. The P&P indicated, . 4. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. 5. Ensure that the call light immediately becomes re-accessible once it's identified that it is no longer accessible due to resident turning, and or repositioning. The DON confirmed and acknowledged that the staff was not adhering to it the facility's P&P. The Admin also confirmed that it was their policy.		

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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