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	11/18/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure an assessment for safe self administration of medication was conducted, for three of 21 residents (Residents 38, 42, and 77) when: 1. One opened bottle of 15 ml (milliliter - unit of measurement) eyedrops (medication that relieves eye irritation) was found on the overbed table of Resident 38; 2. One opened respiratory inhaler medication (a handheld device that delivers medication directly to the lungs through breathing) of albuterol HFA (brand name) 108 mcg/act (microgram/actuation - unit of measurement) was found on the overbed table of Resident 42; and 3. One opened glass container of Muscle Balm pain relieving ointment (brand of ointment) 18 g (gram-unit of measurement) was found on the overbed table of Resident 77. These failures had the potential for Residents 38, 42, and 77 to receive multiple doses of medication without proper monitoring, which could lead to harmful effects. Findings: 1. On November 12, 2024, at 9:36 a.m., during a concurrent observation and interview with Resident 38 in his room, one opened bottle of 15 ml eyedrops was found on the overbed table. In a concurrent interview with Resident 38, he stated he administered the medication himself when he wanted relief from his eye irritation and redness. On November 14, 2024, Resident 38's record was reviewed. Resident 38 was admitted on [DATE], with diagnoses which included hypertension (elevated blood pressure). A review of Resident 38's History and Physical, dated February 28, 2024, indicated Resident 38 was mentally capable of understanding. Further review of Resident 38's medical record indicated there was no documented evidence that a self-administration assessment was conducted for the use of eye drops. (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: 056328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2024
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	

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On November 13, 2024, at 9:58 a.m., during a concurrent interview and review of Resident 38's medical records with Registered Nurse (RN) 1, she stated Resident 38 did not have a physician's order for the eyedrop solution. RN 1 further stated the eyedrop solution should have had a physician's order, and a self-administration assessment should have been completed for the usse of eye drop solution. 2. On November 12, 2024, at 10:45 a.m., during a concurrent observation and interview with Resident 42 in his room, one opened respiratory inhaler medication of albuterol HFA aerosol solution 108 mcg/act was observed on the overbed table. In a concurrent interview with Resident 42, he stated he administered the medication himself when he wanted to be relieved from shortness of breath and he was not aware of how often he supposed to take the inhaler medication. Resident 42 further stated, the nurse put it on my table so I can take it later. On November 14, 2024, Resident 42's records was reviewed. Resident 42 was admitted on [DATE], with diagnoses which included chronic obstructive pulmonary disease (lung disease) and respiratory failure (lungs have difficulty getting enough oxygen into the blood). A review of Resident 42's Order Summary, dated October 8, 2024, included a physician's order which indicated, Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) MCG/ACT, 2 (two) puff inhale orally every 6 (six) hours as needed for SOB (shortness of breath) and or wheezing (whistling sound when airways in the narrowed lungs). A review of Resident 42's History and Physical, dated November 8, 2024, indicated Resident 42 was mentally capable of understanding. Further review of Resident 42's medical record indicated there was no documented evidence that a self medication administration assessment was conducted. On November 12, 2024, at 11:03 a.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 1, he stated the respiratory inhaler medication was Albuterol Sulfate HFA Aerosol Solution and stated, it should not be left on resident's overbed table. LVN 1 further stated Resident 42 should have had an assessment for self-administration of Albuterol Sulfate HFA Aerosol Solution. On November 13, 2024, at 1:57 p.m., Registered Nurse (RN) 1 was interviewed. RN 1 stated there was no assessment for self-administration of medications for Resident 42. RN 1 stated there was no physician order for Resident 42 to self-administer medications. RN 1 further stated if Resident 42 continued to self-medicate, then it could lead to further issues like palpitation (increase heart beat), chest pain or adverse effect from the medication. 3. On November 12, 2024, at 4 p.m., during a concurrent observation and interview with Resident 77 in his room, one opened glass container of muscle balm pain relieving ointment 18 g was on the overbed table. In a concurrent interview with Resident 77, he stated he administered the medication himself when he wanted to be relieved from pain.Resident 77 stated he would apply the ointment more if he wanted to. On November 12, 2024, Resident 77's records was reviewed. Resident 77 was admitted on [DATE], with diagnoses which included polyneuropathy (damaged nerves [fibers that transmits electrical impulses throughout the body] that cause pain). (continued on next page)

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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	

