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	08/20/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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
	056328	A. Building B. Wing	08/20/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an evaluation of elevated blood pressure and notification to the physician was conducted, for one of three residents reviewed (Resident 1). This failure had the potential for a delay in the care and treatment of Resident 1's uncontrolled hypertension (high blood pressure) and had the potential to experience complications related to high blood pressure. Findings:On July 22, 2025, at 8:25 a.m., during observation of medication pass conducted by Licensed Vocational Nurse (LVN) 1, LVN 1 was preparing medications for Resident 1. LVN 1 stated she checked Resident 1's blood pressure and was 171/70 mm HG (millimeters of mercury - a unit used to measure pressure, specifically blood pressure; normal blood pressure is 120/80). LVN 1 stated Resident 1 had a PRN (as needed) Clonidine (medication to treat high blood pressure) every eight (8) hours if more than 160. LVN 1 was observed to explain to Resident 1 the medications she prepared to be administered including the resident's blood pressure medication. LVN 1 was observed to tell Resident 1 that she will come back later to check her blood pressure again later as she administer the medications as the BP was high. On July 22, 2025, at 9:17 a.m., an interview was conducted with Resident 1. Resident 1 stated her BP went up and she was transferred to the acute hospital.On July 22, 2025, at 9:35 a.m., LVN 1 was observed to rechecked Resident 1's BP and it was 190/82. LVN 1 was observed to explain to Resident 1 she would prepare to give her PRN BP medication. On July 22, 2025, at 9:42 a.m., LVN 1 was observed to administer to Resident 1 PRN Clonidine and explained to the resident she will recheck her BP in a little while. On July 22, 2025, at 11;56 a.m., a follow up interview was conducted with Resident 1. Resident 1 stated her BP was rechecked and was still a little high at 170 over something (unable to recall). Resident 1 stated she would feel her eyes get wavy when her BP was high, and stated it felt less now. A review of Resident 1's record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included heart failure and hypertension (high blood pressure).A review of Resident 1's History and Physical Examination, dated June 10, 2025, indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's, care plan (Plan of care specific to a health condition, with interventions, and time framed goals), titled, . Altered Cardiovascular status (related to) . (HTN) ., initiated June 10, 2025, indicated, resident's care plan was not re-evaluated, or updated, after Resident 1's return from GACH on July 6, 2025.A review of Resident 1's Order Summary Report, included the following medications to address hypertension:- Losartan Potassium, 50 MG (milligram - a unit of measure) one time a day for HTN, Hold if SBP < (less than)110 or (Heartrate {HR}) <60, date ordered June 9, 2025;- Hydralazine 25 MG , two times a day (BID) for HTN, hold if SBP is under 110, date ordered June 24, 2025, - Clonidine 0.1 MG, every 8 hours, as needed for HTN. Give if SBP (Systolic BP - top number of BP) is 160 or higher, date ordered June 26, 2025; and- Metoprolol ER (Dose changed to) 50 MG, Daily, Hold if SBP <110 or HR <60; date ordered June 26, 2025.A review of Resident 1's Medication Administration Record (MAR), for the month of July 2025, indicated PRN Clonidine was administered to Resident 1 13 times from July 1, 2025 to July 23, 2025, when the resident's BP was above 160. Further review of Resident 1's MAR indicated BP being checked twice daily and Resident 1's BP was above 160 almost daily. - A review of Resident 1's Progress Notes, dated, July 6, 2025, at 5:37 p.m., by Registered Nurse (RN) 1, indicated, .(Resident 1) had a Hypertensive episode. BP of 223/111. Nurse Administered Clonidine.and Hydralazine (Both medications to control HTN).(Resident 1's) BP went down to 183/79.(Resident's representative) (notified) and requested (resident) be sent. (to GACH) for HTN. (Resident 1) sent to (GACH).for further evaluation . A review of Resident 1's Progress Notes, dated July 7, 2025, at 7:28 a.m., indicated (Resident 1) back from (GACH) at (7:20 a.m.). returned in stable condition. No new orders for HTN noted.A review of Resident 1's Progress Notes, dated July 23, 2025, at 6:42 a.m., indicated, .At 0600 (6 a.m.) BP was 198/95 gave patient evaluated BP medication PRN as ordered 15 mins (minutes) later recheck BP was 205/95 called 911. Patient was sent out to (name of acute hospital) due to hypertension .Further review of Resident 1's record indicated there was no evaluation conducted or referral to the physician of Resident 1's elevated BP after readmitted from GACH on July 7, 2025, despite Resident 1's BP still above 160 almost daily. On July 24, 2025, at 2:03 p.m., an interview was conducted with the DON. The DON stated the process to treat uncontrolled HTN included documenting a change of condition (COC), notification to the physician of COC, and follow-up monitoring of the resident's BP, documented every shift, for 72 hours. The DON stated if a resident was transferred to GACH due to

