STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056328	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Care Center for Palm Springs	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on observation, interview, and record review, the facility failed to treat resident with respect and dignity when the staff failed to cover the urinary bag, for one of one resident reviewed (Resident 2). This failure increased the potential to negatively affect Resident 2's psychosocial wellbeing. Findings: On December 23, 2024, at 8:52 a.m., during a concurrent observation and interview with Resident 2 in his room, Resident 2's urinary catheter drainage bag was observed to be not covered with a dignity bag (used to cover urine collection bag) and was hanging below the level of bed. Resident 2 stated he was not comfortable if someone would see his pee. On December 23, 2024, at 8:54 a.m., during a concurrent observation and interview with the Licensed Vocational Nurse (LVN). The LVN stated the urinary bag was exposed and was not covered with a privacy bag. The LVN further stated, he will feel not comfortable if that was his bag and was not covered, It should have been covered. On December 23, 2024, Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included neuromuscular dysfunction of bladder (lack of bladder control). A review of Resident 2's Minimum Data Set (MDS - a tool for assessment), dated November 1, 2024, indicated Resident 2 had a BIMS (Brief Interview for Mental Status - a tool used to assess cognition) of cognitively intact. A review of Resident 2's Order Summary, dated December 4, 2024, indicated, .SUPRA PUBIC CATHETER CARE (tube that is used to drain urine from the bladder) Q SHIFT . A review of Resident 2 ' s care plan, dated December 4, 2024, indicated, .Has Suprapubic Catheter related to Neurogenic Bladder (lack of bladder control) .Agreed to place catheter bag inside a basin . (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 23, 2024, at 1:30 p.m., during an interview with the Director of Nursing (DON), the DON stated residents should be treated with respect and dignity. The DON further stated the urinary bag uncovered will cause psychosocial effect to resident and it should have been covered with dignity bag. A review of the facility's policy and procedure titled, Resident Rights, dated October 2024, indicated, .It is the policy of this facility that all residents be treated with kindness, dignity and respect .The staff shall display respect for Resident ' s when .caring for .as constant affirmation of their individually and dignity as human beings . A review of the facility's policy and procedure titled, Indwelling Urinary Catheter Care, dated October 2024, indicated, .It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection .Cover the drainage bag with privacy bag to maintain dignity .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 40000 Based on observation, interview, and record review, the facility failed to ensure the call light (device that produce a tone and light) was available for the resident to use and call for assistance, for one of two residents reviewed (Resident 2). This failure had the potential to result in the resident being unable to call for staff assistance when needed. Findings: On December 23, 2024, at 8:20 a.m., an unannounced visit was conducted at the facility for the investigation of a complaint. On December 23, 2024, at 8:48 a.m., during a concurrent observation and interview with Resident 2 in his room, Resident 2 was observed with a metallic silver portable call bell on top of his overbed table. There was no call light wiring attached to the socket on the wall and there was no push button wire connected to it. In a concurrent interview, Resident 2 stated the call light system was broken and staff gave him a call bell and was placed on top of his over bed table. Resident 2 further stated he cannot press the bell because his arms were unable to move, I yelled if I need help, It so frustrating. On December 23, 2024, at 8:50 p.m., an interview with the Licensed Vocational Nurse (LVN) was conducted. The LVN stated a portable call bell was given to Resident 2 because the call light system was broken. The LVN stated Resident 2 had a condition of paralysis (loss of muscle function) and used sensor pads to call for assistance. The LVN stated Resident 2 could not move and he could not use the bell to call for assistance. The LVN further stated if the call light system would not be fixed, the resident's needs would not be met. On December 23, 2024, Resident 2's record was reviewed. Resident 2 was admitted to facility on December 4, 2024, with diagnoses which included quadriplegia (a condition where all four limbs arms and legs are paralyzed). A review of Resident 2's Minimum Data Set (MDS - a tool for assessment), dated November 1, 2024, indicated Resident 2 had a BIMS (Brief Interview for Mental Status - a tool used to assess cognition) of cognitively intact. On December 23, 2024, at 8:57 a.m., an interview with the Maintenance Assistant (MA) was conducted. The MA stated the call light system was broken. The MA further stated, it should have been