

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 06/18/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a safe environment when:</p> <ol style="list-style-type: none"> 1. Use of siderails were not implemented in accordance with the siderail evaluation conducted on May 24, 2025, for Resident 2. 2. A physician order was not obtained to implement siderails for one of three sampled residents (Resident 1). <p>These failures had the potential to result in accidents or injury while in bed for Residents 1 and 2.</p> <p>Findings:</p> <p>On June 17, 2025, at 9:35 a.m., an unannounced visit was conducted to investigate a quality care issue.</p> <ol style="list-style-type: none"> 1. On June 17, 2025, at 9:44 a.m., an interview was conducted with the Administrator (ADM), who stated Resident 2 had an unwitnessed fall out of bed. The ADM stated the following: <ol style="list-style-type: none"> a. The staff heard a Thump from resident's room, and found resident face down on the floor, next to her bed. b. The nursing staff called 911, and resident was sent to the General Acute Care Hospital (GACH) for evaluation. c. The resident had a history of seizures and was supposed to have siderails on her bed for safety. d. The Unit Manager (UM) assessed Resident 2's bed, after the fall, and stated there were no siderails. <p>On June 17, 2025, at 2:30 p.m., an observation of Resident 2 was conducted. Resident 2 was observed resting in bed, connected to a ventilator, side rails noted on both sides of the bed. Resident 2 opened her eyes to the sound of this writer's voice, but unresponsive to questions.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 2's admission record dated, June 18, 2025, indicated resident was admitted to the facility on [DATE], with diagnoses which included respiratory failure with dependence on a ventilator, and epilepsy (A brain disorder that causes seizures).</p> <p>Further review indicated, the resident was discharged from the facility on May 21, 2025, and re-admitted to the facility on [DATE].</p> <p>A review of Resident 2's, Progress Notes, dated, June 2, 2025, at 3:47 a.m., edited at, 5:52 a.m., by Respiratory Therapist (RT), indicated, . (Resident 2) was found fallen out of bed onto face . Alerted all nearby staff . placed pillow under head as 911 was called. Gave report to (911) . hand off (of Resident 2) to (Emergency Medical Staff) .</p> <p>Further review of Resident 2's, Progress Notes, dated, June 2, 2025, at 5:46 a.m., by Registered Nurse (RN) 2, indicated, . RT heard loud thud . (RT) found (Resident 2) lying on right side next to bed on the floor. (RT) alerted staff and we assessed (resident), (resident) had a red right knee. (Resident 2) was still alert and appeared to have no change in mental status . (Resident in stable condition) . 911 was called at (4:50 a.m.). (Emergency Medical Staff) & (Fire Department) arrived at 4:58 (a.m.) . (Resident 2) was transferred to General Acute Care Hospital {GACH} at 05:07 (a.m.) .</p> <p>On June 17, 2025, at 2:55 p.m., an interview was conducted with Registered Nurse (RN) 1, who stated, residents with a history of seizures and required total care (total dependence on nursing staff for all care) have siderails for safety to help prevent falls out of bed. RN 1 stated, during the admission process, nursing staff would complete a siderail evaluation, and if the evaluation indicated resident required siderails for safety, the nurse would notify the physician, and upon receiving a physician order for siderails, siderails would be placed on the resident's bed.</p> <p>A review of Resident 2's re-admission progress note, dated, May 24, 2025, at 5:42 p.m., indicated, . re-admitted (Resident 2) at . 5:18 p.m., (May 24, 2025) from (GACH) .</p> <p>A review of Resident 2's Side Rail Evaluation, dated, May 24, 2025, at 10:20 p.m., indicated resident did require the use of siderails as a safety precaution.</p> <p>A review of Resident 2's physician dated, May 24, 2025, at 6:44 p.m., indicated resident had a physician order for, . Quarter side rails up . when in bed to minimize risk .</p> <p>On June 17, 2025, at 3:52 a.m., an interview was conducted with the Unit Manager (UM), who stated her expectations are for staff to keep residents safe. The UM further stated side rails were used to keep residents safe from falling out of bed.</p> <p>On June 17, 2025, at 5:35 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1, who stated, she was working on (June 2, 2025), when Resident 2 was found on the floor. LVN stated the RT called out for staff to help, and she went to resident's room, she observed Resident 2 face down on the floor next to her bed, and the bed had no side rails. LVN 1 further stated, she was Resident 2's nurse that night, and she did not see physician orders for side rails.</p> <p>Further review of Resident 2's physician orders, indicated resident's side rail orders were discontinued on May 25, 2025, at 6:22 a.m., and not renewed, prior to Resident 2 falling out of bed on June 2, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On June 18, 2025, at 11:58 a.m., a concurrent interview was conducted with the UM, and record review of Resident 2's side rail physician order. The UM verified Resident 2's physician order for the siderails was discontinued on May 25, 2025, and not renewed prior to resident falling out of bed on June 2, 2025. The UM stated, she was not sure why Resident 2's physician order for side rails was discontinued, but the order should have been renewed, as resident's side rail evaluation from May 24, 2025, indicated Resident 2 needed side rails for safety. The UM further stated, her expectations were for nursing staff to check the resident's previous side rail evaluation, physician orders, and should notify the physician if they think a resident is missing side rails on their bed.</p> <p>On June 18,2025, at 12:55 p.m., a concurrent interview with the Director of Nursing (DON), and record review of Resident 2's Side Rail evaluation completed on May 24, 2025, and physician orders was conducted. The DON verified, resident's Side Rail evaluation indicated, resident did require the use of siderails for Safety precaution. The DON further verified, Resident 2's physician order for side rails was discontinued on May 25, 2025, and not renewed, prior to resident's fall out of bed on June 2, 2025. The DON stated, her expectations were for nursing staff to check the last side rail evaluation to ensure residents have side rails if deemed necessary, make sure side rail physician orders were received following the evaluation, and should implement the side rails.</p> <p>A review of the facility policy and procedure(P & P) titled, Side Rails, undated, indicated, . An example of appropriate, medically necessary side rail use for a non-mobile resident might be protection from falls related to strong involuntary spasms or seizures . Nursing completes Side Rail Evaluation form . Obtain MD order, including diagnosis/medical necessity for use of restraint .</p> <p>A review of the facility P&P titled, Fall Management, undated, indicated, . Purpose: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to reduce the risk of the resident falling and to try to minimize complications from falling . The nursing staff, in conjunction with the attending physician . will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information . The nursing staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of fall .</p> <p>2. A review of Resident 1's admission record dated June 19, 2025, indicated the resident was admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure and dependence on a ventilator (a mechanical breathing device to assist with inadequate independent breathing).</p> <p>On June 17, 2025, at 2:55 p.m., during an interview, Registered Nurse (RN) 1 stated, residents with history of seizures and need total care (total dependence on nursing staff for all care) have siderails for safety to help prevent falls from bed. RN 1 stated, during the admission process, nursing staff would complete a siderail evaluation, and if the evaluation indicated resident would require siderails for safety, the nurse would notify the physician. RN 1 stated as soon as a physician order for siderails were obtained, then side rails would be implemented and placed on the resident's bed.</p> <p>A review of Resident 1's, Side Rail evaluation, dated, March 13, 2025, at 2:51 a.m., indicated, .Resident (1) require(s) the use of siderails(s) .</p> <p>A review of Resident 1's physician orders did not indicate an order for a side rail until April 8, 2025.</p> <p>(continued on next page)</p>		

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