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 77's History and Physical, dated September 9, 2024, indicated Resident 77 was mentally capable of understanding. Further review of Resident 77's medical record indicated there was no documented evidence that a self medication administration assessment was conducted. In addition, there was no physician order for the use of the muscle balm pain relieving ointment. On November 12, 2024, at 4:16 p.m., during a concurrent interview and review of Resident 77's medical records with LVN 2, she stated Resident 77 had one opened glass container of muscle balm pain relieving ointment 18 gram at the overbed table without a physician's order. LVN 2 stated medication should not be kept at the bedside. LVN 2 further stated the muscle balm pain relieving ointment should not be applied without a physician's order and a self-medication administration assessment should have been made. On November 13, 2024, at 2:49 p.m., during an interview with the Director of Nursing (DON), he stated he expected licensed nurses to follow the policy and procedure regarding self medication administration assessment and administration of medications for all residents. The DON further stated if the policy and procedures were not followed, there was a potential for residents to not receive medications according to the physician's order, and to not be monitored for any adverse (negative) effects. A review of the facility's undated policy and procedure titled, Self Administration of Medication, indicated, .It is the policy of this facility to respect the wishes of alert, competent residents to self-administer prescribed medication choosing to and capable of self-administration .If a resident desire to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate .The residents cognitive, communication, visual and physical ability to carry out this responsibility will be evaluated . A review of the facility's undated policy and procedure titled, Medication Administration, indicated, .It is the policy of this facility to accurately prepare, administer and document oral medications .No medication is to be administered without a physician's written order .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure the call light (device that produce a tone and light up indicating the location of the call, used by the residents to signal a need for assistance from facility staff) was answered promptly, for one of 93 sampled residents (Resident 9). This failure increased the potential for delayed nursing and medical management, as well as actual unmet care needs. Findings: On November 12, 2024, at 10:20 a.m., an observation with a concurrent interview was conducted with Resident 9 in his room. Resident 9's call light button was turned on because he wanted to request a refill his pitcher of fruit juice. Resident 9 stated he was not able to get assistance for 30 minutes, and usually happened during the morning shift. On November 12, 2024, at 10:25 a.m., Resident 9 was observed to press his call light and waited a staff to come to his room. There were two licensed nurses sitting at the nurse's station, talking while in front of the computer and did not answer Resident 9's call light. On November 12, 2024, at 10:40 a.m., Certified Nursing Assistant (CNA) 1 entered the room and asked Resident 9 what his request and proceeded to assist Resident 9 in refilling his ptcher of juice. CNA 1 stated she was not able to get to Resident 9 quicker this morning because it was not her assigned resident and the person assigned was busy. CNA 1 stated it was not acceptable for Resident 9's call light to be answered after a 15-minute wait. She further stated the expectation was, if the assigned CNA was busy with another resident, any staff available should have helped Resident 9. CNA 1 stated the Licensed Nurses who were in the station should answer the call lights as well. Resident 9 had to wait for assistance from his CNA from 10:25 a.m. to 10:40 a.m. On November 13, 2024, at 1:58 p.m., Registered Nurse (RN) 1 was interviewed. RN 1 stated the staff should answer the call lights timely. RN 1 stated the staff could see in the front TV monitor in the nurses station if the residents call light was turned on. RN 1 stated the nurses in the station should also respond to the call lights to meet resident's need. RN 1 stated responding to the call light timely could lead to responding to emergency as needed and accommodate the resident's needs. On November 13, 2024, at 2:23 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated it was not acceptable for the staff to respond to Resident 9's call light after a 15-minute wait. The DON further stated he expected everyone was responsible to answer and respond to the residents' call light timely, at least five (5) seconds or as soon as possible. On November 14, 2024, Resident 9's record was reviewed. Resident 9 was admitted on [DATE], with diagnoses which included muscle weakness and nutritional deficiency. (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 Resident 9's History and Physical, dated September 19, 2024, indicated Resident 9 was mentally capable of understanding. A review of the facility's undated policy and procedure titled, Call Light, indicated, .It is the policy of this facility to provide the resident a means of communication with nursing staff .Answer the light/bell within a reasonable time .Respond to the request .If the item is not available or you are unable to assist, explain to the resident and notify the charge nurse for further instructions . A review of the facility's undated policy and procedure titled, ADL care, indicated, .It is the policy for this facility that residents are given treatment and services to maintain or improve his/her abilities .Residents who are unable to carry out activities of daily living (ADL) will receive assistance as needed .

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F 0578

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40988

Based on interview and record review, the facility failed to ensure a copy of the Advance Directive (AD - a written instruction, such as a living will, relating to the provision of treatment and services when the individual becomes unable to decide) was available in the medical record, for one of seven residents reviewed for Advance Directives (Resident 11).

This failure had the potential to result in Resident 11's wishes related to the provision of medical treatment and services to not be followed, if Resident 11 became unable to make decisions for himself.

Findings:

On November 14, 2024, Resident 11's record was reviewed. Resident 11 was admitted to the facility on [DATE], with diagnoses which included sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection) and diabetes (abnormal blood sugars).

A review of Resident 11's undated History and Physical indicated Resident 11 had the capacity to understand and make decisions.

A review Resident 11's Social Services Assessment/Evaluation, dated September 13, 2024, indicated Resident 11 had an AD and a copy was requested from Resident 11 and his family member (FM). However, further review of Resident 11's record indicated there was no copy of the AD in the record.

On November 14, 2024, at 4:01 p.m., the Social Service Director (SSD) and Social Services Assistant (SSA) were concurrently interviewed. When asked when the latest follow up was conducted with Resident 11's FM regarding the AD, the SSA stated the FM came to the facility every other day and was here the previous day. The SSD stated he was planning to follow up with the FM but saw that both were having a conversation at the dining area and did not bother them. The SSD stated they should have followed up regarding the AD sooner and the AD should have already been in Resident 11's chart.

On November 18, 2024 at 5:48 p.m., The Administrator (ADM) was interviewed. The ADM stated if a resident had an AD, he expected the AD to be readily available in the chart.

A review of the undated facility's policy and procedure titled, Advance Directives, indicated, .It is the policy of this facility that a resident's choice about advance directives will be recognized and respected .The facility recognizes and respects the resident's right to choose his/her treatment and make decisions about care to be received at the end of his/her life .Should the resident indicate that he or she has issued advance directives about his/her care and treatment, the facility will require that (sic) a copy of such directives .Once the advance directive .is received by the facility, it will be communicated to the members of the care plan team .will also notify the physician .so that, if necessary, the appropriate orders can be documented in the resident's medical record and plan of care .

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to provide a safe and comfortable homelike environment, for one of six residents reviewed for environment (Resident 86) when the chair rail molding above the resident's bed was detached and damaged from the wall. This failure had the potential for Resident 86 to experience lack of sleep, discomfort, and irritability, which could affect the resident's overall health and well-being. Findings: On November 12, 2024, at 9:45 a.m., during a concurrent observation and interview with Resident 86 in his room, Resident 86 was observed sitting on his bed looking at the wall. Resident 86 stated he woke up early because he was not comfortable sleeping while a broken piece of wood was hanging above his head. Resident 86 further stated he was worried that if he raised up from the bed, he might hit his head to the wood. On November 13, 2024, at 11 a.m., Registered Nurse (RN) 1 was interviewed. RN 1 stted the broken chair molding should be reported to the maintenance staff so it could be fixed. RN 1 stated she would feel uncomfortable sleeping and it was not safe for the resident as they could bump on his head and hurt the resident. On November 13, 2024, at 11:10 a.m., during an interview with the Maintenance Supervisor (MS), the MS stated the chair rail molding was not properly attached to the wall and was hanging above the residnet's head board. The MS further stated, it should have been fixed and repaired. On November 14, 2024, Resident 86's record was reviewed. Resident 86 was admitted to the facility on [DATE], with diagnoses which included hypertension (high blood pressure). A review of Resident 86's History and Physical, dated October 17, 2024, indicated Resident 86 was mentally capable of understanding. On November 15, 2024, at 8:22 a.m., during an interview with the Administrator (ADM), the ADM stated he expected to the maintenance staff adderessed anything that needed. The ADM further stated, chair rail molding should had been fixed and repaired to prevent any accidents and a provide comfortable and homelike environment for the resident. A review of the facility's policy and procedure titled, Equipment Maintenance, dated May 2021, 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 .Routine inspections and maintenance will be recorded in the Preventive Maintenance Log .In the event that equipment maintenance or servicing is required between scheduled checks, alert maintenance supervisor about the issue . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy and procedure titled, Homelike Environment, indicated, .It is the policy of this facility to encourage and provide opportunities for each resident to occupy an area reflecting his/her interests, family, or is made homelike .To provide a homelike environment for residents . A review of the facility's undated policy and procedure titled, Quality of Life, indicated, .It is the policy of the facility to identify and provide reasonable accommodation of resident needs and preferences .The facility will provide safe, clean, comfortable, and homelike environment .