fixed and repaired. On December 23, 2024, at 9 a.m., during an interview with the Administrator (ADM), the ADM stated, he expected to all maintenance staff that anything in repair should had been addressed immediately. The ADM further stated, the call light system should had been fixed and repaired to accommodate the needs of the resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Equipment Maintenance, dated October 2024, indicated, . It is the policy of this facility to establish procedures for routine and non-routine care of equipment and to ensure that equipment remains in good working order for resident and staff safety .Electrical and hydraulic equipment will be inspected by the Maintenance Supervisor or Designee to ensure that equipment is working properly . A review of the facility's policy and procedure titled, Accommodation of Needs, dated October 2024, indicated, .It is the policy of this facility to be aware of the importance of awareness of accommodation of needs for each resident as individual Nursing staff will communicate with Don/Designee and/or Administrator after assessing residents if there is any specific accommodation for a particular resident .Examples of accommodation of needs .Call lights . A review of the undated facility's policy and procedure titled, Resident ' s Rights, indicated, .It is the policy of this facility to provide accommodation of reasonable needs to the residents while in the facility .Staff will Review resident ' s preference and accommodate their needs as soon as possible .If the request or need cannot be met, another intervention will be in place to ensure resident is comfortable .Examples of accommodation of needs, but not limited to .Devices to use .call lights .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on interview and record review, the facility failed to ensure residents was free from verbal abuse, for one of five residents reviewed (Resident 5), when the Certified Nurse Assistant Student (CNAS) called Resident 5 an inappropriate word. This failure had the potential for Resident 5 to experience emotional distress. Findings: On December 23, 2024, at 8:20 a.m., an unannounced visit was made to the facility to investigate one facility reported incident. On December 23, 2024, Resident 5's record was reviewed. Resident 5 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (both medical conditions that cause weakness or paralysis on one side of the body). A review of Resident 5's History and Physical, dated December 5, 2024, indicated Resident 5 was mentally capable of understanding. A review of Resident 5 ' s eInteract Change in Condition Evaluation, dated December 19, 2024, indicated, . VERBAL ALTERCATION . A review of Resident 5 ' s care plan, dated December 19, 2024, indicated, .Potential for a psychosocial well-being problem r/t (related to) verbal altercation with staff .When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings . A review of Resident 5 ' s progress notes IDT, dated December 23, 2024, indicated, .IDT met to review allegation of verbal altercation with staff .With this incident resident was cussing and threatening staff and appears staff responded inappropriately . On December 23, 2024, at 10:10 a.m., an interview was conducted with Resident 5. Resident 5 stated the Certified Nursing Assistant (CNA) assigned to him requested a CNA Student (CNAS) to assists in providing care. Resident 5 stated during the start of care he mentioned to both staff that the care for him was useless due to his body condition was not capable to improve. Resident 5 stated the CNAS told him Resident 5 should have been cooperative with care, so he would be better. Resident 5 stated he did not understand what the CNAS meant, so he asked to clarify it from the CNAS and then they started exchanging inappropriate words. Resident 5 further stated, the CNAS told him f____ off and gave him the middle finger. Resident 5 further stated, I felt disrespected. On December 23, 2024, at 10:35 a.m., an interview was conducted with the CNA. The CNA stated she was standing on the right side of Resident 5 ' s bed when she heard the CNAS stated inappropriate words to Resident 5. The CNA further stated, I was shocked. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 23, 2024, at 11:01 a.m., an interview was conducted with the Licensed Vocational Nurse (LVN). The LVN stated the CNA reported Resident 5 and the CNAS had a verbal altercation on December 17, 2024. The LVN stated the CNAS should have not been engaged in verbal altercation with Resident 5. The LVN further stated, its verbal abuse. On December 23, 2024, at 1:55 a.m., an interview was conducted with the Administrator (ADM). The ADM stated he expected to all staff to maintain the facility free from any types of abuse. The ADM further stated the verbal altercation should have been prevented if the CNAS did not mentioned inappropriate words towards Resident 5. A review of the facility ' s policy and procedure titled, Abuse: Prevention of and Prohibition Against, dated October 2024, indicated, .It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation .This policy applies to all Facility staff including, but not limited to, employees .students and other caregivers who provide care and services to residents on behalf of the Facility .Residents also have the right to be free from verbal, sexual, physical, and mental abuse .Verbal abuse includes the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within the hearing distance, regardless of their age, ability to comprehend or disability .