

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/04/2025
NAME OF PROVIDER OR SUPPLIER Indian Canyon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 57333 Joshua LN 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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections, in a universe of 95 residents (Residents 1 to 95), when:1. Laundry Staff 1 (LS 1) and the Housekeeping Lead (HL) did not follow the manufacturer's guidelines for the disinfectant (DS 1) used to disinfect soiled laundry carts and soiled laundry barrels. In addition, the facility staff did not clean and disinfect the clean linen carts located in the resident hallways. This failure had the potential to cause the development and transmission of communicable diseases (an illness or infection that can spread from one person to another, or from a surface to a person) and infections to residents.2. Resident 82 who had contact isolation precautions (a set of infection control practices used to prevent the spread of germs that are transmitted by direct or indirect physical contact with a resident or the resident's environment) in place was not provided dedicated or disposable equipment such as a blood pressure cuff (an inflatable band wrapped around a resident's arm-or sometimes a thigh or wrist-to measure the resident's blood pressure), thermometer (a device used to measure the resident's temperature), stethoscope (a medical instrument used by healthcare professionals to listen to the internal sounds of a resident's body) or pulse oximeter (a device that measures the oxygen saturation level of a resident's blood and their heart rate).3. Room [room number] for Residents' 36, 21, and 59 was found with the following: 1. Under the beds there were various items had accumulated, including blankets, pillows, urine-soaked towels, tissues, food wrappers, medicine cups, ice cream cups, Styrofoam cups, straws, and dirty utensils.2. The trash can was overflowing with waste. 3. The floor was visibly dirty, covered with crumbs, sticky substances, and scattered pieces of paper. These failures had the potential to cause cross-contamination (the unintentional physical transfer of harmful bacteria, viruses, and fungi from one resident, object, or surface to another) and spread of infections to other residents, healthcare workers, and the wider Skilled Nursing Facility (SNF) environment.Findings: 1. During a Laundry Services and Facility Cleaning and Disinfection observation and interview on December 3, 2025, from 11:54 AM to 1:56 PM with the Housekeeping Lead (HL), Laundry Staff 1 (LS 1), Environmental Services Director (ESD), Certified Nursing Assistants 3, 4, 5, and 6 (CNAs 3, 4, 5, and 6) and the Infection Preventionist (IP), the HL stated that each hallway had two dirty linen receptacles which were on a plastic frame with net bags holding plastic trash bags with a plastic lid on the top. The HL stated she was responsible for cleaning and disinfecting the dirty linen receptacles on the 400 hallway but did not clean and disinfect the clean linen carts, I think the CNAs do that. The HL stated she used a disinfectant (DS 1) on the hard plastic surfaces of the dirty linen receptacles and kept the surfaces wet for 10 minutes before wiping the surface down or letting it air dry. The HL stated she sprayed the mesh bags with the DS 1 but was unable to keep the mesh bags wet for 10 minutes and she was not aware of the directions for the DS 1 indicated to use on non-porous surfaces (a material that is sealed and does not have any tiny holes, pores, or crevices) only. The HL stated when the dirty linen receptacles got full (Laundry Staff-LS- monitored the (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	possible. 3. During an observation on December 1, 2025, at 11:22 AM, in Room [room number], the room was found with the following: 1. Under the beds there were various items had accumulated, including blankets, pillows, urine-soaked towels, tissues, food wrappers, medicine cups, ice cream cups, Styrofoam cups, straws, and dirty utensils. 2. The trash can was overflowing with waste. 3. The floor was visibly dirty, covered with crumbs, sticky substances, and scattered pieces of paper. During an interview on December 1, 2025, at 11:24 AM, with Resident 36, he stated the room had not been cleaned and the trash had not been removed for the past three days. Resident 36 further stated that due to his medications, which include diuretics (medications that increase the production of urine), he frequently urinates in towels because his urinal fills up quickly, and staff are not quick enough to dump it. Subsequently, he places these urine-soaked towels on the floor to avoid soiling his bed. Resident 36 further stated he uses tissues to wipe his nose and discards them on the floor due to the trash can being full and overflowing. During an interview on December 1, 2025, at 11:26 AM with Resident 21, he stated, They did not clean my room for days now, look! pointing to the floor and under his bed. During an interview on December 1, 2025, at 11:28 AM, with Resident 59, he stated, Last time this room was cleaned was Friday morning. No one came to sweep and mop the floor over the weekend. Hopefully someone will come clean it today, but I haven't seen any housekeeper yet. During an interview on December 1, 2025, at 11:30 AM with Certified Nurse Assistant 3 (CNA 3), CNA 3 stated room [room number] is dirty because the housekeeping staff did not clean the room and did not remove the trash over the weekend. CNA 3 further stated housekeeping had not been seen cleaning the room on the day of the interview either. During an interview with the Environmental and Maintenance Services Director (EMSD) on December 2, 2025, at 9:20 AM, the EMSD acknowledged that the scheduled housekeeper did not clean the room this past weekend. The EMSD stated every room in the facility gets cleaned and moped at least once a day, sometimes multiple times depending on the residents' needs and housekeepers are expected to revisit and clean rooms that become messy throughout the day. The EMSD explained