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204 Based on observation, interview, and record review, the facility failed to ensure, for one of one resident reviewed for ADL (Activities of Daily Living) was provided nail care (Resident 9). This failure prevented the resident from receiving maintaining proper grooming and personal hygiene. Findings: On November 12, 2024, at 9:46 a.m., Resident 9 was observed in his room with long yellowish, rough edged toenails growing outwards and were hypertrophied (thick). In a concurrent interview with Resident 9, he stated he asked the staff to trim his toenails and his request was ignored. Resident 9 stated he was not seen by the nail doctor to evaluate and trim his toe nails. He further stated, it looks like hawk nails. On November 12, 2024, at 10:51 a.m., Certified Nurse Assistant (CNA) 1 was interviewed. CNA 1 stated Resident 9 required total care and she had to do everything for him. CNA 1 stated she did not see Resident 9's long toe nals as she was in a hurry providing care to all the residents. She stated she would inform the charge nurse if a resident needed his toenails trimmed. CNA 1 stated she did not trim Resident 9's toenails. CNA 1 further stated any staff could cut the resident's toenails. She stated if the resident was diabetic (person with abnormal blood sugar level), the licensed nurse would cut the toenails of the residents. On November 13, 2024, Resident 9's records was reviewed. Resident 9 was admitted on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar). A review of Resident 9's History and Physical, dated September 19, 2024, indicated Resident 9 was mentally capable of understanding. A review of Resident 9's care plan, dated September 27, 2024, indicated, .At risk for ADL Self Care Deficit as exhibited by .needs assistance with ADL tasks .at risk for developing complications associated with decreased ADL self performance .Will safely perform .Personal Hygiene with either supervision, independence, and or modified independence through the review date . On November 13, 2024, at 2 p.m., a concurrent observation and interview was conducted with Registered Nurse (RN) 1. RN 1 stated Resident 9's toenails were too long, and CNAs could cut residents' toenails. RN 1 was observed to measure Resident 9's toenails, approximately 5.0 mm (millimeter, a unit of measurement) long from the toenail tips. RN 1 further stated Resident 9's toenails should have been trimmed and cleaned to prevent infection and injury. A review of the facility's undated policy and procedure titled, Foot Care, indicated, .It is the policy of this facility to clean feet and identify foot concerns .Clean and trim nails accordingly .Only licensed nurses perform Nail Care orFoot Care on residents with Diabetes .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on observation, interview, and record review, the facility failed to ensure, for three of 21 residents reviewed (Residents 28, 33, and 88): 1a. For Resident 28, the medication Lisinopril and Metoprolol (medications to treat high blood pressure) was not held according to the physician's order. In addition, the medication Midodrine (medication to treat low blood pressure) was not administered according to the physician's order. This failure had a potential for Resident 28 to have low blood pressure and could affect overall health condition; 1b. For Resident 28, there was no follow up assessment and monitoring after the resident was readmitted from the hospital on July 23, 29, and August 6, 2024. This failure had the potential for any changes in Resident 28's condition to be unidentified and could have a delay in the care and treatment; 2. For Resident 33, the discolorations on the forearms were not identified and monitored. This failure had the potential for Resident 33 to have complications related to the discolorations on the forearms; and 3. For Resident 88, the physician was not notified of a change in condition prior to transport to an appointment. This failure resulted to a delay in the care and treatment for Resident 88 and was brought to the hospital by the family member while at the appointment. Findings: 1a. On November 14, 2024, Resident 28's record was reviewed. Resident 28 was admitted to the facility on [DATE], with diagnoses which included hypertension (elevated blood pressure) and hemoptysis (coughing out of blood). A review of Resident 28's Order Summary Report, included the following physician's order: - dated August 6, 2024, Metoprolol Tartrate Oral Tablet 25 MG (milligram - unit of measurement) .Give 0.5 tablet by mouth two times a day for HTN (hypertension) HOLD IF SBP (systolic blood pressure - maximum pressure in the aorta when the heart contracts and pumps blood into the body's arteries) < (less than) 110 OR HR (heart rate) < 60 .; -dated October 10, 2024, Lisinopril Oral Tablet 5 MG .Give 1 (one) tablet by mouth one time a day for HTN; HOLD IF SBP < 110 or HR < 60 .; and -dated October 6, 2024, Midodrine HCl Tablet 10 MG Give 1 (one) tablet by mouth every 12 hours as needed for HYPOTENSION (low blood pressure) for sbp <90 . A review of Resident 28's Medication Administration Record (MAR), indicated the Lisinopril and Metoprolol were administered with an SBP < 110 on the following dates and times: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- November 2, 2024, at 9 a.m.; SBP 103; - November 11, 2024, at 5 p.m.; SBP 106; - November 12, 2024, at 9 a.m.; SBP 107; A review of Resident 28's November 2024 MAR indicated Midodrine was not administered on the following dates and times when the SBP was below 90: - November 5, 2024, at 9 a.m.; SBP 82; and - November 11, 2024, at 9 a.m.; SBP 89 A review of Resident 28's MAR indicated Lisinopril and Metoprolol were held but no documentation of SBP on the following dates and times: - October 3, 2024, at 5 p.m.; - October 6, 2024, at 5 p.m.; - October 7, 2024, at 5 p.m.; - October 9, 10, 11, 2024, at 5 p.m.; - October 24 and 25, 2024, at 5 p.m.; - October 27, 2024, at 5 p.m.; - October 30, 2024, at 5 p.m.; - October 31, 2024, at 9 a.m.; - November 1, 2024, at 5 p.m.; -November 2, 2024, at 9 a.m. and 5 p.m.; On November 14, 2024, at 3:18 p.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 stated there was no Midodrine administered to Resident 28 when the SBP was below 90. LVN 3 stated there were no blood pressure readings documented in Resident 28's MAR for October and November 2024. LVN 3 stated the blood pressure reading should be documented to evaluate if the SBP was below the parameters and if Midodrine should have been given. On November 14, 2024, at 3:46 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated Lisinopril and Metoprolol should have been held if the SBP is below the parameters according to the physician's order. The DON stated Midodrine should have been given if the SBP was below 90. The DON stated blood pressure readings should have been documented to better evaluate the blood pressure of Resident 28 and effectiveness of the medications prescribed. (continued on next page)