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on interview and record review, the facility failed to report an allegation of verbal abuse by a Certified Nursing Assistant Student (CNAS) towards a resident to the California Department of Public Health (CDPH) immediately or within 2 hours after the allegation was made, for one of five residents (Resident 5). This failure had the potential to result in further abuse for Resident 5, affecting the resident's emotional, and psychosocial well-being. Findings: On December 23, 2024, at 8:20 a.m., an unannounced visit to the facility was conducted to investigate an allegation of abuse. A review of Resident 5's record indicated, Resident 5 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (both medical conditions that cause weakness or paralysis on one side of the body). A review of Resident 5's History and Physical, dated December 5, 2024, indicated Resident 5 was mentally capable of understanding. A review of Resident 5 ' s eInteract Change in Condition Evaluation, dated December 19, 2024, indicated, . VERBAL ALTERCATION . A review of Resident 5 ' s care plan, dated December 19, 2024, indicated, .Potential for a psychosocial well-being problem r/t (related to) verbal altercation with staff .When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings . A review of Resident 5 ' s LN-(Licensed Nurse) Condition Monitoring, dated December 23, 2024, indicated, . PSYCHOSOCIAL MONITORING DUE TO VERBAL ALTERCATION WITH STAFF . On December 23, 2024, at 10:10 a.m., an interview was conducted with Resident 5. Resident 5 stated the Certified Nursing Assistant (CNA) assigned to him requested a CNA Student (CNAS) to assists in providing care. Resident 5 stated during the start of care he mentioned to both staff that the care for him was useless due to his body condition was not capable to improve. Resident 5 stated the CNAS told him Resident 5 should have been cooperative with care, so he would be better. Resident 5 stated he did not understand what the CNAS meant, so he asked to clarify it from the CNAS and then they started exchanging inappropriate words. Resident 5 further stated, the CNAS told him f____ off and gave him the middle finger. Resident 5 further stated, I felt disrespected and was verbally abused. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 23, 2024, at 10:35 a.m., an interview was conducted with the CNA. The CNA stated she was standing on the right side of Resident 5 ' s bed when she heard the CNAS stated inappropriate words to Resident 5. The CNA further stated, I was shocked. The CNA stated she reported the altercation incident to the Licensed Vocational Nurse and was told that the LVN would report it. The CNA stated the Director of Nursing (DON) talked to her after her lunch break and was told not to worry about it as Resident 5 would do that a lot. The CNA stated she was not asked by the DON of the details of the incident, and she assumed the LVN had already discussed it to the DON. On December 23, 2024, at 11:35 a.m., during an interview with the Social Service Director (SSD), the SSD stated the Ombudsman came in the facility on December 19, 2024, and was notified of the abuse allegation incident on December 17, 2024. The SSD stated, any allegation of abuse should be reported immediately within 2 hours. The SSD stated the Administrator reported the incident to CDPH on December 19, 2024, (2 days from when the allegation was reported). The SSD further stated, the staff should have been reported the incident within 2 hours. On December 23, 2024, at 1:30 p.m., during an interview with the DON, the DON stated he received a report from the Licensed Vocational Nurse (LVN) that Resident 5 had cussed and yelled with a staff. The DON stated he did not investigate further and did not report to CDPH. The DON further stated he should have reported the alleged abuse to CDPH for resident safety. A review of the facility ' s policy and procedure titled, Reporting Alleged Violation of Abuse, Neglect, Exploitation or Mistreatment, dated October 2024, indicated, .In response to allegations of abuse .the Facility will .Ensure that all alleged violations involving abuse .are reported immediately .Not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse .Ensure that all alleged violations involving abuse .are reported to .The administrator of the Facility .The state Survey Agency .Adult Protective Services .