that the housekeeper 3 (HH 3) who is responsible for the cleanliness of rooms in 300-hall, was previously identified to have work performance deficiencies in the past and appropriate action was taken. The EMSD acknowledged that the room should have been cleaned and moped daily, and his expectations are that all housekeeping staff follow the daily cleaning schedule and facility's policy and procedures. HH3 was not available for interview. During an interview with the facility's Infection Preventionist (IP) on December 2, 2025, at 3:32 PM, the IP stated that her expectations are for the facility to be always maintained clean and for the staff to adhere to the daily cleaning schedule and follow facility's policies and procedures. During an interview with the Operations Manager (OP) on December 3, 2025, at 1:58 PM, the manager (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, and record review, the facility failed to act promptly upon the resident council's grievances and recommendations when the Grievance Official (GO) failed to address or provide a rationale for the inability to act on the resident council's grievances and recommendations over a three-month period (August 2025 to October 2025) for 16 sampled residents (Residents 1 to 16). This failure had the potential to cause an undermining of residents' independence, a hindering of effective problem resolution and quality improvement, and ultimately creating an atmosphere of fear and distrust within the facility. Findings: During the entrance conference with the Interim Director of Nursing (IDON) on December 1, 2025, at 9:30 AM, the IDON stated Resident 41 was the resident council president. During an interview with Resident 41 and the Administrator (Admin) on December 1, 2025, at 3:17 PM, Resident 41 stated he was no longer the president of the resident council because he felt it was a waste of time since the facility never addressed the concerns raised by the council. The Admin stated the resident council president was Resident 19. During an interview with Resident 19 on December 1, 2025, at 3:28 PM, Resident 19 confirmed he was the resident council president and the group met about once per month. Resident 19 granted permission for a review of the resident council's meeting minutes over a three-month period. A review of the resident council meeting minutes dated August 2025, September 2025, and October 2025, was conducted. The following is a summary of the documented grievances and recommendations: Physical Therapy (PT): PT not doing enough, More PT not just once per week, resident not getting walks, PT for all body parts, an open gym for exercise. Nursing: Coming in turning call light off and walk back out again, staff complaining about getting things from the kitchen, not cleaning well after toilet use, sugar drop in independent residents and no one checks. Medications on time and correct medications, listen and respond to resident concerns, night shift nurses sleeping on the job and not providing showers. Dietary: More options for meal substitutions, more variety for daily meals, more variety for nighttime snacks, hot cereal not made correctly. Housekeeping: Clean the rooms better. Only cleaning bathroom not room itself, more clothes for men, more linen. Laundry to return correct clothes to the correct residents. Administration: listen and be more responsive. Operations Manager (OM) to attend meetings to understand residents' concerns. A resident council meeting was conducted on December 2, 2025, from 10 AM to 10:45 AM, 16 residents attended the meeting including the former president, Resident 41, and the current president, Resident 19. A summary of the documented grievances and recommendations from the resident council meetings held in August 2025, September 2025, and October 2025, was reviewed with the attendees. The attendees were asked whether the facility had addressed or responded to the council's grievances and recommendations for this three-month period. Approximately 50 percent of the attendees, including Residents 41 and 19, indicated that the facility had neither responded to nor addressed the council's grievances and recommendations during this three-month period. During an interview with the Admin on December 3, 2025, at 7:42 AM, the Admin stated the Grievance Official (GO) was the Social Services Director (SSD). The Admin stated the GO acted upon the resident council's grievances and recommendations. During an interview with the GO and the Activities Director (AD) on December 4, 2025, from 7:18 AM to 7:37 AM, The GO confirmed her role and responsibilities and stated that it was her responsibility to address grievances and recommendations from resident council meetings. However, the GO stated that the activities director had not provided her with minutes from these meetings for approximately six months, preventing her from addressing any issues or suggestions raised by the residents. The Activities Director (AD) stated she assumed her position in July 2025. The AD stated that no orientation or training was provided for the AD role, and she was unaware of the requirement to forward the resident council meeting minutes to the GO for action. The AD stated she handwrote the minutes for the resident council meetings and acknowledged the grievances and recommendations raised. The AD verbally communicated these issues to the Operations Manager (OM), the IDON, and the Dietary Services Supervisor (DSS), but noted that since (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	it was not documented in writing, those individuals likely forgot. The GO stated that she could not adhere to the facility's policy and procedure titled Grievances, dated January 25, 2025, as she had not received the grievances and recommendations from the resident council meetings. During an interview with the OM and the Admin on December 4, 2025, at 8:04 AM, The OM and Admin stated it was the responsibility of the AD to provide the resident council meeting minutes to the GO, and it was the GO's responsibility to act upon the grievances and recommendations documented in the meeting minutes. The OM and Admin stated the facility had not acted promptly upon the resident council's grievances and recommendations. A review of the facility's policy and procedure (P&P) titled, Grievances, dated January 25, 2025, indicated, Policy: It is the policy of this facility to establish a grievance process to 1. Address resident concerns without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their facility stay; and 2. Make prompt efforts to resolve grievances the resident may have. Procedures: 1. The facility's grievance official is responsible for overseeing the grievance process, receiving and tracking grievances; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident, if requested; and coordinating with state and federal agencies as necessary. 