

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/27/2024
NAME OF PROVIDER OR SUPPLIER Premier Care Center for Palm Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 2990 East Ramon Road Palm Springs, CA 92264	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000</p> <p>Based on interview and record review, the facility failed to address or update care plans with measurable goals and interventions to address gastrointestinal (GI) symptoms (nausea, vomiting, and diarrhea), for four of nine residents (Resident 1, 2, 6, 21).</p> <p>This failure had the potential for the staff not to be aware of the interventions implemented to address the residents' GI symptoms.</p> <p>Findings:</p> <p>On December 6, 2024, at 9:45 a.m., an unannounced visit was conducted at the facility for the investigation of a facility reported incident regarding infection control.</p> <p>1. On December 9, 2024, a review of Resident 1 ' s medical record was conducted. Resident 1 was admitted to the facility on [DATE], with diagnoses which included nutritional deficiency and anemia (low blood cell count).</p> <p>A review of Resident 1 ' s Progress Notes, dated November 21, 2024, at 2:35 p.m., indicated, .Patient noted to have 3 (three) episodes of vomiting and C/O (complaint of) nausea .new orders for Zofran (medication to treat nausea and vomiting) 4 mg (milligram - unit of measurement) and IV (intravenous - through the vein) NS (Normal Saline - types of fluid) x (times) 2 (two) days .</p> <p>A review of Resident 1 ' s care plans, initiated on November 21, 2024, indicated, .Potential Fluid Deficit related to nausea and vomiting . The care plan did not include interventions of IV hydration and Zofran.</p> <p>2. A review of Resident 2 ' s medical record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included heart failure.</p> <p>A review of Resident 2's Progress Notes, dated November 21, 2024, at 3:08 p.m., indicated the resident had diarrhea and the physician ordered for Resident 2 to be transferred to the acute hospital for further evaluation and treatment.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 2 ' s hospital records, indicated on November 22, 2024, at 1:40 p.m., lab results for Norovirus were detected, primary diagnosis was abdominal pain with colitis (colon swelling), and vomiting.</p> <p>A review of Resident 2 ' s care plans, indicated there was no care plan to address episodes of diarrhea.</p> <p>3. On December 9, 2024, a review of Resident 6 ' s medical record was conducted. Resident 6 was admitted to the facility on [DATE], with diagnoses which included nutritional deficiency and Type 2 diabetes mellitus (a condition with too much sugar in the blood).</p> <p>A review of Resident 6's Progress Notes, dated November 23, 2024, at 4:18 p.m., indicated Resident 6 had diarrhea and was ordered to give Immodium (medication to treat diarrhea) and IV hydration.</p> <p>Further review of Resident 6's record did not indicate a care plan to address episodes of diarrhea on November 23, 2024, was initiated, not until December 3, 2024.</p> <p>4. On December 9, 2024, a review of Resident 21 ' s medical record was conducted. Resident 21 was admitted to the facility on [DATE], with diagnoses which included spinal stenosis (spinal pressure causing pain, numbness or weakness in the arms or legs) and an elevate white blood cell count.</p> <p>A review of Resident 21 ' s Progress Notes, dated December 1, 2024, at 7:03 p.m., indicated, .Resident reported nausea and was provided with new order of zofran which was effective however patient was more lethargic than usual .MD (physician) ordered UA & CS (urinalysis with culture and sensitivity - a laboratory test to check for urine infection), CBC (complete blood count) & BMP (Basic Metabolic Panel - a laboratory test to check electrolyte level) .</p> <p>A review of Resident 21's care plan, indicated a care plan to address episode of nausea and vomiting was initiated on December 3, 2024 (two days after initial onset of change of condition on December 1, 2024). The care plan did not indicate physician's order for zofran and laboratory test.</p> <p>On December 9, 2024, at 4:30 p.m., an interview was conducted with the DON. The DON stated the residents who have had symptoms or tested positive for norovirus, several of the care plans did not indicate the resident has symptoms and what interventions were put in place to help treat the resident. The DON stated yes several of the care plans were not updated in a timely manner and he is aware that many still need to be reviewed and updated.</p> <p>A review of the facility ' s policy and procedure titled Care Planning, dated October 2024, indicated, .the interdisciplinary team (IDT) shall develop and implement comprehensive person-centered care plans for each resident .that include measurable objectives and timeframes to meet a resident ' s medical .needs that are identified .A summary of the IDT Care Plan review shall be documented .</p> <p>A review of the facility ' s policy and procedure titled Change of Condition Reporting, dated October 2024, indicated, .Any change in the resident ' s condition manifested by a marked change in physical or mental behavior will be communicated to the physician .Document resident change of condition and response .in nursing progress notes, and update the resident care plan .