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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	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled Medication Administration, dated August 2021, indicated, . It is the policy of this facility that medications shall be administered as prescribed by the attending physician . Medications must be administered in accordance witht he written orders of the attending physician .Should a drug be withheld .should be appropriately documented on the MAR . 1b. On November 14, 2024, at 3:46 p.m., a concurrent interview and record review was conducted with the DON. The DON stated Resident 28 was sent out to the hospital and readmitted back to the facility on the following dates due to hemoptysis: - July 20, 2024 (hospital); July 23, 2024 (readmit); - July 26, 2024 (hospital); July 29, 2024 (readmit); and - August 3, 2024 (hospital); August 6, 2024 (readmit). The DON stated there was no documentation follow up assessment and monitoring was conducted after Resident 28 was readmitted to the facility from the hospital due to hemoptysis on July 23, 28, and August 6, 2024. The DON stated there should be follow up assessment and monitoring of Resident 28 after each readmission back to the facility to ensure effectiveness of care and treatment to address the resident's condition and identify other changes in health condition. A review of Resident 28's Progress Notes, indicated the following: - July 20, 2024, at 12:46 p.m., .Sent to (name of hospital) for evaluation and treatment due to coughing up blood . - July 23, 2024, at 10:16 p.m., .Patients (sic) presented to ER (emergency room) due to coughing blood with diagnosis of Hemoptysis. No coughing of blood upon admission, nonproductive cough noted . - July 26, 2024, at 7 p.m., .Resident was sent out d/t (due to) coughing out blood continuously . - July 29, 2024, at 9:51p.m., .Patients (sic) presented to ER due to Coughing blood and SOB (shortness of breath) with diagnosis of Hemoptysis .No coughing of blood upon admission . - August 3, 2024, at 6:30 a.m., .Patient on toilet and mentioned that he is bleeding after he had BM (bowel movement). Checked toilet and patient has bright red blood in toilet . -August 3, 2024, at 9:19 a.m., .Spoke to (name of hospital nurse) to give report on patients (sic) COC (change of condition) and recommendations from (name of physician) about sending patient out to hospital due to GI (gastrointestinal) bleed and coughing blood for further evaluation . -August 6, 2024, at 10:43 p.m., .Patients (sic) presented to ER due to Blood in the stool with diagnosis of colitis (inflammation of the large intestine) . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's undated policy and procedure titled, Change of Condition, indicated, .The initial change of condition must be documented completely and accurately. Be certain to include a complete description of the assessment and any information used to determine that the change of condition occurred . Documentation of the resident's status should continue each shift for a minimum of 72 hours or until the condition is resolved. Include vital signs and any pertinent signs and symptoms relating to the change of condition .Resident on antibiotic therapy should be documented on q (every) shift for the duration of the ABT (antibiotic) and 72 hours beyond. Include vital signs and any pertinent signs or symptoms relating to the condition being treated . 41459 47374 2. On November 13, 2024, at 2:06 p.m., a concurrent observation and interview was conducted with Resident 33. Resident 33 was observed to have multiple purple, red, and green discolorations on her bilateral (both) forearms. Resident 33 stated she did not know what happened to her arms, and she did not take any anticoagulants (blood thinners). A review of Resident 33's record indicated Resident 33 was admitted to the facility on [DATE], with diagnoses which included traumatic subdural hemorrhage (blood leaking out of a torn blood vessel below the membrane covering the brain) and diabetes mellitus (abnormal blood sugar). A review of Resident 33's Skin Evaluation, dated November 13, 2024, indicated Resident 33 had MASD (moisture associated skin damage) to perineal (groin) area. The document did not indicate presence of multiple discolorations on the forearms. A review of Residents 33's Medication Administration Record (MAR) for the month of November 2024, indicated Resident 33 had been prescribed aspirin (medication used to lower risk of heart attack) 81 milligrams (mg - unit measurement) oral (by mouth) tablet one time a day, and ibuprofen (medication used to treat pain) 600 mg oral tablet every 24 hours as needed. On November 15, 2024, at 3 p.m., a concurrent observation and interview was conducted with Resident 33. Resident's 33's forearm discolorations appeared lighter in color. Resident 33 continued to state she was unaware where the discolorations came from. A review of Resident 33's Skin Evaluation, dated November 15, 2024, indicated Resident 33 had redness to the groin and bilateral buttock area (new area of skin affected), as well as scabs to both lower legs, but no documentation of the multiple discolorations on both forearms. On November 15, 2024, at 3:08 p.m., a concurrent observation and interview was conducted with LVN 4. LVN 4 stated there were discolorations to Resident 33's forearms, and she did not notice the discolorations prior to today. LVN 4 was observed reviewing Resident 33's record and stated there was no documentation regarding Resident 33's discolorations. LVN 4 further stated there should have a skin evaluation done and this should have been documented in the change of condition form. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On November 15, 2024, at 3:15 p.m., an interview was conducted with Registered Nurse (RN) 1. RN 1 was observed reviewing Resident 33's record and stated there was no documentation regarding Residents 33's skin discolorations. RN 1 stated we are supposed to document any changes. RN 1 stated there should have been a change in condition initiated regarding the skin discolorations, and this should have been documented. On November 15, 2024, at 3:16 p.m., a concurrent interview and review of Resident 33's record was conducted with the DON. The DON stated he did not see any kind of information regarding Resident 33's skin discolorations documented at this time. The DON further stated there should have been documentation of Resident 33's skin discolorations in the change in condition form or the skin assessment/evaluation form. A review of the facility's policy and procedure titled, Significant Change in Condition, Response, revised January 2022, indicated, .The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions .each department notified will perform their own evaluation and assessment to determine if the change requires further intervention and implementation actions accordingly. The nurse will transcribe the treatment and plan of care relative to the change of condition on the resident Electronic Medical Record-EMR . 3. On November 14, 2024, Resident 88's medical record was reviewed. Resident 88 was admitted to facility on October 2, 2024, with diagnoses that included muscle weakness, syncope (sudden loss of consciousness) and collapse (to fall with loss of consciousness) and a history of falling. A review of the Order Summary Report, for October 2024, included a physician's order, dated October 3, 2024, which indicated an appointment on October 8, 2024, at 2:45 p.m .(name of medical transport) to provide transportation to be arranged. The appointment was about 50 miles from the facility. A review of the Change of Condition (COC), form on October 7, 2024, at 2:25 p.m., indicated Resident 88 had symptoms and signs of lethargy. Resident 88's COC was reported to the primary care physician and the physician ordered blood draw and was unable to obtain blood sample. A review of the Condition Follow-up Notes, for October 7, 2024, at 10:43 p.m., indicates Resident 88 was lethargic during the shift . A review of the Progress Notes for October 8, 2024, at 1:30 p.m., indicated Resident 88 was very lethargic. Noted resident was able to answer yes or no to questions. Resident 88 left for appointment by (name of transportation). A review of the Progress Note, for October 9, 2024, at 9:39 a.m., indicated Resident 88 was sent to appointment to (name of city) gurney transportation was provided by the facility. The DON was in communication with the family for past two days. Family stated that they were taking resident to the (name of hospital) . Further review of Resident 88's record indicated no documentation of notification to primary clinical physician of continued declining change of condition nor was resident medically cleared for travel to his appointment via transport. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On November 15, 2024, at 4 p.m., the DON was interviewed. The DON stated with a change of condition of that severity of Resident 88, the transport to resident's appointment should have been cleared by the primary clinical physician. A review of the facility's policy and procedure titled Significant Change of Condition, Response dated January 2022, indicated, .if, at any time, it is recognized by anyone of the team members that the condition or care needs of the resident has changed .change in mental status .change of behavior .the supervisor or nurse should be made aware .the nurse will perform and document an assessment of the resident and identify need for additional interventions .through communication with residents' provider using SBAR or similar process to obtain new orders or intervention .