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	08/20/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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	08/20/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of three residents reviewed (Resident 1), the facility failed to ensure:1. A physician's order was obtained to discontinue or remove a urinary catheter prior to removal of the catheter; and 2. Monitoring and documentation of the resident's urine output, any signs and symptoms of pain and/or bladder distention, after the urinary catheter was removed. These failures had the potential for a delay in the care and treatment to address possible adverse effects from removal of the catheter. Findings: On July 22, 2025, at 8:22 a.m., an unannounced visit was conducted at the facility to investigate a quality-of-care issue. On July 22, 2025, at 8:32 a.m., Resident 1 was observed alert, oriented, and was lying in bed. In a concurrent interview, Resident 1 stated she had a urinary catheter (a flexible tube inserted into the bladder to drain urine) and the facility staff recently pulled it out. Resident 1 stated she had burning sensation when she urinated and was being given medication to help her urine to come out. On July 22, 2205, at 9:35 a.m., a follow up interview was conducted with Resident 1, who stated she was having symptoms of painful urination and was sent to the General Acute Care Hospital (GACH) for an unrelated health concern, and returned to the facility diagnosed with a Urinary Tract Infection (UTI - a bacterial infection of the bladder, which can cause a sense of unrelieved urination, burning and/or painful urination). A review of Resident 1's, Resident Information, indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis of heart failure, and hypertension (elevated blood pressure). A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), Brief Interview for Mental Status (BIMS}-A cognitive assessment), indicated a score of 13 (cognitively intact). A review of Resident 1's Progress Notes, dated July 7, 2025, at 10:02 p.m., indicated, . DURING PM (3 p.m. to 11 p.m.) SHIFT PATIENT REPORTED THE URGE TO VOID WITHOUT ANY URINARY RELIEF. PATIENT BECAME DISTENDED (sic) AND EXPRESSED PAIN. PATIENT WAS STRAIGHT CATHETED (a procedure where a thin, flexible tube (a straight catheter) is inserted into the urethra to drain urine from the bladder and then removed) WITH A review of Resident 1's Order Summary Report, indicated Resident 1 had a physician's order, dated July 7, 2025, which indicated, .INDWELLING CATHETER .DX (diagnosis) TO SUPPORT USE; urinary retention (refers to the condition where there is an inadequate amount of urine produced and excreted, leading to a buildup of urine in the bladder) . A review of Resident 1's Progress Notes, dated, July 7, 2025, at 7:28 a.m., indicated, (Resident 1) back from (GACH) at 7:20 a.m.in stable condition with new order for Bactrim (a medication to treat UTI's).two times a day for 7 (seven) days. A review of Resident 1's care plans indicated there was no care plan initiated for UTI after Resident 1 was readmitted from GACH on July 7, 2025, with diagnosis and treatment for UTI. On July 22, 2025, at 3:27 p.m., an interview was conducted with Registered Nurse (RN) 1, who stated Resident 1 had a foley catheter inserted on July 7, 2025. RN 1 stated Resident 1 had completed her antibiotics, and requested to have the catheter be removed. RN 1 stated Resident 1's catheter was then removed by Licensed Vocational Nurse (LVN) 1. RN verified, there was no physician's order to remove Resident 1's urinary catheter. RN 1 further stated she could not recall the exact date Resident 1's urinary catheter was removed, as there was no documentation the urinary catheter was removed. RN 1 stated there should be a physician's order before removing a urinary catheter and documentation when the procedure of removal was conducted and monitoring of the resident's response after the urinary catheter was removed. RN 1 stated there should be documentation of monitoring of any signs and symptoms after the urinary catheter was removed. RN 1 further stated, a care plan should be initiated with any new diagnosis or change of condition. RN 1 verified there was no care plan initiated when Resident 1 returned from GACH on July 7, 2025, with a new diagnosis of a UTI. On July 22, 2025, at 4:42 p.m., an interview was conducted with LVN 2, who stated Resident 1's urinary catheter was removed on July 19, 2025, at 8:50 p.m., after RN 1 asked her to remove the urinary catheter. LVN 2 stated she did