

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555773	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Indian Canyon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 57333 Joshua Lane Yucca Valley, CA 92284	

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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>37683</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure the preadmission screening and resident review (PASRR) was accurately completed for 1 (Resident #44) of 3 sampled residents reviewed for PASRR requirements. Specifically, Resident #44 had a serious mental illness (SMI) that was not captured in their Level I PASRR screening.</p> <p>Findings included:</p> <p>A facility policy titled, PASRR Completion Policy, reviewed 12/2023, specified, The Center will a [sic] make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed. The policy specified, 1. Center Administrator will designate the medical records to make sure that the [PASRR]and/or Level of Care (LOC) is done on all potential residents. If the referral indicates anything which might constitute an SMI or ID [intellectual disability], the PASRR must be completed prior to admission.</p> <p>An Admission Record revealed the facility admitted Resident #44 on 08/02/2024. According to the Admission Record, the resident had a medical history that that included diagnoses of bipolar disorder (onset 08/02/2024) and anxiety disorder (onset 08/02/2024).</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/08/2024, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #44 had active diagnoses to include anxiety disorder and of manic depression (bipolar disease).</p> <p>Resident #44's care plan included a focus area initiated 08/05/2024, that indicated that the resident had a mood problem related to bipolar disorder and anxiety disorder. Interventions directed staff to refer the resident for behavioral health consultations as needed.</p> <p>Resident #44's physician orders revealed an order dated 08/04/2024, for quetiapine fumarate (an antipsychotic) oral tablet 24 milligrams, one tablet by mouth at bedtime for bipolar manifested by mood swings.</p> <p>Resident #44's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 08/02/2024, indicated that the resident had no diagnosed SMIs and did not have a suspected mental illness.</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
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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/13/2024 at 3:35 PM, the Social Services Director stated that the hospital completed the resident's Level I PASRR screening. She stated that she was not sure what the process was for the facility staff to review Level I PASRR screenings for accuracy or who was responsible for reviewing them.</p> <p>During an interview on 11/13/2024 at 3:57 PM, the Medical Records Resource stated that the hospital created Resident #44's Level I PASRR screening. She stated that she did not know of any process to review hospital Level I PASRR screenings for accuracy or who was responsible for reviewing them.</p> <p>During an interview on 11/13/2024 at 12:57 PM, the Director of Nursing stated that he was not sure if there was anyone in the facility who reviewed Level I PASRR screenings from the hospital for accuracy, but he believed that it was the responsibility of medical records staff.</p> <p>During an interview on 11/13/2024 at 1:13 PM, the Administrator stated that medical records staff were responsible for PASRR accuracy.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>37683</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure staff administered medication as ordered for 1 (Resident #16) of 5 sampled residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>An undated facility policy titled, Medication Administration - General Guidelines specified, Medications are administered in accordance with written orders of the attending physician.</p> <p>An Admission Record revealed the facility admitted Resident #16 on 01/28/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of hypertensive heart disease with heart failure.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/16/2024, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment.</p> <p>Resident #16's Order Summary Report, for active orders as of 11/13/2024, revealed an order dated 01/28/2024, for bumetanide oral tablet 2 milligrams, give one tablet by mouth one time a day for congestive heart failure, hold for systolic blood pressure (SBP) less than 110 millimeters of mercury (mmHg).</p> <p>Resident #16's medication administration record (MAR) for the timeframe from 10/01/2024 through 10/31/2024, revealed evidence to indicate Licensed Vocational Nurse (LVN) #2 administered bumetanide 2 mg to the resident when the resident had a SBP of 102 mmHg on 10/02/2024.</p> <p>During an interview on 11/13/2024 at 1:37 PM, LVN #2 stated that staff were supposed to check that the resident's blood pressure was within parameters before administering medication. She stated that Resident #16's MAR indicated the resident received their bumetanide when the resident's blood pressure was outside of the physician-ordered parameters. She stated that she had been a nurse long enough to know not to do that.</p> <p>During an interview on 11/13/2024 at 3:10 PM, Medical Doctor #10 stated staff should have followed the parameters set by the physician with regards to medication administration.</p> <p>During an interview on 11/14/2024 at 12:57 PM, the Director of Nursing (DON) stated that nurses should follow the physician-ordered parameters with regards to medication administration.</p> <p>During an interview on 11/14/2024 at 1:13 PM, the Administrator referred to the DON regarding medication administration and physician-ordered parameters.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46194</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to provide facial grooming for 1 (Resident #76) of 2 sampled residents reviewed for activity of daily living (ADL) care.</p> <p>Findings included:</p> <p>A facility policy titled, ADL, Services to carry out, reviewed 12/2023, revealed, It is the policy of this facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities. The policy revealed, 2. Residents who are unable to carry out activities of daily living (ADL) will receive necessary services to maintain, including Grooming.</p> <p>An Admission Record indicated the facility admitted Resident #76 on 09/26/2024. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis (muscle weakness and paralysis on one side of the body) following a cerebral infarction (a stroke) and complete traumatic trans metacarpal amputation of left hand.</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/13/2024, revealed Resident #76 had moderate impairment in cognitive skills for daily decision making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS indicated the resident did not exhibit any behavior of rejecting care during the assessment timeframe. Per the MDS, the resident was totally dependent on staff for personal hygiene needs.</p> <p>Resident #76's care plan included a focus area initiated 08/20/2024, that indicated the resident had an ADL self-care performance deficit. The care plan indicated that the resident was totally dependent on staff for personal hygiene.</p> <p>Resident #76's Skin Monitoring: Comprehensive CNA [certified nurse aide] Shower Review, dated 11/08/2024 and completed by CNA #9, indicated the resident had a bed bath. T</p> <p>During an interview and observation on 11/11/2024 at 9:45 AM, Resident #76 was observed with facial hair on their chin, cheeks, and upper lip approximately 1/4 inch long. When asked if they liked having facial hair, Resident #76 shook their head, indicating that they did not.</p> <p>During an interview on 11/12/2024 at 10:16 AM, Resident #76's family member stated the staff shaved the resident about once a month.</p> <p>On 11/13/2024 at 1:43 PM, CNA #9 stated that it was her first time to work with Resident #76 on 11/08/2024. She stated that she did not know if the resident preferred to be shaved or not. She stated she did not shave Resident #76 on 11/08/2024 during the resident's bed bath.</p> <p>On 11/14/2024 at 7:54 AM, Licensed Vocational Nurse #7 stated that staff should know the preferences of the residents, and if they did not know, they should ask. She stated Resident #76 liked to be clean shaved.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/14/2024 at 8:32 AM, the Director of Nursing stated that whatever the resident could not do, the staff should do for them. He stated that staff should wash the residents' hair and offer to shave.</p> <p>On 11/14/2024 at 10:53 AM, the Administrator stated that staff should assist the resident with bathing. She stated the staff should offer to shave the resident during that time. She stated that the staff should know the residents' preferences.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>46194</p> <p>Based on interview, record review, and facility policy review, the facility failed to transcribe a physician order from an outside ear, nose, and throat (ENT) physician for 1 (Resident #70) of 1 resident reviewed for communication sensory concerns.</p> <p>Findings included:</p> <p>A facility policy titled, Physicians, Consulting, revised 12/2023, revealed, Purpose To promote continuity of care. The policy revealed, 5. If treatment or medications are ordered by the consulting physician, it will be communicated to a licensed staff to carry out the new treatment order. 6. Medication/treatment will be transferred to MAR [medication administration record]/TAR [treatment administration record], ordered from pharmacy/other, and treatment or medication regime initiated, and family and/or resident informed of change in plan of care.</p> <p>An Admission Record indicated the facility admitted Resident #70 on 02/07/2024. According to the Admission Record, the resident had a medical history that included diagnoses of intraspinal abscess and granuloma and muscle weakness.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/01/2024, revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment.</p> <p>A physician note, dated 10/02/2024, revealed Resident #70 was seen by a physician assistant for diminished hearing, nasal congestion, throat congestion/clearing, and stuffy ears. According to the physician note, the plan included use an earwax removal aid drops twice a day for four days in the resident's left ear.</p> <p>Resident #70's MAR for the timeframe from 10/01/2024 through 10/31/2024 revealed no evidence of an order that directed staff to instill drops in the resident's left ear.</p> <p>On 11/11/2024 at 11:13 AM, Resident #70 stated they were seen by an ENT physician a month ago and the facility did not administer the ear drops as ordered.</p> <p>On 11/13/2024 at 7:52 AM, the Social Services Director (SSD) stated the ENT physicians came in every nine weeks. She stated the physicians were able to write orders. She stated that the orders were given to the nurse and the nurse placed (transcribed) the orders into the computer.</p> <p>On 11/13/2024 at 9:51 AM, Registered Nurse (RN) #6 stated that orders were given to the charge nurse on the hall or the desk nurse. She stated that nursing staff were supposed to follow up on the orders. She stated that the RN supervisor should be following up as well to ensure the orders were completed. RN #6 reviewed Resident #70's medical record and stated that the order was not carried out. She stated that the order should have been carried out and stated that there was a delay of care.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/13/2024 at 10:53 AM, Licensed Vocational Nurse (LVN) #7 stated that when the physician completed their rounds, the physician found a floor nurse to give the orders to. She stated that from there, the orders were carried out and put (transcribed) into the medical system. She stated that she remembered the physician giving her the orders for the day, but not sure if there were any orders for Resident #70. She stated she did not recall transcribing an order for Resident #70. LVN #7 stated that the orders should be put in that same day and if not, they could pass it on to night shift. She reviewed resident #70's medical record and the order summary for October 2024 and November 2024 and stated that she must have just not transcribed the order in the computer.</p> <p>On 11/13/2024 at 3:25 PM, the Director of Nursing (DON) stated that the staff should work with the ancillary physician and follow through with what the physicians asked of the facility.</p> <p>On 11/13/2024 at 3:32 PM, the Administrator stated that she expected the nursing department to follow up with the order to clarify if needed, and to carry out the order. She stated that she expected the order to be put in the day the order was received or the following day. She stated that the order from the ENT was not carried out.</p> <p>On 11/14/2024 at 1:51 PM, the DON stated the facility was unable to produce the physician orders that were given to the nurse on duty.</p>		