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25281 Based on observation, interview, and record review, the facility failed to ensure medications were administered as prescribed by the physician to meet the needs of the residents, when: 1. During a medication pass observation, a wrong dose of fluticasone (medication used for nasal congestion) nasal spray was administered, for one of five residents observed (Resident 65); 2. Four doses of an IV (intravenous; into vein) antibiotic medication was not administered in November 2024 without a reason documented in the medical record, for one of five residents reviewed (Resident 191); 3. For one of five residents reviewed (Resident 11), one blood pressure medication was held without properly documenting the reason for not administering the dose in accordance with the parameters ordered by the physician; 4. For one of five residents reviewed (Resident 3), two tablets of oxycodone (controlled substance for pain) were administered instead of one tablet for severe pain as ordered by the physician. These failures had the potential for residents not receiving effective medication treatments. Findings: 1. On November 13, 2024, at 8:40 a.m., during a medication pass observation, Licensed Vocational Nurse (LVN) 5 was observed to administer four medications to Resident 65, which included, fluticasone nasal spray, two sprays in each nostril. On November 13, 2024, during a review of Resident 65's medical record, Resident 65 was admitted to the facility on [DATE], with diagnoses which included allergic rhinitis (allergic reaction that causes sneezing, congestion, and sore throat). A review of Resident 65's physician order for fluticasone, started on August 23, 2024, indicated one spray to each nostril be administered to the resident one time a day for allergic rhinitis; and A review of Resident 65's Medication Administration Record, indicated one spray of fluticasone was administered to each nostril on November 13, 2024, at 9 a.m. On November 13, 2024, at 2:15 p.m., during an interview with LVN 5, she acknowledged Resident 65 received two sprays in each nostril and agreed the fluticasone dose should have been one spray in each nostril, not two. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On November 14, 2024, during a review of Resident 191's medical record, indicated Resident 191 was admitted to the facility on [DATE], with diagnoses which included, encounter for other orthopedic (includes bones, ligaments, tendons, and muscles) aftercare, other specified disorders of muscle, infection, and inflammatory reaction due to internal right hip prosthesis (artificial replacement body part); Resident 191's Order Summary Report, indicated a physician's order for cefazolin (IV antibiotic) 3 grams, started on October 26, 2024, indicated one dose to be administered to the resident intravenously two times a day for right hip joint prosthetic infection until November 19, 2024. Resident 191's Medication Administration Record (MAR), indicated, in November, two evening doses were not documented as administered with no reason given on the 11th and 12th, and two doses were documented as not given with the reason code 7, See Nursing Notes, on the 9th and 10th. On November 15, 2024, at 8:50 a.m., during an interview with the Director of Nursing (DON), he stated the administering nurse should have signed off and administered the IV medication. The DON acknowledged missing documentation on the MAR on November 11 and 12. The DON also confirmed there was no nursing notes entered in Resident 191's medical record for not administering the doses of IV cefazolin on November 9 and 10. 3. On November 14, 2024, during a review of Resident 11's medical record, indicated Resident 11 was admitted to the facility on [DATE], with diagnoses which included primary hypertension (high blood pressure); Resident 11's physician order for lisinopril (medication for high blood pressure) 10 mg (milligram; unit of measurement), started on September 26, 2024, indicated one tablet to be administered to the resident one time a day with the parameter to hold the dose if SBP (systolic blood pressure; top number in a blood pressure reading) less than 110 and pulse less than 60. Resident 11's Medication Administration Record (MAR), indicated ten doses of lisinopril 10 mg were held in November 2024 without SBP and pulse documented. On November 15, 2024, at 8:54 a.m., during an interview the DON, he stated the physician's order for lisinopril was transcribed incorrectly in the electronic health record by the nurse. The DON stated the order should have had the means to document SBP and pulse in the resident's record. The DON stated there was no way to verify the SBP and the pulse because they were not documented in the record and to tell if the doses were appropriately held according to the physician order. 4. On November 14, 2024, during a review of Resident 3's medical record, indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included, unspecified fracture of shaft of right tibia (shin bone), primary osteoarthritis (painful movement in joint) and palliative (providing relief from pain) care; Resident 3's physician order for oxycodone (controlled substance for pain) 5 mg (milligram; unit of measurement), started on September 15, 2024, indicated one tablet to be administered to the resident every 4 hours as needed for moderate pain between 4 and 6 (on a scale of 1 to 10, with 10 being the most painful), and two tablets every 4 hours as needed for severe pain between 7 and 10; and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 3's Medication Administration Record (MAR), indicated one tab of oxycodone 5 mg was administered to Resident 3 when the pain scale was between 7 and 10 on the following dates: - October 23, 2024, pain level = 7; - October 29, 2024, pain level = 8; - November 9, 2024, pain level = 9; - November 10, 2024, pain level = 8; and - November 12, 2024, pain level = 8. On November 15, 2024, at 9:10 a.m., during an interview with the DON, he stated oxycodone was given in error because the physician order was not followed according to the pain scale. The facility's policy and procedure titled, Medication Administration, revised, August 2021, indicated, .It is the policy of this facility that medications shall be administered as prescribed by the attending physician . Medications must be administered in accordance with the written orders of the attending physician .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 25281 Based on observation, interview, and record review, the facility failed to ensure proper storage of medications did not include unusable, expired medications when: 1. There were two expired daptomycin (antibiotic) IVPB (intravenous piggyback; a method of administering IV antibiotics by piggybacking it to a primary IV fluids) stored in the medication refrigerator for Resident 82; 2. There was one discontinued medication for Resident 35 in the medication cart along with other active medications; and 3. There was one injectable insulin (medication to control blood sugar) pen without an open date or expiration date in the medication cart. These failures had the potential for residents to receive expired and ineffective medications. Findings: 1. On November 12, 2024, at 11:30 a.m., during an inspection of the Medication Room with Registered Nurse (RN) 2, there were two IVPB daptomycin (antibiotic) 450 mg (milligram; unit of measurement) in normal saline 50 ml (milliliter; unit of measurement) bags labeled with, Discard after 11/9/24 (November 9, 2024), stored inside the medication refrigerator with other in-date medications for Resident 82. In a concurrent interview, RN 2 acknowledged the medication was expired and confirmed the medication was discontinued by the physician. RN 2 stated, when medications were expired, they would get destroyed in the blue pharmaceutical waste bin located in the Medication Room. 2. On November 12, 2024, at 12:30 p.m., during an inspection of the E Wing Medication Cart with Licensed Vocational Nurse (LVN) 6, there was a blister pack containing benzonatate (cough medication) 200 mg with the dispensed date of May 2, 2024 for Resident 35. On November 12, 2024, Resident 35's medical record indicated the physician order for benzonatate 200 mg, started on May 2, 2024, was discontinued on September 27, 2024. On November 12, 2024, at 12:30 p.m., during an interview, LVN 6 stated there was no current order for benzonatate 200 mg for Resident 35. LVN 6 stated expired, discontinued medications needed to be disposed the same day they expired. The facility's policy and procedure titled, Storage of Medications, last updated, August 2019, indicated, . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medications . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On November 13, 2024, at 2:25 p.m. during an inspection of Medication Cart B with LVN 5, there was one used 3-ml Insulin Lispro Qwickpen, labeled with no open date or expiration date, stored in the medication cart at room temperature. In a concurrent interview, LVN 5 agreed there was no open date on the used insulin pen. The Dailymed, which provides the most recent drug monographs submitted to the Food and Drug Administration (FDA) by companies and currently in use, indicated, for Insulin Lispro Qwikpen, . When stored at room temperature, Insulin Lispro can only be used for a total of 28 days, including both not in-use (unopened) and in-use (opened) storage time . The facility's policy and procedure titled, Vials and Ampules of Injectable medications, dated, May 2022, indicated, .Medication in multidose vials may be used [until the manufacturer's expiration date/for the length of time allowed by state law/according to facility policy/for thirty days] if inspection reveals no problems during that time. USP <797> guidelines recommend discarding multidose vials .at 28 days after opened. The date opened and the triggered expiration date should be recorded on a label for such purpose affixed to the vial. Expiration dates triggered by opening should be available either in the manufacturer's labeling or package insert, on a chart provided by the pharmacy, or from the pharmacist .