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000</p> <p>Based on observation, interview, and record review the facility failed to ensure infection control practices to control and manage gastrointestinal outbreak (GI outbreak - occurs when there are more cases of vomiting or diarrhea than expected in a given place or time) according to the facility's policy and procedure and CDC (Centers for Disease Prevention and Control) guidelines were implemented, when:</p> <ol style="list-style-type: none"> 1. The facility staff did not perform hand hygiene after having contact with high-touch areas; 2. The facility staff did not wear the appropriate PPE (personal protective equipment - protective clothing or equipment designed to protect the wearer's body from infection) while providing care to a resident requiring Enhanced Barrier Precautions (EBP - a set of infection control measures that use of PPE to reduce the spread of infections); and 3. The facility did not monitor residents with GI symptoms and conduct surveillance tracking of the residents with GI symptoms. As a result, the facility failed to identify a GI outbreak among residents and staff and appropriate isolation precautions were not provided timely to prevent the spread of infection. In addition, the facility did not report to the California Department of Public Health (CDPH) a GI outbreak in the facility timely. <p>These failures resulted to 30 out of 90 residents and seven (7) staff to be afflicted with the GI symptoms. Three residents were tested positive for Norovirus (a very contagious virus that causes vomiting and diarrhea). In addition, the facility failures had the potential for the spread and transmission of gastrointestinal infection.</p> <p>Findings:</p> <p>On December 3, 2024, at 4:52 p.m., CDPH received a report from the facility regarding a GI outbreak with multiple residents affected with symptoms of nausea, vomiting, and diarrhea.</p> <p>On December 4, 2024, at 10:48 a.m., a telephone call to the facility was conducted. The Infection Preventionist (IP) stated one resident developed excessive diarrhea and lethargy on November 21, 2024, and was sent out to the acute hospital. The IP stated the resident came back to the facility on [DATE], and had a diagnoses of Norovirus. The IP stated she reviewed other residents/staff that had GI symptoms from November 22, 2024 to November 28, 2024, and came out with five residents and five staff had GI symptoms. The IP stated the five residents with GI symptoms were not placed on isolation precautions at the time symptoms were present. The IP stated additional 15 residents and 2 staff developed GI symptoms from November 29, 2024, to December 3, 2024.</p> <p>On December 5, 2024, at 1:43 p.m., a follow up call to the facility was conducted. The IP stated laboratory testings for norovirus was conducted for affected residents and two came out positive for Norovirus.</p> <p>On December 6, 2024, at 9:45 a.m., an unannounced visit was conducted at the facility for the investigation of an facility reported incident regarding infection control.</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 - Some</p>	<p>1. On December 6, 2024, at 11:20 a.m., five staff members were observed to use the electronic time clock to check in and out by using their fingers for identification. The five staff members were observed not to perform hand hygiene (use of ABHR [alcohol based hand rub] or hand hygiene) before or after using the electronic time clock. In a concurrent interview with the Director of Nursing (DON), he stated the electronic time clock was considered a high touch area and the staff should be using an ABHR or wash their hands before and after touching the time clock.</p> <p>2. On December 6, 2024, at 11:30 a.m., an observation and concurrent interview was conducted with the IP. Certified Nursing Assistant (CNA) was observed in Resident 31 ' s room, assisting the resident from the wheelchair to the bed. Resident 31's door was observed to have a signage indicating he was to receive EBP and a cart with PPE was outside of the room, next to the door. The CNA was observed touching the floor mat to the right of Resident 31 ' s bed, then going to the left side of the bed and moved the floor mat, as well as adjusted the bed height, without wearing appropriate PPE (gloves or gown). The CNA was observed to walk out of Resident 31 ' s room, holding a used basin, with her bare hands, and continued toward the nurse ' s station, she stopped and applied ABHR to one hand. The IP stated the CNA should not be performing patient care without gloves and a gown as Resident 31 was on EBP for the use of indwelling urinary catheter.</p> <p>On December 6, 2024, at 11:55 a.m., an interview was conducted with the CNA. The CNA stated she was in the room assisting Resident 31 get into bed. The CNA stated she did not wear the appropriate PPE and she should used gown and gloves, and should not have been touching the floor without gloves on. The CNA stated she had brought the basin out of the room to throw it away as it was used to place the resident ' s indwelling urinary catheter bag in so it did not touch the floor. The CNA stated she did not throw it away in the room, because it would have filled the entire trash can. The CNA stated she was aware she did not follow proper infection control practice and exposed both herself and Resident 31 to potential infections.</p> <p>On December 9, 2024, a review of Resident 31 ' s medical record was conducted. Resident 31 was admitted to the facility on [DATE], with diagnoses which included cognitive communication deficit (difficulty communicating due to a mental process impairment) and a urinary tract infection (UTI-infection in the bladder/urine). Resident 31 ' s order summary report indicated, Resident 31 was placed on enhanced barrier precautions due to an indwelling urinary catheter on October 10, 2024.