2. Resident and/or Resident Representatives have the right to file grievances orally or in writing. 3. General concerns may be voiced at Resident Council meetings. 4. The Grievance Official evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations of any resident's right while the alleged violation is being investigated. 6. The Grievance Official or designee responds to the individual expressing the concern within (3) three working days of the initial concern to acknowledge receipt and describe steps taken toward resolution.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to provide interpretive services to residents including Resident 45, whose primary language is other than English. This failure had the potential to compromise residents the ability to understand, comprehend, and effectively communicate their needs, rendering them unable to fully participate in their plan of care, likely leading to residents experiencing diminished self-esteem, social interaction withdrawal, and significant emotional distress. Findings: During an interview conducted on December 1, 2025, at 11:36 AM with Resident 45, it was revealed that Spanish is Resident 45's primary language, and he does not speak or understand English. Although he could respond to simple Yes/No questions spoken in English, he did so with visible hesitation and reservation. Resident 45 utilized his cell phone to contact his daughter, who subsequently assisted as a translator through the phone's speaker. Through his daughter's translation, Resident 45 communicated his frustration with being unable to convey his needs and preferences to the staff due to the language barrier. He expressed feeling more comfortable when Spanish-speaking staff members are available. However, he is not always assigned to Spanish-speaking staff due to staffing variances. This inconsistency in communication had contributed to his feelings of frustration and unease during his stay at the facility. Resident 45 indicated a strong preference for the facility to provide an interpreter to facilitate better communication and dialogue with staff members. He emphasized that having an interpreter would greatly enhance his overall experience through direct dialog with staff, ensuring that his needs and concerns are adequately addressed in a timely manner. A review of residents' 45 face sheet (a facility document that contains basic information about the resident) indicated he was admitted at the facility on January 7, 2025, with diagnoses which include hemiplegia with hemiparesis [weakness (hemiparesis) on one side of the body, ranging from mild to severe, often accompanied by complete paralysis (hemiplegia) on the same side, typically affecting the arm, leg, and sometimes face, due to brain injury disrupting nerve signals] following cerebral infarction affecting right dominant side, aphasia (disorder caused by brain damage that affects a person's ability to communicate by interfering with their speech), unspecified intracranial injury (damage to the brain or its surrounding structures inside the skull) without loss of consciousness, lack of coordination, type 2 diabetes, neuropathy (nerve damage or disease, often in the hands and feet, that causes symptoms like numbness, tingling, burning pain, or muscle weakness), chronic kidney disease stage 4 (kidneys have severe damage and function at only 15-29% of normal), hypertension (high blood pressure), and major depressive disorder (a mood disorder characterized by persistent feelings of sadness and a loss of interest in activities). A review of the Comprehensive Material Data Sheet (MDS - contains demographic information, resident assessment and care screening) dated September 26, 2025, identified Resident 45 ethnicity as Hispanic and noted that his preferred language is Spanish, requiring an interpreter for communication with medical or healthcare staff. A review of the Resident 45's Care Plan indicated, the resident has a communication problem related to a language barrier, impaired hearing, neurological symptoms, impaired cognition, depression, and aphasia. However, there are no interventions addressing the language barrier. During an interview with Licensed Vocational Nurse 4 (LVN 4) on December 1, 2025, at 3:22 PM, LVN 4 indicated that the facility does not provide interpretive services for residents who do not speak English. LVN 4 further stated that she utilizes the Google Translate App on her personal cell phone to communicate with these residents. During an interview with the Social Services Director (SSD) on December 1, 2025, at 3:49 PM, the SSD confirmed that the facility does not offer translation services for non-English speaking residents. The SSD further explained that she relies on staff members for translation when they are available and uses a translation application on her phone to communicate with residents when staff assistance is not accessible. During a concurrent record review and interview with the (SSD) on December 1, 2025, (continued on next page)		

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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 12/04/2025
NAME OF PROVIDER OR SUPPLIER Indian Canyon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 57333 Joshua LN 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.			