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 40988 Based on observation, interview, and record review, the facility failed to ensure special dietary needs were provided, for three residents reviewed during the lunch meal preparation on November 15, 2024, (Residents 46, 76, and 192) . This failure had the potential to place residents at risk of not having their nutritional and dietary needs met. Findings: On November 15, 2024, beginning at 12:10 p.m., an observation of the lunch meal preparation was conducted. The steam table (a table having openings to hold containers of cooked food over steam or hot water circulating beneath them) was observed to have a 1/6 size 6-inch deep stainless steel pan containing pureed regular chili. Beside it was another 1/6 size 6-inch deep stainless steel pan containing pureed cornbread. On the right side, above the steam table, was a 1/4 size 6-inch deep stainless steel pan containing pureed salad on ice. Behind the steam table, on the stove, was a 1/6 size 6-inch deep stainless steel pan containing pureed fortified chili. 1. The [NAME] placed one serving of pureed (food prepared in a blender to attain a consistency of food that it is smooth with no lumps and has a texture like pudding) regular chili in a bowl for Resident 46 and placed the bowl on a plate. The [NAME] proceeded to place one serving of pureed salad and pureed cornbread on the plate and handed the plate to the Dietary supervisor (DS), who placed the plate on the tray then placed the tray on the meal cart. Resident 46's meal ticket was concurrently reviewed and indicated Diet Order: Puree - Level 4, Fortified (foods that have had extra nutrients added to them to improve their nutritional value, goal of fortification is to prevent or correct nutritional deficiencies in the population) . 2. The [NAME] placed one serving of pureed regular chili in a bowl for Resident 76 and placed the bowl on a plate. The [NAME] proceeded to place one serving of pureed salad and pureed cornbread on the plate and handed the plate to the Dietary Supervisor (DS), who placed the plate on the tray then placed the tray on the meal cart. Resident 76's meal ticket was concurrently reviewed and indicated Diet Order: Puree - Level 4, Fortified . The diet orders were verified with the [NAME] and the [NAME] stated the chili for Residents 46 and 76 should have been fortified, and proceeded to provide fortified chili in bowls and handed them to another dietary staff to replace the ones on the residents' plates. On November 18, 2024, at 4:06 p.m., the Registered Dietitian (RD) was interviewed. The RD stated Residents 46 and 76 should have received fortified chili to ensure they received the proper nutrients they needed. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The [NAME] placed one serving of pureed regular chili in a bowl for Resident 192 and put in on a plate. The [NAME] then placed one serving of pureed salad directly on the plate beside the bowl of pureed regular chili, handed the plate to the DS, who covered the plate and placed the plate on Resident 192's meal tray. Resident 192's meal ticket was concurrently reviewed with the DS and the meal ticket indicated, .Diet Order: Dysphagia (difficulty swallowing) Mechanical Soft (a diet of soft, moist foods that are easy to chew and swallow) .dislikes .toast .bread .rice . When asked why the plate did not contain any starch (carbohydrate) component on the plate, the DS stated it was because resident 192 did not like any bread or rice, so it was not served. The DS further stated Resident 192 usually finished the meal contents on his plate even without the starch component and his tray included other food items like yogurt and milk to supplement his intake. After observation of the lunch meal preparation, the DS approached the Surveyor and stated there should have been a starch component on Resident 192's plate and the dietary staff were now preparing mashed potatoes for the resident. On November 18, 2024, at 4:06 p.m., the RD was interviewed, the RD stated Resident 192 should have received an alternative starch component on his plate. A review of the facility policy and procedure titled, Menus, dated August 2024, indicated, .It is the policy of this facility to assure that menus are developed and prepared to meet the nutritional needs of the residents . while using established national guidelines .