</p> <p>3. On December 6, 2024, at 10:00 a.m., an interview was conducted with the IP. The IP stated Resident 2 developed GI symptoms on November 21, 2024, and went to the hospital on the same day. The IP stated Resident 2 returned to the facility on [DATE], and the hospital notes indicated Resident 2 was tested positive for Norovirus on November 22, 2024. The IP stated all communal dining and activities were stopped on November 27, 2024, and she notified the local public health of the outbreak on December 2, 2024, and the California Department of Public Health (CDPH) on December 3, 2024.</p> <p>On December 6, 2024, at 2:30 p.m., a a follow up interview was conducted with the IP. The IP the facility implemented infection control measures such as placing residents with GI symptoms in contact isolation (a precaution used when a person has a type of bacteria or virus that can be transmitted to someone else if that person touches the infected individual or contaminated surfaces near the infected person), stopped all group activities, and sent an email to all the residents and/or their families alerting them about the outbreak after they were notified of becoming aware of the norovirus for Resident 2 on November 27, 2024. The IP stated the facility began a surveillance line list for residents and staff with GI symptoms.</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 - Some</p>	<p>On December 6, 2024, at 3:00 p.m., an interview was conducted with the DON. The DON stated the cases of residents with GI symptoms were discussed during their staff meeting but the facility determined the facility had a GI outbreak on November 27, 2024. The DON stated the facility initiated infection control measures related to the GI symptoms after they determined that it was a GI outbreak on November 27, 2024. The DON stated they did not implement infection control measures timely. The DON stated they did not report the GI outbreak to local and state agencies timely.</p> <p>On December 6, 2024, the facility document of infection surveillance for the GI outbreak for residents and staff was reviewed. The document indicated the following:</p> <ul style="list-style-type: none"> - Five residents developed GI symptoms on different onset dates starting November 21, 2024 to November 22, 2024; - 24 residents developed GI symptoms on different onset dates starting November 26, 2024 to December 8, 2024; and - Five staff developed GI symptoms on different onset dates starting November 21, 2024 to November 27, 2024, and two additional staff on December 1, 2024 and December 4, 2024. <p>A review of a webarticle published by Centers for Disease Prevention and Control (CDC) titled Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, last updated February 15, 2017, indicated, .Isolation Precautions .During outbreaks, place patients with norovirus gastroenteritis on Contact Precautions for a minimum of 48 hours after the resolution of symptoms to prevent further exposure of susceptible patients .Consider suspending group activities for the duration of norovirus outbreak .Actively promote adherence to hand hygiene among healthcare personnel, patients, and visitors in patient care areas affected by the outbreaks of norovirus gastroenteritis .During outbreaks, use soap and water for hand hygiene after providing care or having contact with patients suspected or confirmed with norovirus gastroenteritis .consider submitting stool specimens as early as possible during a suspected norovirus gastroenteritis outbreak .If norovirus infection is suspected, adherence to PPE use according to Contact and Standard Precautions is recommended for individual entering the patient care area to reduce the likelihood of exposure to infectious vomitus or fecal material AS with all outbreaks, notify appropriate local and state health departments, as required by state and local public health regulations, if an outbreak of norovirus gastroenteritis is suspected .</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 - Some</p>	<p>A review of the California Department of Health Services, Division of Communicable Disease Control, titled Recommendations for the Prevention and Control of Viral Gastroenteritis Outbreaks in California Long-Term Care Facilities, dated October 2006, indicated .Outbreaks of gastroenteritis in long-term care facilities (LTCFs) are not uncommon .Viruses (norovirus specifically) cause most of these outbreaks .transmitted from person-to-person .contamination of the environment plays a key role in transmission .norovirus infection .can be severe in the elderly, particularly those with underlying medical problems .Norovirus outbreaks can be detected early by recognizing the typical symptoms of illness, and can be controlled by promptly taking specific steps to prevent the virus from being transmitted from person-to-person. When appropriate infection prevention and control measures are not implemented immediately, outbreaks can continue for weeks with many residents becoming ill resulting in some hospitalization s and occasionally death from dehydration and other complications of vomiting and diarrhea .The main symptoms of viral gastroenteritis are sudden onset of vomiting and diarrhea .affected person may also have headache, fever (usually low-grade), chills and abdominal cramps .illness begins between one to two days following exposure to the virus .Norovirus is extremely contagious