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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 4:03 PM, the SSD confirmed that Resident 45 needs an interpreter to effectively communicated with staff. The Policy and Procedure (P&P) titled, Translation and/or Interpretation of Facility Services, undated, was reviewed with the SSD. The P&P states . 8. Competent oral translation of vital information that is not available in written translation, and non-vital information shall be provided in a timely manner and at no cost to the resident through the following means as available to the facility: . c. Contracted interpreter service; d. Voluntary community interpreters who are trained and competent in the skill of interpreting; and e. telephone interpretation service. The SSD acknowledged that the facility lacked interpreter services as of December 1, 2025, and agreed the facility's P&P was not followed. During an interview with the Operations Manager (OP) on December 3, 2025, at 8:58 AM, the OP acknowledged that the facility did not ensure non-English speaking residents could communicate effectively with staff through an interpreter as per the facility's policies and procedures.During an interview with the Director of Nursing (DON) on December 4, 2025, 11:33 AM, the DON acknowledged that non-English speaking residents were unable to effectively communicate with staff and participate in their plan of care due to facility's failure to provide interpreter services as specified in facility's policy and procedure. The DON recognized that consistent provision of language support would not only enhance residents' comfort but also promote a more inclusive and supportive environment within the facility.During a follow-up interview with the Social Services Director (SSD) on December 4, 2025, at 2:22 PM, the SSD confirmed that a total of eight non-English speaking residents currently residing at the facility require interpreter services to effectively communicate with staff and participate in their plans of care. The SSD acknowledged that as of December 1, 2025, the facility lacked adequate interpreter services to meet residents' needs.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan to ensure Resident 89's optimal physical, mental, and psychosocial well-being when Resident 89 displayed a behavior of aggressively chewing on the thumb and first three fingers of the left hand, and the first two fingers of the right hand. This failure resulted in damage to the fingernails on Resident 89's left hand. Findings: A review of Resident 89's face sheet (a document that gives a summary of resident's information), undated, indicated an admission date of October 3, 2023. Resident 89 had diagnoses that included Alzheimer's disease (a progressive type of brain disease and is the most common cause of dementia) and dementia (an umbrella term for a collection of symptoms, such as memory loss, language problems, and impaired thinking skills, severe enough to interfere with daily life). During an observation and interview with Resident 89, Certified Nursing Assistants 2 and 3 (CNA 2 and 3) on December 1, 2025, from 4:05 PM to 4:35 PM, Resident 89 was in his room in bed and was wearing a short sleeve hospital gown with the blanket pulled up to his waist. The surveyor tried to engage Resident 89 in conversation, but Resident 89 made no eye contact nor spoke to the surveyor. Resident 89 was positioned in his bed, so he faced the wall to his right. Resident 89 was awake, staring at the wall and had his right two fore fingers in his mouth which he was aggressively chewing on and making vocalizations as he chewed. CNA 2 and CNA 3 stated the finger chewing had been an ongoing issue. They had attempted to give Resident 89 toys to hold and chew on, but Resident 89 would almost immediately drop the toy and forget about it. CNA 2 and CNA 3 explained that Resident 89 did not know to search for the toy once he had dropped it, so this approach had not been successful. CNA 2 stated he had asked the Licensed Vocational Nurse (LVN) charge nurse for mittens, but nothing came of it. CNA 3 assisted in visualizing Resident 89's fingers, it was observed that the fingernails on the left hand's thumb and first three fingers were severely affected. They were misshapen and deformed, exhibiting significant yellow discoloration, thickening, brittleness, and a crumbly texture. Furthermore, some of the affected fingernails had separated from the underlying nail bed. CNA 3 stated Resident 89 had chewed his left hand fingers a lot and had just started chewing on his right hand. Resident 89's right two fore fingers' nails and skin still looked healthy. During an observation and interview with the Interim Director of Nursing (IDON) on December 4, 2025, from 9:33 AM to 10:01 AM, the IDON stated she was not aware Resident 89's finger chewing had escalated to this point. The IDON stated there was no assessment on the fingernails on the Resident 89's left hand. This should have been picked up on the skin assessments and brought to the attention of the physician and then the wound nurse and it was not. The IDON stated when the CNAs did not get a response from the charge nurse they should have gone up the chain to the Registered Nurse (RN) supervisor and not waited this long to tell her on Monday December 1, 2025, that Resident 89 had a problem. The IDON stated there was no care plan to address this issue. After examining Resident 89's left hand fingernails, the IDON stated, This didn't happen overnight. The IDON stated Resident 89's finger-chewing behavior and nail deterioration should have been assessed and included in a care plan but were not. A review of the facility's policy and procedure (P&P) titled, Care Planning, dated January 25, 2025, indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 8. When (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 9. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents ' conditions change. 10. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS [Minimum Data Set] assessment as needed.