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 11/18/2024
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	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988 Based on observation, interview and record review, the facility failed to store food in accordance with professional standards for food service safety, when multiple residents' food items were stored in the nurses' station refrigerator undated and out of date. This failure had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed these foods in the facility. Findings: On November 15, 2024, beginning at 3:30 p.m., the nurse's station refrigerator, which contained residents' food, was inspected with the Director of Nursing (DON). The following were observed: - One opened 24 oz (ounce- unit of measurement) tub of plain original yogurt was labeled with room [ROOM NUMBER]-B, and undated. In a concurrent interview, the DON stated the food item should have been dated when it was received, should not have been in the fridge anymore, and should be taken out; - One opened 500 ml (milliliter - unit of measurement) bottle of Coffeemate original creamer, was labeled with room [ROOM NUMBER]-C, the resident's last name, and dated 11/11-11/14 (November 11 - November 14). In a concurrent interview, the DON stated the creamer was past its storage date and should have been taken out of the fridge; - One opened 240 ml bottle of Mott's apple juice was labeled with room [ROOM NUMBER]-B, the resident's first name, and undated. In a concurrent interview, the DON stated the bottle was open and undated, and should have been taken out of the fridge. The DON further stated that for open food items, they can be stored in the fridge for 72 hours, after which they were supposed to be discarded; - One plastic take out box with transparent lid containing leftover food was labeled with room [ROOM NUMBER]-B, the resident's first name, and dated 11/14/24 (November 14, 2024). In a concurrent interview, the DON stated it was unclear if the date on the box was a received date or use by date, so this should have also been discarded; - One plastic transparent take out box containing pancakes, was labeled with room [ROOM NUMBER]-C, and dated 11/11/24, UB 11/13/24 8:06. In a concurrent interview, the DON stated the food item was received on November 11, 2024 and was good until November 13, 2024 which was the use by (UB) date, and should have been discarded; and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Half a peanut butter and jelly sandwich was labeled with room [ROOM NUMBER]-A, the resident's first name, and undated. In a concurrent interview, the DON stated the sandwich was undated and should have already been discarded; The DON further stated the facility's storage guideline for resident food indicated food could be stored for 72 hours in the fridge. The DON stated food items were received by nursing staff, and were labeled and dated on the day they were received before storing them in the fridge, so they can be monitored. The DON stated opened food packages were good for 72 hours in the fridge, and discarded after that time frame and unopened food packages were good until the manufacturer's expiration dates, use by dates, or best by dates. A review of the facility's policy and procedure titled, Foods Brought by Family or Visitor, July 21, 2021, indicated, .It is the policy of the facility that food(s) brought to a resident by family/visitors must be accepted by the resident; inspected before facility storage; and stored and served in accordance with food safety professional standards .Resident food shall be stored in the facility in the following location(s): Nurses Station Fridge. All foods shall be labeled with the resident identifier and date .Perishable prepared foods will be discarded after 72 hours of storage. Perishable manufactured foods stored in the manufacturer packaging will be discarded as per the best by or use by date. If no date, follow the facility refrigerated storage guidelines .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459 Based on observation, interview, and facility record review, the facility failed to maintain infection control practices when: 1. Resident 65 was observed in the dining room with his urinal hanging from the back of his wheelchair; and 2. One staff was observed not wearing the appropriate N95 respirator mask (disposable filtering device respirator) when providing care to COVID-19 (corona virus - a contagious respiratory disease) positive residents. These failures had the potential to spread infectious disease to other residents and staff in the facility. Findings: 1. On November 12, 2024, at 12:23 p.m., an observation was conducted in the dining room during lunchtime. Resident 65's urinal was observed hanging from the back of his wheelchair. A review of Resident 65's record indicated Resident 65 was admitted to the facility on [DATE] with diagnoses which included fracture (a break in the bone) of left foot and chronic kidney disease (long-term disease where kidneys are damaged and cannot filter properly). On November 12, 2024, at 12:25 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 7. LVN 7 stated the urinal should not have been there, adding Definitely infection control. On November 12, 2024, at 12:35 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated, The urinal should never be hanging on the back of a wheelchair, this is an infection control issue. A review of the facility's undated policy and procedure titled, Infection Prevention and Control Precautions, indicated, .Waste Disposal - Proper containment of waste can minimize the transmission of infection. Waste must be placed in appropriate containers at the point-of-care/use and stored in a designated enclosed room . 2. On November 18, 2024, at 9:53 a.m., Certified Nursing Assistant (CNA) 2 was observed wearing N95 while providing care to the resident in room [ROOM NUMBER]. In a concurrent interview with CNA 2, she stated she was wearing the N95 since the beginning of her shift and just grabbed it from the lobby where the masks were available. CNA 2 stated she was not aware of the N95 brand she was supposed to use so she just grabbed the Honeywell mask (brand of N95 mask). CNA 2 stated she was not fit tested with the Honeywell N95 mask. CNA 2 further stated, she should have used the N95 she was fit tested of. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On November 18, 2024, at 9:55 a.m., LVN 8 was observed wearing N95 when doing medication administration in Residents 48 and Resident 86's room, which was an isolation room. LVN 8 was observed to be using Honeywell N95 mask. In a concurrent interview with LVN 8, he stated he was wearing a N95 respirator mask with a brand name Honeywell DC365N95HC NIOSHN95 (serial number) when providing care to both residents in room [ROOM NUMBER] who were recently diagnosed with COVID 19. LVN 8 stated he just grabbed the N95 respirator mask from the reception area and did not know what type of N95 he was supposed to use. LVN 8 further stated he was not fit tested for this brand of N95 mask. LVN 8 stated he could get infected with COVID 19 and could spread the infection as well if he was not wearing the appropriate N95 mask. On November 18, 2024, at 10:32 a.m., during a concurrent interview and record review with the Infection Preventionist (IP), the IP stated Residents 48 and 86 were both tested positive for Covid 19 on November 15, 2024, and were currently on transmission-based droplet precaution (set of measures used to prevent the spread of infectious diseases). The IP stated LVN 8 and CNA 2 who were assigned to room [ROOM NUMBER], should have followed the policy and procedure of wearing appropriate N95 fit tested respirator mask. The IP stated it defeats the purpose of N95 fit testing if staff will just used any kind of mask. The IP further stated if staff not fit tested , there would increase staff and resident exposure to the Covid-19 virus. A review of the document titled, Respirator Fit Test and Education Acknowledgement Form, dated February 19, 2024, for LVN 8 indicated, LVN 8 passed fit testing for the BYD N95 (brand of N95). A review of Resident 48 and 86's Order Summary, dated November 15, 2024, indicated, .Isolation (contact/Droplet Precautions): PPE (PPE: personal protective equipment - used to protect against infection or illness) including N95 mask, gown, eye protection, gloves every shift for POSITIVE COVID 19 . On November 18, 2024, at 10:10 a.m., during an interview with the DON, he stated he expected the staff to follow the facility's infection control policy and procedure. The DON further stated LVN 8 and CNA 2 should have worn the appropriate fit tested N95 respirator mask to prevent the spread of infection to the facility's staff and residents. A review of the facility's undated policy and procedure titled, Fit Testing Employees, indicated, .It is the policy of this facility to enforce all required Federal and State requirements to ensure the fit testing requirements are adhered to .Fit test each employee to be assigned a respirator . A review of the facility's policy and procedure titled, Infection Control, dated June 2021, indicated, .It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions .Standard precautions include .proper selection and use of PPE, such as gowns, gloves, facemasks, respirators and eye protection .