and is primarily spread when microscopic viral particles are transferred from contaminated hands to the mouth and ingested .persons who have been exposed but do not develop symptoms may also transmit the virus .the virus is spread primarily when ill persons (residents, healthcare workers, visitors) contaminate their hands with feces or vomitus containing the viral particles .decisions to institute control measures should not be delayed while waiting for results .an outbreak of viral gastroenteritis should be suspected when two or more residents and/or staff develop a new onset of vomiting or diarrhea within one to two days .symptoms may include nausea with or without vomiting and low grade fever .LTCFs that are aware of outbreaks in the community should be extremely vigilant of the development of acute viral gastrointestinal illness occurring in their facilities .transmission prevention precautions are implemented when the first two to three cases are suspected .Notification .new cases should be recorded daily, using a case log .notify the medical director immediately .notify the local health department and the licensing and certification district office with jurisdiction over your facility .confine symptomatic residents to their rooms until 48 hours after symptoms cease. Exclude non-essential staff from entering the room. Request symptomatic staff, visitors and volunteers to stay home until symptom-free for at least 24 hours. Discontinue ' floating ' staff from the affected unit to non-effected units .Institute control measures when a viral gastroenteritis outbreak is suspected without waiting for diagnostic confirmation .Cancel or postpone group activities until at least 48 hours after the last identified case .limit new admissions until the incidence of new cases have reached zero for at least 48 hours .wear gloves, gown and a surgical or procedure mask when in contact with the symptomatic resident .A log should be maintained to record ill staff symptoms, the date when they became ill, and when they returned to work .educate staff about the need to maintain strict hand hygiene . increase the frequency of routine environmental cleaning .particular attention should be given to cleaning objects that are frequently touched .visits to symptomatic residents should be discouraged .</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 - Some</p>	<p>A review of the facility ' s policy titled Infection Prevention and Control Program, revised July 31, 2024, indicated .the infection prevention and control program consist of coordination/oversight, surveillance, data analysis .outbreak management, prevention of infection, and employee health and safety .will be carried out by the infection preventionist .policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards .Goals. Decrease the risk of infection to residents and personnel. Recognize infection control practices while providing care .ensure compliance with state and federal regulations related to infection control .Surveillance tools are used to recognize the occurrence of infections .detect outbreaks and epidemics .reporting of communicable diseases per Centers for Disease Control (CDC) guidelines .the infection control program . investigate, control and prevent infections in the facility. Decide what measures/Interventions should be applied .Maintain a record of incidence of infection and corrective action taken .personnel will conduct themselves and provide care in a way that minimizes the spread of infection .personnel will wash their hands after each direct resident contact for which hand washing is indicated by acceptable professional practice . effective cleaning and disinfecting equipment as needed, to include bathing areas between each resident use. Chemicals and equipment for cleaning and disinfection will be used in accordance with manufacturer ' s directions and recommendations. The facility will conduct an annual review of the Infection Prevention and Control Program and .updated as necessary .facility uses McGeer criteria as the nationally recognized surveillance criteria to define infections .</p> <p>A review of the facility ' s policy titled IPCP Standard and Transmission-Based Precautions, revised July 31, 2024, indicated .policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions .standard precautions are infection prevention practices .use and type of PPE is based on the predicted staff interaction with residents and the potential for exposure .hand hygiene .environmental cleaning and disinfection .Contact precautions .are used with a known infection . acute diarrhea, or ongoing transmission within the unit or facility .wear a gown and gloves for all interactions that may involve contact with the patient or the patient ' s environment .Enhanced Barrier Protection (EBP) . the use of gown and gloves during high-contact resident care activities .residents with wounds and indwelling medical devices are at especially high risk .activities requiring gown and glove use for Enhanced Barrier Precautions include .transferring .device care or use .facility will implement a system to alert staff, residents and visitors that a resident is on TBP (Transmission-Based Precautions). Post clear signage on the door or wall outside or the resident room indicating the type of precautions and required PPE .make PPE .available immediately outside of the resident room. Ensure access to alcohol-based hand rub .provide education .as needed .</p> <p>(continued on next page)</p>		

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