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that physician's orders were followed for one of one resident (resident 11) reviewed for antibiotic use when the monitoring and documentation of intake and output (I&O) was not done as ordered by the physician. This failure resulted in an incomplete assessment and monitoring of Resident 11's hydration status and fluid balance while on the antibiotic (medication used to treat infections). Findings: A review of Resident 11's admission Record (contains medical and demographic information), indicated Resident 11 was admitted to the facility on [DATE], with diagnoses which included pneumonia (a lung infection), quadriplegia (paralysis affecting all four limbs), Chronic Obstructive Pulmonary Disease (a condition involving constriction of the airways and difficulty in breathing). During a review of Resident 11's care plan (an individualized plan for the medical care of a resident) titled, The resident has a Urinary Tract Infection r/t cloudy urine, lethargy (lack of energy) and generalized malaise (an overall feeling of being unwell), dated November 11, 2025, the care plan indicated, Goal. the resident will be free of symptoms of dehydration. Interventions. Encourage adequate fluid intake. During a review of Resident 11's care plan titled, The resident has potential for fluid deficit r/t [related to] PNA [pneumonia], dated October 4, 2025, the care plan indicated, Goal. The resident will be free of symptoms of dehydration. Interventions. Administer medications as ordered. Monitor/document for side effects and effectiveness. Educate the resident/family/caregivers on importance of fluid intake. Monitor/document/report PRN [as needed] any s/sx [signs and symptoms] of dehydration: decreased or no urine output. During a review of Resident 11's physicians orders, an order dated November 11, 2025, indicated Ertapenem sodium injection [an antibiotic] Solution reconstituted [the process of adding a diluent or solvent to a dry, powdered, or concentrated medication to create a usable liquid solution or suspension for administration] inject 1 gram [gm -unit of measure] intramuscularly [administered into the muscle] one time a day for UTI [urinary tract infection] for 5 [five] days with lidocaine [a numbing agent]. During a review of Resident 11's physicians orders, an order dated November 12, 2025, indicated Monitor intake and output every shift for antibiotic use until 11/16/2025 [November 16, 2025]. During a review of Resident 11's intake and output record titled, Documentation Survey Report V2, dated November 2025, the document indicated intake volumes were not documented by staff for three of ten (3 of 10) shifts between November 12, 2025, and November 16, 2025. Additionally, there was no output documentation found anywhere in Resident 11's medical record for the ten shifts between November 12, 2025, and November 16, 2025. During a concurrent interview and record review on December 3, 2025, at 2:47 PM, with the Director of Nursing (DON), Resident 11's intake and output record titled, Documentation Survey Report V2, dated November 2025, was reviewed. The DON acknowledged there were three of ten shifts where intake was not documented. Additionally, the DON acknowledged there was no output documentation noted for any of the ten shifts from November 12, 2025, through November 16, 2025. The DON stated nursing staff were supposed to document intake and output each shift as ordered by the physician, but they had not. During a concurrent interview and record review on December 3, 2025, at 2:48 PM, with the Corporate Medical Records Staff (CMR), Resident 11's entire electronic health record (EHR) was reviewed. The CMR acknowledged there were three shifts between November 12, 2025 and November 16, 2025, where input was not documented. The CMR stated output was not documented at all by staff, but should have been. During a review of the facility's policy and procedure (P&P) titled, Intake and Output, revised January 2025, the P&P indicated, It is the policy of this facility to maintain an intake and output record when needed to monitor residents for adequate fluid balance. Intake and output shall be recorded by each shift.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two residents (Resident 3) reviewed for pressure ulcers (injury to skin and underlying tissues that develops as a result of prolonged pressure, shear, or friction) had a low air loss mattress (LAL mattress - a specialized mattress which is air filled and is designed to help prevent and treat pressure ulcers) which was programmed to Resident 3's weight. This failure resulted in the low air loss mattress to not have the most therapeutic effect for the prevention and treatment of pressure ulcers and for Resident 3 to have increased risk for the development of new pressure ulcers and a delay in wound healing. Findings: A review of Resident 3's admission Record (contains medical and demographic information), indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included heart failure, methicillin resistant staphylococcus aureus infection (an infection caused by an antibiotic-resistant bacteria), diabetes mellitus type 2 (a metabolic disorder characterized by persistent high blood sugar levels), and cellulitis of the left and right lower limbs (a bacterial infection of the skins deeper layers and underlying tissues). During a concurrent observation and interview on December 1, 2025, at 10:58 AM, Resident 3 was lying in bed on a low air loss mattress. The mattress was set to 360 pounds (lbs - unit of measure). Resident 3 stated he weighed approximately 275 lbs and that he was on the LAL mattress because he occasionally had bed sores and pressure ulcers. During a concurrent observation and interview on December 1, 2025, at 11:03 AM, with the Interim Director of Nursing (DON), the DON reviewed Resident 3's Electronic Health Record (EHR) and stated Resident 3 weighed 276 lbs. The DON stated the setting of the LAL mattress was supposed to be according to the physician's order and if there was no specific setting indicated in the physician's order, it was supposed to be set to the resident's body weight. The DON reviewed Resident 3's order for the LAL mattress and stated since there were no parameters for settings in the order, Resident 3's LAL mattress was supposed to be set to his body weight. The DON further stated the LAL mattress and its appropriate use was important to help prevent skin breakdown and to promote healing of wounds. During a concurrent observation and interview on December 1, 2025, at 11:08 AM, with the DON, Resident 3's LAL mattress was observed to be set to 360 lbs. The DON acknowledged the mattress was set to 360 lbs and stated the mattress was supposed to be set to 240 lbs. The DON then showed a label on the LAL mattress unit which stated Setting 240. The DON stated 240 lbs was the closest selectable level to the residents weight of 275 lbs. The DON further stated the wound care nurse puts the label on each LAL mattress to ensure the staff know what weight it was supposed to be programmed to. The DON stated she was not sure why Resident 3's LAL mattress was set incorrectly. During a review of Resident 3's EHR, the residents most recent weight documented in the vitals and weights portion of the EHR was recorded as 276 lbs on November 9, 2025. During a review of Resident 3's physician's orders, an order dated October 28, 2025, indicated, Low air loss mattress for itssue [tissue] load management, check placement, motor and setting every shift. During a review of Resident 3's care plan (an individualized plan for the medical care of a resident) titled, At risk for regression related to admitted with multiple pressure injuries, vascular ulcers. episodes of refusing to reposition, noncompliance with turning and repositioning and off loading of bilateral leg Dated October 28, 2025, the care plan included the