STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER: California Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2299 North Indian Canyon Drive Palm Springs, CA 92262	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0557

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48870

Based on interview and record review, the facility failed to promote care that maintained the dignity and respect for one resident (Resident 1), when he was told by facility staff to stop turning his f****** (expletive) call light on if he wanted to be left alone.

This failure had the potential to affect Resident 1's psychosocial well-being.

Findings:

On July 30, 2024, at 12:00 p.m., an unannounced visit to the facility was made to investigate a complaint. Resident 1's record was reviewed.

Resident 1 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD- a lung disease that causes restricted airflow and breathing difficulties), asthma, and depression (a mood disorder that causes a persistent feeling of sadness).

A review of Resident 1's Progress Notes , dated July 28, 2024, indicated, Resident 1 was experiencing shortness of breath and called 9-1-1 (emergency services) for an ambulance. The LVN offered the resident a rescue inhaler and a breathing treatment, but he refused and was transported to the hospital.

A review of Resident 1's Care Plans, dated June 28, 2024, indicated, .Focus: The resident has COPD, at risk for ineffective/impaired breathing pattern .

During an interview on July 30, 2024, at 2:10 p.m., with the Certified Nursing Assistant (CNA), the CNA stated the facility has a strong policy on not using foul language.

During a review of 9-1-1 dispatch calls on August 5, 2024, a staff member can be heard on an open line saying, .you want us to leave you alone, but you keep turning your f****** (expletive) call light on . in response to a statement made by Resident 1.

During a concurrent record review and interview on August 8, 2024, at 10:20 a.m., with the Administrator and Director of Nursing (DON), the 9-1-1 call was played. The Administrator and DON stated they could not identify the voice of the staff member.

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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: 056428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Resident Rights , revised January 1, 2012, indicated . Employees are to treat all residents with kindness, respect, and dignity . A review of the facility's policy and procedure titled, Employee Relations Conduct , dated January 2024, indicated, .The following are examples of conduct that are prohibited and will not be tolerated .Boisterous and other disruptive conduct .creating discord with clients .Rude, discourteous, condescending, unprofessional or otherwise socially unacceptable behavior .the use of disparaging or offensive language on Company's premises .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Nursing & Rehabilitation Center	2299 North Indian Canyon Drive Palm Springs, CA 92262

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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 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48870

Based on observation, interview, and record review, the facility failed to ensure one of three residents reviewed (Resident 4) was assessed, monitored, and supervised to prevent elopement (leaving the facility without permission).

This failure resulted in Resident 4 eloping from the facility and had the potential to cause injury and harm to the resident.

Findings:

On July 30, 2024, an onsite visit was made to the facility to investigate a complaint regarding the elopement of Resident 4.

A record review for Resident 4 indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills).

A review of Resident 4's Progress Notes dated July 29, 2024, indicated, Resident 4 was alert and verbally responsive, was seen walking through the hallways, with episodes of wandering and confusion.

A review of Resident 4's Brief Interview of Mental Status (BIMS - an assessment tool), noted as In Progress , indicated Resident 4 had a score of 6 (severely impaired cognition).

A review of Resident 4's Health Status Notes, dated July 29, 2024, entered at 9:00 p.m., documented by a Licensed Vocational Nurse (LVN), indicated, Resident 4 eloped on July 29, 2024, at approximately 7:35 p.m., a search for Resident 4 was conducted and the local police department was contacted at 8:00 p.m. Resident 4 was brought back to the facility by police at 8:45 p.m., unharmed.

During an observation on July 30, 2024, at 2:45 p.m., with Resident 4 in his room, Resident 4 was observed with a wander guard bracelet (sensor to signal an alarm if a resident tries to leave through an alarmed door) on the right wrist.

During a concurrent observation and interview on July 30, 2024, at 2:55 p.m., with Resident 4, in his room, Resident 4 was lying in bed, eyes closed, and was responsive to verbal stimuli. Resident 4 stated he was ok and was not able to recall the elopement incident.

During an interview on July 30, 2024, at 4:00 p.m., with the LVN, the LVN stated on the evening of July 29, 2024, Resident 4 was sitting by the nurse's station so the LVN could keep an eye on Resident 4 since Resident 4 wandered. The LVN stated he should have ensured there was another staff member at the desk to watch Resident 4 when he left the desk to make rounds.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on July 30, 2024, at 6:55 p.m., with the Administrator, the Administrator stated when a nurse identifies wandering behavior in residents, the nurse does not need to call the doctor for a sitter order, sitters can be provided whenever the risk for elopement is identified so the resident remains safe. A review of the facility's policy and procedure (P&P) titled, Wandering & Elopement, Revised July 2017, indicated, .The facility will identify residents at risk for elopement .The licensed nurse, in collaboration with the Interdisciplinary Team .will assess residents upon admission .and upon identification of significant change in condition .to determine their risk of wandering/elopement .