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on interview and record review, the facility failed to report an allegation of verbal abuse by a Certified Nursing Assistant Student (CNAS) towards a resident to the California Department of Public Health (CDPH) immediately or within 2 hours after the allegation was made, for one of five residents (Resident 5). This failure had the potential to result in further abuse for Resident 5, affecting the resident's emotional, and psychosocial well-being. Findings: On December 23, 2024, at 8:20 a.m., an unannounced visit to the facility was conducted to investigate an allegation of abuse. A review of Resident 5's record indicated, Resident 5 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (both medical conditions that cause weakness or paralysis on one side of the body). A review of Resident 5's History and Physical, dated December 5, 2024, indicated Resident 5 was mentally capable of understanding. A review of Resident 5 ' s eInteract Change in Condition Evaluation, dated December 19, 2024, indicated, . VERBAL ALTERCATION . A review of Resident 5 ' s care plan, dated December 19, 2024, indicated, .Potential for a psychosocial well-being problem r/t (related to) verbal altercation with staff .When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings . A review of Resident 5 ' s LN-(Licensed Nurse) Condition Monitoring, dated December 23, 2024, indicated, . PSYCHOSOCIAL MONITORING DUE TO VERBAL ALTERCATION WITH STAFF . On December 23, 2024, at 10:10 a.m., an interview was conducted with Resident 5. Resident 5 stated the Certified Nursing Assistant (CNA) assigned to him requested a CNA Student (CNAS) to assists in providing care. Resident 5 stated during the start of care he mentioned to both staff that the care for him was useless due to his body condition was not capable to improve. Resident 5 stated the CNAS told him Resident 5 should have been cooperative with care, so he would be better. Resident 5 stated he did not understand what the CNAS meant, so he asked to clarify it from the CNAS and then they started exchanging inappropriate words. Resident 5 further stated, the CNAS told him f____ off and gave him the middle finger. Resident 5 further stated, I felt disrespected and was verbally abused. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 23, 2024, at 10:35 a.m., an interview was conducted with the CNA. The CNA stated she was standing on the right side of Resident 5 ' s bed when she heard the CNAS stated inappropriate words to Resident 5. The CNA further stated, I was shocked. The CNA stated she reported the altercation incident to the Licensed Vocational Nurse and was told that the LVN would report it. The CNA stated the Director of Nursing (DON) talked to her after her lunch break and was told not to worry about it as Resident 5 would do that a lot. The CNA stated she was not asked by the DON of the details of the incident, and she assumed the LVN had already discussed it to the DON. On December 23, 2024, at 11:35 a.m., during an interview with the Social Service Director (SSD), the SSD stated the Ombudsman came in the facility on December 19, 2024, and was notified of the abuse allegation incident on December 17, 2024. The SSD stated, any allegation of abuse should be reported immediately within 2 hours. The SSD stated the Administrator reported the incident to CDPH on December 19, 2024, (2 days from when the allegation was reported). The SSD further stated, the staff should have been reported the incident within 2 hours. On December 23, 2024, at 1:30 p.m., during an interview with the DON, the DON stated he received a report from the Licensed Vocational Nurse (LVN) that Resident 5 had cussed and yelled with a staff. The DON stated he did not investigate further and did not report to CDPH. The DON further stated he should have reported the alleged abuse to CDPH for resident safety. A review of the facility ' s policy and procedure titled, Reporting Alleged Violation of Abuse, Neglect, Exploitation or Mistreatment, dated October 2024, indicated, .In response to allegations of abuse .the Facility will .Ensure that all alleged violations involving abuse .are reported immediately .Not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse .Ensure that all alleged violations involving abuse .are reported to .The administrator of the Facility .The state Survey Agency .Adult Protective Services .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on observation, interview, and record review, the facility failed to ensure nutritional care and services were provided, for one of three sampled residents reviewed (Resident 7), when the nutritional recommendations of the Registered Dietitian (RD) to address Resident 7's significant weight loss were not followed. This failure resulted to Resident 7 not receiving the interventions to address resident's weight loss. In addition, this failure had the potential to result for further weight loss on Resident 7. Findings: On December 23, 2024, at 8:20 a.m., an unannounced visit was conducted to investigate a complaint on quality of care concerns. On December 23, 2024, at 2:20 p.m., during a concurrent observation and interview with Resident 7 in her room, Resident 7 was observed lying in bed and was wearing a loose-fitting white shirt. Resident 7 stated she use to wear the same clothes and it was well fit before but now the shirt was loose a little bit. Resident 7 further stated, This shirt started to loosen up. On December 23, 2024, Resident 7's