intervention, Administer treatments as ordered and monitor for effectiveness. LAL mattress to promote tissue load management. During a review of Resident 3's Treatment Administration Record (TAR - a document used to record treatments administered to the resident), dated November 2025, the TAR indicated a task for, Low air loss mattress for itssue [tissue] load management, check placement, motor and setting every shift. For 26 out of 27 shifts between November 1, 2025, through November 30, 2025, staff documented that the LAL mattress was set to between 360 lbs and 370 lbs. Additionally, three shifts had blanks and were incomplete. During a concurrent interview and record review on December 3, 2025, at 2:35 PM, with the DON, Resident (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3's TAR dated November 1, 2025, through November 30, 2025, was reviewed. The DON stated the nurses were supposed to document the current LAL mattress setting on the TAR and acknowledged the setting documented was between 360 and 370 lbs and was incorrect because the resident weighed 275 lbs in November 2025. The DON further stated nurses were supposed to be monitoring the residents weight and ensuring the LAL mattress was set per the residents weight, but it was not done. During a review of the facility's policy and procedure (P&P) titled, Low Air Loss, Alternating Pressure Pad or Mattress, dated January 2025, the policy indicated, It is the policy of this facility to prevent and treat pressure ulcers, alternate pressure under bony prominences and provide resident comfort. 4. Low Air Loss mattress will be set up and serviced according to manufacturer's recommendations. During a review of the manual for Resident 3's low air loss mattress titled, [brand name] Operation Manual for Protekt Aire 4000DX/5000DX, (undated), printed December 1, 2025, the operators manual indicated, The Protekt Aire 4000DX/5000DX system is intended to reduce the incidence of pressure ulcers while optimizing patient comfort. Product Function. Press up or down buttons to select the correct patient weight.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure controlled substances (a drug or medication whose use is strictly regulated by the government due to its high potential for abuse) were reconciled accurately and in accordance with facility's policy and procedure (P&P), when a licensed nurse signed the facility's narcotics reconciliation log prior to completing the required physical count of the controlled substances. This failure had the potential to result in inaccurate accountability of controlled medications, delayed identification of discrepancies, and risk for medication diversion (the unauthorized use of a medication by someone other than whom it was prescribed for). Findings: During an observation on December 3, 2025, at 7:12 AM, the narcotic reconciliation log titled, Controlled Drugs - Count Record (narcotic reconciliation log for the medication cart in the 400 hall), dated December 2025, the log was signed by the PM shift nurse (Licensed Vocational Nurse 1 [LVN 1]) for the 7am - 7pm shift but the AM shift nurse (LVN 2) had not yet signed the log and the physical count of the narcotics had not yet been performed by LVN 1 or LVN 2. During an interview on December 3, 2025, at 7:16 AM, with the Director of Nursing (DON), the DON stated nurses were supposed to sign the controlled drug reconciliation record after physically counting the controlled drugs and after verifying the count of the medications. During an interview on December 3, 2025, at 7:27 AM, with LVN 2, LVN 2 stated the normal process for reconciliation of controlled medications was that the AM and PM nurses (the nurse coming off shift and the nurse coming on shift) count the physical medications and then sign the reconciliation log after the count is verified. LVN 2 further stated the controlled substances log dated December 3, 2025, 7am-7pm shift was already signed by LVN 1 (PM nurse) but the physical counting of the medications had not yet been done. LVN 2 stated the counting of the controlled substances was supposed to be done concurrently (at the same time) with both the PM nurse (LVN 1), and AM nurse (LVN 2). During an interview on December 3, 2025, at 7:38 AM, with LVN 1, LVN 1 stated she signed the controlled substances reconciliation log titled, Controlled Drugs - Count Record, dated December 2025, for the med cart in the 400 hall, prior to performing the physical count of the controlled substances. LVN 1 further stated the facility policy was that the PM nurse and the AM nurse were supposed to count the controlled substances together first, then both nurses would sign the log. LVN 1 again acknowledged that she had signed the reconciliation log prior to physically counting the medications. During concurrent interview and record review on December 3, 2025, at 8:04 AM, with the DON, the facility's policy and procedure (P&P) titled, Narcotic Count, dated January 2025, was reviewed. The P&P indicated, It is the policy of this facility to justify amount of narcotics remaining when control of supply is released to nurse coming on duty. 1. One RN [registered nurse] or one LVN/LPN [licensed vocational nurse/licensed practical nurse] going off duty and one RN or one LVN/LPN coming on duty must count and justify narcotics supply for each individual resident at the change of each shift. 2. After the supply is counted and justified, each nurse must record the date and his/her signature verifying that the count is correct. The DON stated the policy and procedure was not followed by staff.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide evidence it received, documented, and acted upon pharmacist recommendations of monthly medication regimen reviews (a pharmacist evaluation of a patient's entire medication regimen with recommendations in order to identify potential problems with ineffective drugs, harmful interactions, incorrect dosages etc.) for one of five residents (Resident 8) reviewed for unnecessary medications. This failure resulted in Resident 8 to be at increased risk for irregularities in the resident's medication regimen to go unidentified and uncorrected which could result in adverse drug effects and avoidable negative outcomes for the resident. Findings: During a review of Resident 8's admission Record (contains medical and demographic information), the admission Record, indicated Resident 8 was initially admitted to the facility on [DATE], with diagnoses which included hypertensive heart disease (heart problems that occur because of high blood pressure present over a long period of time), major depressive disorder (a serious mood disorder causing persistent sadness, loss of interest, and significant impact on daily life), anxiety disorder (a condition characterized by excessive fear or apprehension), and schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). During a review of the facility document titled, Current Resident Listing for [name of the facility] with