

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056229	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024
NAME OF PROVIDER OR SUPPLIER Palm Springs Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 277 S Sunrise Way Palm Springs, CA 92262	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000</p> <p>Based on observation, interview, and record review, the facility failed to accommodate the needs for one of three sampled residents (Resident 2), when the call light button was observed not within reach.</p> <p>This failure had the potential for Resident 2 not to be able to call staff for assistance which could result in unmet resident's needs.</p> <p>Findings:</p> <p>On September 4, 2024, at 9:45 a.m., during an observation and concurrent interview with Resident 2, the resident's call light button was observed hanging on the wall behind the resident's bed. Resident 2 stated he was not sure where the call light was.</p> <p>On September 4, 2024, at 10:02 a.m., an observation and concurrent interview was conducted with Certified Nursing Assistant (CNA) 1, CNA 1 agreed the resident (Resident 34) was not able to reach the call light, and the call light should be within reach. CNA 1 stated that the call light should not be hanging on the wall behind the bed. CNA 1 further stated Resident 2 can fall or not be able to get assistance and he (Resident 2) would need to use the call light to let us know what he needs.</p> <p>On September 4, 2024, at 10:05 a.m., an observation and concurrent interview was conducted with Licensed Vocational Nurse (LVN) 1, LVN 1 acknowledged that call light should not be hanging on the back of the bed and was not in reach of the resident. LVN 1 stated the risk associated with Resident 2's call light not being within reach increases his risk of fall and injuries. LVN 1 further stated Resident 2 could hurt is arm reaching for it and if there was an emergency, it would take longer for him to get help.</p> <p>Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses that included fracture (a complete or partial break in a bone) of the pelvis and age-related osteoporosis (when bones become weak and brittle).</p> <p>An undated facility policy and procedure, titled Call Lights-Answering Of, undated, indicated . Facility staff will provide an environment that helps meet the Resident's needs. The policy and procedure further indicated . ensure that the call light is placed within the Resident's reach .</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000</p> <p>Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was assessed timely following an unwitnessed fall. The facility also failed to provide notification to the physician following an unwitnessed fall.</p> <p>This failure had the potential for Resident 1 to experience a delay in the provision of care and complications such as, pain, bruising, scratches, lacerations (a deep cut or tear in skin), and fractures (a complete or partial break in a bone).</p> <p>Findings:</p> <p>On September 4, 2024, at 8:45 a.m., an unannounced visit was conducted at the facility to investigate a facility reported incident.</p> <p>Resident 1 was unavailable for an interview or observation due to being transferred out of the facility to a general acute care hospital (GACH) on August 18, 2024.</p> <p>A review of Resident 1's facility medical record indicated she was admitted to the facility on [DATE], with diagnoses that included osteoporosis (causes bones to become weak and brittle), cerebral infarction (stroke) and contracture of muscles (a shortening of muscles, tendons, or skin).</p> <p>On September 4, 2024, at 12:59 p.m., an interview was conducted with the facility's Respiratory Therapist (RTT). The RTT stated on August 15, 2024, at approximately 7:30 p.m., he overheard someone calling out for help. The RTT stated he went to Resident 1's room to investigate and found two Certified Nurse Assistants (CNAs) holding her at ground level attempting to get her back in bed. The RTT stated he entered Resident 1's room to assist the two CNAs. The RTT stated he informed the Licensed Vocational Nurse (LVN) Charge Nurse that there was an incident in Resident 1's room. The RTT stated he was informed by the two CNAs that the resident slid out of bed. The RTT stated he informed the LVN Charge Nurse the area where Resident 1 was located and what happened.</p> <p>On September 4, 2024, at 1:29 p.m., a telephone interview was conducted with CNA 2. CNA 2 stated she did work at the facility on Thursday, August 15, 2024, and was assigned to take care of Resident 1. CNA 2 stated she was providing care to another resident when she heard screaming coming from Resident 1's room. CNA 2 stated she when to Resident 1's room to investigate and found that half of Resident 1's body was on the floor and her head and chest were still on the bed. CNA 2 stated another CNA (CNA 3) came into the room to assist her. CNA 2 stated when the other CNA came in to help, she ran out of the room and told the Licensed Vocational Nurse (LVN) Charge Nurse what she found. CNA 2 stated she heard CNA 3 state to the LVN charge nurse that it was important that she come and see Resident 1. CNA 2 stated it was her understanding that the nurse should come to the room to check the patient if something like that happened. CNA 2 stated that she never saw the nurse enter Resident 1's room. CNA 2 stated the resident did not complain of pain but expressed that she was scared.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On September 4, 2024, at 1:41 p.m., a telephone interview was conducted with the LVN Charge Nurse (LVN 2). LVN 2 stated she worked at the facility for approximately one month. LVN 2 stated she received training on resident rights and resident safety upon hire at the facility. LVN 2 further stated she was no longer employed at the facility. LVN 2 stated she was assigned to provide care for Resident 1 on August 15, 2024. LVN 2 stated there was no incident that occurred that was out of the ordinary and there were no incidents that were reported to her on August 15, 2024. LVN 2 denied being told that there were any changes with Resident 1.</p> <p>On September 4, 2024, at 1:41 p.m., a telephone interview was conducted with CNA 3. CNA 3 stated she did work at the facility on August 15, 2024, but was not assigned to take care of Resident 1 that day. CNA 3 stated on August 15, 2024, she was picking up all the trays from dinner and heard the sound of screaming. CNA 3 stated CNA 2 was in Resident 1's room trying to help Resident 1 back in bed. CNA 3 stated she began helping CNA 2, when the RTT entered the room and began to help. CNA 3 stated they called the nurse and informed her of what happened. CNA 3 stated she was not aware if the nurse went to see that resident but the LVN Charge Nurse was told about the incident.</p> <p>On September 4, 2024, at 2:54 p.m., an interview was conducted with Registered Nurse (RN) 2. RN 2 stated she did work at the facility on Thursday, August 15, 2024. RN 2 stated if a CNA or other facility staff reports a fall or unusual occurrence to the LVN charge nurse, an assessment of the resident should be completed immediately. RN 2 further stated that it is the expectation that the LVN charge nurse notify the Nursing Supervisor immediately. RN 2 further stated the risk associated with failing to immediately assess the resident is that an injury or change in the resident's condition could be missed. RN 2 also stated that the physician and resident's family should have been notified when the fall occurred.</p> <p>On September 4, 2024, at 3:11 p.m., an interview was conducted with the facility Administrator (ADM). The ADM stated it is the expectation that the LVN charge nurse complete an assessment and notify the Nursing Supervisor if there is any reported fall or change in the resident's condition. The ADM further stated that Resident 1's physician and family should have been notified of the incident.</p> <p>On September 5, 2024, at 11:08 a.m., a telephone interview was conducted with the facility's Medical Director (MD) who stated he did not receive any notice of Resident 1's fall on August 15, 2024.</p> <p>A review of Resident 1's facility medical record did not indicate any documentation of the incident or notification to the physician on August 15, 2024.</p> <p>A review of the facility's policy and procedure titled Changes in Resident Condition, undated, was reviewed. The policy indicated .the resident, attending Physician and resident representative .are notified when changes in condition or certain events occur. Communication with the interdisciplinary team and direct care staff is also important to ensure that consistency and continuity of care are maintained. The policy and procedure also indicated .The Licensed Nurse will contact the Physician based on the urgency of the situation . The facility policy further indicated .Changes in condition will be documented in the Change of Condition form or Nurses' Progress notes every shift .</p>		