| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **055307** | A. BUILDING _____ B. WING _____ | **08/04/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **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) |
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| F 0604<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure residents were free from physical restraints when a gait belt (an assistive safety device that is secured around a person's waist to assist in lifting or moving a person) was used to secure a resident to their wheelchair for one of three sampled residents (Resident 1). This deficient practice had the potential to result in entrapment and impact the psychosocial wellbeing of Resident 1. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Quarterly Minimum Data Set (MDS - a standardized assessment and screening tool) dated 3/19/20, indicated the resident had severely impaired cognition (mental process of thinking and understanding). A review of the Resident Grievance/Complaint Investigation Report, dated 6/6/20, indicated Resident 1 was found with a gait belt around her abdomen connected her to the wheelchair. A review of Certified Nurse Assistant (CNA) 1's written statement, dated 6/6/20, indicated Resident 1 was very agitated and tried to leave the facility. CNA 1's written statement indicated that CNA 1 placed the gait belt on Resident 1. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 7/30/20, at 3:34 p.m., LVN 1 stated on the morning of 6/6/20, he saw Resident 1 sitting in her wheelchair with a gait belt wrapped around her and the wheelchair. LVN 1 stated the gait belt was being used to secure Resident 1 to the wheelchair so the resident was unable to get out of the wheelchair. LVN 1 stated he immediately wheeled Resident 1 to the nurses' station to show Registered Nurse 1 (RN 1). LVN 1 stated he also sent a message to the Administrator (ADM). According to LVN 1, he reported this incident to RN 1 and the ADM because it was an improper use of the gait belt. LVN 1 stated a gait belt should only be used to assist in transferring residents or assisting with mobility. During an interview with the Administrator (ADM) on 6/29/20, at 1:08 p.m., the ADM stated she was aware of the incident and an investigation was conducted by the manager on duty for that weekend. The ADM stated Resident 1 did not have an order for [REDACTED]. shall be used. According to the policy and procedure, a physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The policy and procedure further indicated there must be a physician's orders [REDACTED]. |
| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to report an allegation of staff to resident abuse to the state agency (Department of Public Health) for one of three sampled residents (Resident 1). This deficient practice resulted in a delay of an onsite inspection by the Department of Public Health to ensure the safety of Resident 1 and the other residents in the facility. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Quarterly Minimum Data Set (MDS - a standardized assessment and screening tool) dated 3/19/20, indicated the resident had severely impaired cognition (mental process of thinking and understanding). A review of Certified Nurse Assistant (CNA) 1's written statement, dated 6/6/20, indicated Resident 1 was very agitated and tried to leave the facility. CNA 1's written statement indicated CNA 1 placed the gait belt on Resident 1. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 7/30/20, at 3:34 p.m., LVN 1 stated on 6/6/20, he saw Resident 1 sitting in her wheelchair with a gait belt (an assistive safety device that is secured around a person's waist to assist in lifting or moving a person) wrapped around the resident and the wheelchair. LVN 1 stated the gait belt was being used to secure Resident 1 to the wheelchair so the resident was unable to get out. LVN 1 stated he immediately wheeled Resident 1 to the nurses' station to show Registered Nurse 1 (RN 1). LVN 1 stated he sent a message to the Administrator (ADM). According to LVN 1, he reported this incident to RN 1 and the ADM because it was an improper use of the gait belt as well as mistreatment of [REDACTED]. The ADM further stated after discussing the incident with the facility's consultant, they determined it was a restraint issue and not an abuse issue and therefore did not report the incident to the Department of Public Health. A review of the facility's policy and procedure titled, Abuse Prevention and Prohibition Program, revised 1/30/20, indicated each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The policy and procedure also indicated the facility will report allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime. i. Immediately, but no later than 2 hours - if the alleged violation involves abuse or results in serious bodily injury to the state survey agency, law enforcement, and the Ombudsman. ii. No later than 24 hours - if the alleged violation (e.g., misappropriation of property, neglect) does not involve abuse and does not result in serious bodily injury to the state survey agency, law enforcement, and the Ombudsman. |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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.