Medication Regimen Review activity between 9/1/25 and 9/27/25, (a document which indicates which residents' medication regimens were reviewed by the consultant pharmacist for the month of November) dated November 27, 2025, the document included the name of Resident 8 indicating the pharmacist did perform a review of Resident 8's medications for September 2025. During a review of the facility document titled, Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations, dated September 1, 2025, through September 27, 2025, the document did not include the name of Resident 8 which meant the pharmacist had recommendations regarding Resident 8s medication regimen for September 2025. During a review of the facility document titled, Current Resident Listing for Indiana [Indian] Canyon Post Acute with Medication Regimen Review activity between 8/1/25 and 8/27/25, dated August 27, 2025, the document included the name of Resident 8 indicating the pharmacist did perform a review of Resident 8's medications for August 2025. During a review of the facility document titled, Consultant Pharmacist's Medication Regimen Review: Listing of Residents Reviewed with No Recommendations, dated August 1, 2025, through August 27, 2025, the document did not include the name of Resident 8 which meant the pharmacist had recommendations regarding Resident 8s medication regimen. During a review of Resident 8's electronic medical record, the pharmacist's recommendations regarding Resident 8's monthly medication regimen review for September 2025 and August 2025, was not found. During an interview on December 4, 2025, at 1:30 PM, with the Director of Nursing (DON), Resident 8's consultant pharmacist medication regimen review recommendations for September and August of 2025, were requested. The DON stated she was unable to find evidence of the pharmacist's recommendations for Resident 8's medication regimen review for September and August of 2025. The DON further stated she usually printed the pharmacist recommendations and provided them to the medical records department for follow up but states they were unable to find the recommendations. The DON further stated the consultant pharmacist would have sent her recommendations for Resident 8 for September and August of 2025 since the resident was not on the no recommendations lists for those months. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review (MRR), dated January 25, 2025, the P&P indicated, 1. The drug regimen of each resident, which includes a review of the resident's medical chart; will be reviewed at least once a month by a licensed pharmacist; 2. Irregularities will be documented on a separate written report; that is sent to the attending physician, (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's medical director and the director of nursing services and lists the resident's name, the relevant drug, and the irregularity the pharmacist identified. These reports will be acted upon. Procedure: 1. The pharmacist reviews each resident's medication regimen at least once a month in order to identify irregularities and to identify clinically significant risks and/or adverse consequences resulting from or associated with medications.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident 3's antibiotic medication (medication used to treat an infection) was labeled appropriately per facility's policy and procedure (P&P). This failure had the potential to result in administration errors, including administration of the wrong medication, wrong dose, wrong resident, or administration outside the ordered timeframe, thereby affecting Resident 3's safety. Findings: A review of Resident 3's admission Record (contains medical and demographic information), indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included heart failure, methicillin resistant staphylococcus aureus infection (an infection caused by an antibiotic-resistant bacteria), diabetes mellitus type 2 (a metabolic disorder characterized by persistent high blood sugar levels), and cellulitis of the left and right lower limbs (a bacterial infection of the skins deeper layers and underlying tissues). During a concurrent observation and interview on December 1, 2025, at 11:04 AM, with the Director of Nursing (DON), in Resident 3's room, Resident 3 was lying in bed and had an intravenous (IV - medication administered into the veins) bag of vancomycin (antibiotic medication) which had already been administered and was hanging at his bedside. The vancomycin antibiotic had no pharmacy label on it and had a label attached to it which indicated medication added, with the residents last name, room number, date, and time indicated on it. The medication added, label was left blank where it indicated, drug, amount, added by, rate, and base sol'n [solution]. The DON stated the IV antibiotic was not labeled correctly and only had the patient's last name, date and time of administration, and room number indicated on it. During a follow up interview on December 1, 2025, at 11:11 AM, with the DON, the DON stated the nurse who administered the vancomycin IV antibiotic was supposed to remove the pharmacy label from the foil pouch the vancomycin came in and apply it to the vancomycin bag once removed from the pouch, but it was not done. During an interview on December 3, 2025, at 11:50 AM, with the Consultant Pharmacist (CP), the CP stated IV vancomycin comes in a foil pouch which has a patient specific label affixed to the outside of the foil pouch. The CP further stated when the medication bag is removed from the foil pouch for administration to the patient, staff was supposed to remove the patient specific pharmacy label on the foil pouch and apply it to the medication bag. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - Intravenous (IV) Administration of Drugs via Central Venous Catheters (CVC) or Peripherally Inserted Central Catheters (PICC), dated January 2025, the P&P indicated, .8. IV medications must be labeled in accordance with established procedures governing all labeling IV medications and IV solutions. During a review of the facility's P&P titled, Labeling and Storage of Drugs, revised January 2025, the P&P indicated, It is the policy of this facility that medications and biologicals are labeled in accordance with facility requirements, state and federal laws. 1. Each prescription medication label includes: resident's name, specific directions for use, including route of administration, strength of medication. Injectables: strength per ml (cc) and the amount to be given in mls [milliliters - unit of measure] equivalent on label, physician's name, date medication is dispensed, quantity, expiration date, name, address, and telephone number of provider pharmacy, prescription number, accessory label indicating storage requirements and special procedures. Example: shake well; Take on empty stomach. container number and total number of containers. when multiple containers are dispensed for one prescription.		