record was reviewed. Resident 7 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar level in the body). A review of Resident 7 ' s record, Initial Admission Record, dated August 26, 2024, indicated that Resident 7 was alert oriented to person, place, time and able to follow simple commands. A review of Resident 7 ' s record care plan, dated September 5, 2024, indicated, At risk for wt (weight) loss and dehydration due to Poor food intake .Monitor and evaluate any weight loss . A review of Resident 7's Weights and Vitals Summary, indicated the following weights of Resident 7: - August 27, 2024 (admission weight); 156 pounds (lbs); - September 4, 2024; 143 lbs (weight loss of 13 lbs/8.3% in a week); - October 7, 2024; 139 lbs (weight loss of 4 lbs in a month; 17 lbs since admission); - November 5, 2024; 129 lbs (weight loss of 10 lbs/-7.2 % in a month); - November 12, 2024; 130 lbs (weight loss of nine lbs/-6.5 % in a month); - December 5, 2024; 130 lbs (weight loss of 13 lbs/9 % in 3 months); last weight obtained-refusal; and - December 18, 2024; 114 lbs (weight loss of 16 lbs in 2 weeks and in a month) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 7 ' s record, LN-(Licensed Nurse) Nutrition Interdisciplinary Team (IDT - a group of healthcare professionals) UPDATE, dated November 6, 2024, indicated, Resident 7 had weight loss of 10 pounds at 7 percent in 30 days with IDT recommendations of continue weekly weights for four weeks then monthly when stable. There was no documented evidence of weekly weights after November 12, 2024, to address the IDT recommendation to Resident 7 ' s significant weight loss. A review of Resident 7's care plan, revised December 23, 2024, indicated, .At risk for wt loss and dehydration due to Poor food intake .11/06/24 (November 6, 2024) weight loss of -10# (lbs)/7% x (times) 30 days .Interventions .Monitor and evaluate any weight loss . On December 23, 2024, at 3:50 p.m., a follow up interview was conducted with Resident 7. Resident 7 stated she notice she lost some weight and her clothes are bigger than she used it. Resident 7 stated she was being weighed weekly when she was first admitted and had stop for a few weeks. On December 23, 2024, at 4 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated there was no documentation Resident 7 was weighed on November 19 and 26, 2024. The DON stated the weight that was used for December 5, 2024, was the weight on November 12, 2024, which was 130 lbs. The DON stated the Registered Dietitian (RD) recommended to weigh Resident 7 weekly times four weeks and it was not followed. The DON stated Resident 7 should have been weighed on November 19 and 26, 2024 and supposedly on December 5, 2024 (monthly weight). On December 26, 2024, at 9:16 a.m., the Dietary Supervisor (DS) was interviewed. The DS stated the facility did not follow recommendations to weigh Resident 7 on the third and fourth weeks of November 2024 and there was no evidence of documentation for the reason of not weighing Resident 7. The DS further stated Resident 7 should have been weighed and evaluated to further monitor the effectiveness of the IDT interventions. On December 26, 2024, at 9:32 a.m., an interview was conducted with the RD, the RD stated it was important to follow IDT recommendations to weigh the residents who had unexpected significant weight loss. The RD further stated if facility staff will not follow IDT recommendations, Resident 7 would not receive appropriate interventions and may lead to unidentified further weight loss. The RD stated Resident 7 was not weighed on November 19 and 26, 2024 and on December 5, 2024. The RD stated if the resident refused to be weighed, the staff should have notified the RD so further recommendations could have been initiated and identify if the resident had weight loss or gain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056328	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Care Center for Palm Springs	2990 East Ramon Road Palm Springs, CA 92264

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the undated facility ' s policy and procedure titled, Dietary Services, indicated, .It is the policy of the facility to obtain an accurate weight as part of the residence assessment upon admission and at least monthly thereafter .The facility is responsible for obtaining correct weights on a regular basis, and for keeping accurate records .Reweighs may be requested if a discrepancy is presumed or a significant weight change is noted to assure accuracy of the weight. All reweighs should be obtained within 24 hours if being requested .Individuals with unplanned significant/severe weight loss will receive nutrition interventions to prevent further weight loss, stabilize weight .Weekly weights may be necessary to monitor for changes and effectiveness of interventions .Resident identified with unplanned, significant weight loss will have an IDT note completed & weighed for additional 4 weeks. IDT to review weights weekly & do follow-up notes if indicated .Weight Monitoring IDT .Residents necessitating closer weight observation/weekly weights as determined by IDT will be provided to RNAs weekly by IDT .