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	056328	A. Building B. Wing	11/18/2024

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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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50204 Based on observation, interview, and record review, the facility failed to provide a comfortable environment, for one of four residents (Resident 38) when water was leaking from the pipe under the sink, forming a puddle of water on the floor. This failure resulted in the resident feeling uncomfortable and disrupted the resident's daily living needs and environment. Findings: On November 13, 2024, at 9:10 a.m., during a concurrent observation and interview with Resident 38 in his room, a puddle of water was observed under the sink. Resident 38 stated the puddle of water came from the leaking pipe under the sink. Resident 38 stated he requested the staff to fix the pipe long time ago and until now it has not been resolved. Resident 38 further stated it was nasty every time the staff would use the sink, the water drips to the floor. On November 13, 2024, at 9:38 a.m., during an interview with the Maintenance Supervisor (MS), the MS stated he was not aware of the water leak in Resident 38's room. The MS stated if there was water on the floor, staff and residents might step on the wet surface and cause accidents. The MS further stated, the pipe needed to be repaired and tightly sealed. On November 15, 2024, at 8:15 a.m., during an interview with the Administrator (ADM), the ADM stated he was aware that the pipe under the sink needed to be repaired. The ADM further stated, the pipe should have been replaced or repaired to provide a safe, comfortable and functional environment for the residents. A review of the facility's policy and procedure titled, Equipment Maintenance, dated May 2021, 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 .Routine inspections and maintenance will be recorded in the Preventive Maintenance Log .In the event that equipment maintenance or servicing is required between scheduled checks, alert maintenance supervisor about the issue . A review of the facility's undated policy and procedure titled, Homelike Environment, indicated, .It is the policy of this facility to encourage and provide opportunities for each resident to occupy an area reflecting his/her interests, family, or is made homelike .To provide a homelike environment for residents .