not check if there was a physician's order to remove or discontinue the urinary catheter. LVN 2 stated there should be a physician's order to remove an urinary catheter before removing the catheter, document the procedure conducted, and monitor the resident's urine output, presence of pain, or distention, after the urinary catheter was removed. On July 22, 2025, at 4:55 p.m., an interview was conducted with the DON, who stated he would expect the nurse who removed Resident 1's foley catheter to document the procedure, including, results, such as, any trauma and/or blood in urine. The DON verified there was no physician's orders to remove Resident 1's urinary catheter. The DON stated he confirmed LVN 1 removed Resident 1's urinary catheter, and LVN 1 stated she did not document the

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	08/20/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a complete pain assessment was conducted, which included the location of pain, for one out of three residents (Resident 1).This failure had the potential for Resident 1's pain not to be managed effectively. Findings:On July 22, 2025, at 8:22 a.m., an unannounced visit to the facility was conducted to investigate a quality-of-care issue.On July 22, at 8:32 a.m. , an interview was conducted with Resident 1, who stated she had a urinary catheter (a long tube insert into the bladder to drain urine) and the licensed nurse pulled it out (removed/discontinued it). Resident 1 stated she still had burning sensation when she urinated. Resident 1 stated Tylenol (acetaminophen - a non-steroidal anti-inflammatory medication to relieve pain) helps the irritation and discomfort (resident pointed towards her bladder). Concurrently, Licensed Vocational Nurse (LVN) 1, asked Resident 1 what her pain rate was (on a scale from 1-10, 10 being the worst), and resident responded, 6 or 7.On July 22, 2025, at 8:47 a.m., an observation was made of LVN 1, returning to Resident 1's bedroom to administer Tylenol for bladder discomfort.A review of Resident 1's record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of Urinary Tract Infection (UTI - a bladder infection). A review of Resident 1's care plan (an individualized plan of care specific to a related problem, including time framed goals, and nursing interventions), initiated on June 9, 2025, which indicated, .Has acute pain (related to) disease process . Intervention to help relieve resident's pain .Monitor/document for probable cause of each pain episode.A review of Resident 1's physician's orders, dated June 22, 2025, indicated, . Acetaminophen Extra Strength 500 mg (milligrams - a unit of measure), Give 2 (two) tablet (sic) by mouth every 4 (four) hours as needed for Severe Pain 7-10 (on pain scale) .A review of Resident 1's Medication Administration Record (MAR), for July 2025, indicated, Acetaminophen was administered to Resident 1 on July 22, 2025, at 8:45 a.m.A review of Resident 1's Progress Notes, dated July 22, 2025, at 8:45 a.m., by LVN 1, indicated Tylenol was administered to Resident 1 for a pain scale between 7-10. There was no documentation of the location of the pain. A review of Resident 1's Progress Notes, dated, July 22, 2025, at 1:25 p.m., by LVN 2, indicated, . PRN Administration was: Effective. Follow-up Pain Scale was: 5 . Location of the pain not documented.On July 23, 2025, at 8:47 a.m., an interview was conducted with Registered Nurse (RN) 2, who stated the process to document administration of pain medications, includes documenting the medication administered, location of the pain, and effectiveness of the medication.On July 23, 2025, at 1:42 p.m., an interview was conducted, with LVN 1, who verified, on July 22, 2025, (at 8:45 a.m.) she administered acetaminophen to Resident 1 for discomfort from her urinary tract infection. LVN 1 further stated, when she monitors and documents administration of pain medications, she would include documenting the resident's pain rating on a scale of 1-10, the time the medication was given, and the location of the pain. LVN 1 stated when she administers a PRN pain medication, and she did not document the location in the progress notes, she would sometimes document under Condition Monitoring.A review of Resident 1's, Condition Monitoring, dated July 22, 2025, indicated there was no documentation of the pain location from LVN 1.On August 4, 2025, at 4:20 p.m., an interview was conducted with the Director of Nursing (DON), who stated he expected the nursing staff to assess a resident for pain, including the location prior to administration of the pain medication, and document the location in the progress note or condition monitoring.A review of the facility's policy and procedures titled, Medication Administration, revised December 2019, indicated, .When PRN (as needed) medications are administered, the following documentation is provided .Complaints or symptoms for which the medication was given .