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 12/04/2025
NAME OF PROVIDER OR SUPPLIER Indian Canyon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 57333 Joshua LN 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)		
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review, the facility failed to provide special eating equipment in the form of an adaptive drinking aid for one sampled resident (Resident 89) when Resident 89, diagnosed with dysphagia (difficulty swallowing), was provided regular standard straws to drink thin fluids instead of a nosey cup (a cup with a U-shaped cutout on one side of the rim, which provides clearance for the nose and allows individuals to drink fluids without tilting their head or neck backward) during his lunch time meal. This failure had the potential to cause Resident 89 to choke, as standard straws deliver liquids quickly and encourage a head-back position that opens the airway. In contrast, the nosey cup encourages a chin-tucked position, reducing the risk of aspiration pneumonia an infection from fluids entering the lungs. Findings: A review of Resident 89's face sheet (a document that gives a summary of resident's information), undated, indicated an admission date of October 3, 2023. Resident 89 had diagnoses that included dysphagia. During a dining observation and interview with a Certified Nursing Assistant 1 (CNA 1) and Resident 89 on December 1, 2025, at 12:28 PM, Resident 89 was seated at a table in the dining room, and CNA 1 was helping him eat his lunch. A meal card on the table indicated that Resident 89 should use a nosey cup. However, he had a small milk carton with a regular straw and a regular cup of juice covered with cellophane, also with a regular straw poked through. CNA 1 helped Resident 89 drink using these regular straws and stated that Resident 89 did not have a nosey cup, but she did not know why. During an interview with the Dietary Supervisor (DS) on December 1, 2025, at 12:35 PM, the DS confirmed that Resident 89's meal card specified the use of a nosey cup, but this had not been provided. The DS acknowledged that she had not informed the Interim Director of Nursing (IDON), Resident 89's physician, or the Director of Rehabilitation (Dir/Rehab) that Resident 89 had declined and was no longer holding the nosey cup. In addition, the DS admitted to substituting regular straws without obtaining an Occupational Therapy (OT) assessment for straw use or requesting nursing staff to obtain a new dietary order from Resident 89's physician. A review of Resident 89's physician's order dated January 8, 2024, indicated, . nosey cup . During an interview with the IDON on December 1, 2025, at 12:40 PM, the IDON stated she had not been informed of Resident 89's decline and the subsequent need for a new OT evaluation for adaptive equipment, as well as a new physician's order reflecting the recommendations from the new OT evaluation. During an interview with the Dir/Rehab on December 4, 2025, at 10:51 AM, the Dir/Rehab stated Resident 89 should have been re-evaluated before replacing the nosey cup with regular straws, and a new physician's order reflecting the re-evaluation findings should have been obtained. The Dir/Rehab confirmed that her department had not been informed, and no re-evaluation of Resident 89's eating and drinking needs had been conducted. A review of the facility's policy and procedure (P&P) titled, Occupational Therapy . Evaluation and Recommendation of Feeding Adaptive Devices, undated, indicated, I. PURPOSE: To ensure safe, appropriate, and clinically justified evaluation, selection, and recommendation of feeding adaptive devices for residents who have functional limitations affecting self-feeding . III. POLICY STATEMENT: Occupational Therapy will evaluate residents with difficulty in self-feeding and recommend adaptive feeding equipment when clinically indicated. All recommendations will be evidence-based, individualized, documented, and coordinated with the interdisciplinary team (IDT). IV. PROCEDURE: A. Referral and Screening, A feeding adaptive device evaluation may be initiated through physician, nursing, dietary referral, or OT observation. B. Occupational Therapy Evaluation: Complete a comprehensive self-feeding evaluation including ROM [Range of Motion], strength, coordination, posture, cognition, and vision. Review SLP [Speech Language Pathologist] recommendations, IDDSI [International Dysphagia Diet Standardization Initiative] diet, and swallowing safety. Assess environmental factors such as seating, table height, and lighting. Trial appropriate adaptive feeding devices. C. Recommendation and Implementation: Device selection must be based on functional abilities and goals. Educate resident, (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Indian Canyon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 57333 Joshua LN Yucca Valley, CA 92284	
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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	caregiver, nursing staff, and family. Notify nursing and dietary of device recommendations. D. Documentation Requirements: Document evaluation findings and clinical justification. Devices trialed and resident response. Final recommendations and goals. Education provided and care plan updates.		