

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 05/29/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate reconciliation of the controlled medication that had been administered for two of three sampled residents (Residents 2 and 3).</p> <p>This failure increased the risk for medication error, which could negatively impact the residents' health condition.</p> <p>Findings:</p> <p>A review of Resident 2's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included fracture (break in the bone) of right humerus (upper arm bone).</p> <p>A review of Resident 2 ' s Physician Order Report, for May 2025, indicated, oxycodone (narcotic medication) - Schedule II tablet; 5 mg (milligram-unit of measurement); amt (amount): 1 tab; oral Special Instructions: Dx (diagnosis) Moderate pain 5-6 (pain level), Severe pain 7-10 (pain level) Every 4 (four) Hours - PRN . Further review of the physician order report indicated the medication was ordered on May 2, 2025.</p> <p>On May 29, 2025, at 10:20 a.m., during an interview, Licensed Vocational Nurse (LVN) 1 stated when administering narcotics, the nurses are expected to sign on the narcotic sheet that they removed the medication and then sign the Medication Administration Record (MAR) after administering the medication.</p> <p>During a concurrent review of Resident 2' s narcotic sheet and electronic MAR for May 2025, LVN 1 stated Resident 2' s Oxycodone was removed from the medication cart on the following dates and times:</p> <ul style="list-style-type: none"> a. May 6, 2025, at 8:39 a.m., and 8:45 p.m.; b. May 7, 2025, at 6:50 a.m. and 11:30 a.m.; c. May 8, 2025, at 9:34 a.m.; and d. May 11, 2025, at 11:54 p.m. <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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>LVN 1 stated oxycodone was not documented in the MAR as administered on May 6, May 7, May 8, and May 11, 2025. LVN 1 stated the licensed nurses should sign the MAR that they administered the medication.</p> <p>A review of Resident 3's admission record, indicated the resident was initially admitted to the facility on [DATE], and was re-admitted on [DATE], with diagnoses which included urinary tract infection.</p> <p>A review of Resident 3's Physician Order Report, for May 2025, indicated, acetaminophen-hydrocodone (Norco - narcotic) 325-5 mg tablet; 5/325 MG; amt: 1 tab; oral Special Instructions: PRN Moderate pain (SCALE 5-6) OR Severe pain (SCALE 7-10) .Every 4 Hours - PRN . The physician order report indicated the medication was ordered on April 9, 2025.</p> <p>On May 29, 2025, at 11:07 a.m., during an interview and record review of Resident 3 ' s narcotic sheet and electronic MAR for May 2025, the Infection Preventionist (IP) stated, Resident 3 ' s Norco was removed from the medication cart on May 1, 2025, at 4:35 p.m., on May 13, 2025, at 12:47 p.m., and May 14, 2025, at 8:57 a.m., but was not documented on the MAR as administered. The IP stated the practice was when narcotics were given, the licensed nurses should be signing the MAR.</p> <p>On May 29, 2025, at 2:15 p.m. during an interview, the Director of Nursing (DON) stated the licensed nurses should sign the narcotic sheet and the MAR when they administer narcotic medications. The DON stated the facility policy for Controlled Substances should be followed.</p> <p>On May 29, 2025 at 3:40 p.m., during a concurrent interview with LVN 2 and a record review of Residents 2 and 3's narcotic sheet and MAR, LVN 2 stated he would document narcotics administration on the narcotic sheet and on the MAR. LVN 2 stated he administered Resident 3's Norco on May 1, 2025 and Resident 2's oxycodone on May 6, 2025, but he did not document on the MAR. LVN 2 stated he probably got busy and he should have documented on Residents 2 and 3's MAR.</p> <p>A review of the facility policy and procedure titled, Controlled Substances, dated November 2017, indicated . Controlled Medications are . medications are subject to special handling, storage, disposal, and record keeping at the nursing care center, in accordance with federal and state laws and regulations . When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage .Date and time of administration .Amount administered .Signature of the nurse administering the dose .Administer the controlled medication and document dose administration on the MAR .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement proper infection control precaution in accordance with the facility policy and procedure, when one of nine residents (Resident 1) was identified positive of carbapenem-resistant pseudomonas aeruginosa (CRPA - a type of bacteria resistant to a powerful class of antibiotics) on March 28, 2025.</p> <p>This failure had the potential to negatively impact the vulnerable residents in the subacute care (a level of care needed by a resident who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility) unit.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated the resident was initially admitted in the facility on September 28, 2024, and re-admitted on [DATE], with diagnoses which included respiratory failure with tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs) and resistance to carbapenems (occurs when bacteria defeat the antibiotic designed to kill them).</p> <p>A review of Resident 1's Sputum Culture, Final Update Result, dated March 28, 2025, indicated there was heavy growth of CRPA. A review of the same document indicated that the medical doctor (MD) was notified and ordered no antibiotics and for the staff to monitor.</p> <p>On May 28, 2025, at 12:15 p.m., during observation, there was contact precaution (used to prevent the spread of infections transmitted through direct or indirect contact with a patient or environment) and droplet precaution (used to prevent the spread of diseases that are transmitted through respiratory droplets generated by an infected individual when coughing and sneezing) signs posted outside the door of Resident 1's room. Resident 1 was lying in bed, turned to his left side, with tracheostomy connected to oxygen.</p> <p>On May 28, 2025, at 1:20 p.m., during an interview, Registered Nurse (RN) 1 stated on March 16, 2025, the resident had a fever and sputum culture was ordered and an antibiotic therapy was started. RN 1 stated the facility received the final sputum culture result on March 28, 2025, which indicated heavy growth of CRPA. RN 1 stated it was another RN who received the results. RN 1 stated there was no documentation in the progress notes that the RN notified the Infection Preventionist (IP) on Resident 1's sputum culture result. RN 1 stated the IP should be notified when a resident's laboratory result indicated CRPA.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 28, 2025, at 1:35 p.m., during an interview, the IP stated on April 22, 2025, RN 2 reported Resident 2 ' s sputum culture result which came out positive of CRPA on March 28, 2025. The IP stated she moved Resident 1 to a different room and placed the resident on contact and droplet precaution. The IP stated she did not receive any report that Resident 1 had CRPA before April 22, 2025. The IP stated Resident 1 should have been placed on contact isolation immediately on March 28, 2025. The IP stated contact isolation required for the staff to don PPE (Personal Protective Equipment) every time they would enter the residents ' room regardless of what they are going in for and residents have dedicated equipment such as blood pressure machine and stethoscope. The IP stated CRPA required contact isolation.</p> <p>On May 28, 2025, at 4:19 p.m., during an interview, the Director of Nursing (DON) stated the facility received Resident 1's sputum culture result but was not reviewed. The DON stated nothing was implemented until April 22, 2025. The DON stated the RN did not notify the IP when she received Resident 1's sputum culture. In addition, the DON stayed the RN should have reported the culture result to the IP and to the physician and document it.</p> <p>On May 29, 2025, at 11:25 a.m., during an interview, the IP stated Resident 1 was not on contact isolation for a month.</p> <p>A review of the undated facility policy and procedure titled, Carbapenem Resistant Pseudomonas Aeruginosa (CRPA), indicated, . The facility will adhere to the Centers for Disease Control and Prevention (CDC) guidelines for the surveillance, diagnosis, and treatment of Carbapenem-resistant Pseudomonas Aeruginosa (CRPA) . The facility will adhere to the CDC's recommendations to prevent CRPA transmission . Contact Precautions: Place CRPA colonized or infected residents on Contact Precautions (CP) .</p>		