STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056428	A. Building B. Wing	10/07/2024

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

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** 48000 Based on observation, interview, and record review, the facility failed to protect resident rights for dignity and respect for two of six sampled residents (Residents 1 and 2) when both residents were addressed in a disrespectful manner by a Certified Nurse Aide (CNA) 4. This failure had the potential to cause psychosocial harm and emotional distress to Resident 1 and Resident 2. Findings: On October 3, 2024, 5:05 a.m., an unannounced visit was conducted at the facility to investigate allegations of potential abuse and resident rights. A review of Resident 1's admission record indicated Resident 1 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Resident 1's diagnoses included a disorder of the brain, altered mental status (disorders and injuries that affect brain function), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar). A review of Resident 1's Minimum Data Set (MDS - a standardized comprehensive assessment and care planning tool) dated July 8, 2024, indicated Resident 1's BIMS (brief interview for mental status, ranges from 0 to 15) score was 8, which indicated moderate cognitive impairment. A review of Resident 1's History and Physical dated February 16, 2024, indicated Resident 1 could make his needs known but did not have the capacity to make medical decisions. A review of Resident 2's admission record indicated the resident was admitted to the facility on [DATE], with diagnoses which included cerebral infarction and dyarthria. (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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 3, 2024, at 7:36 a.m., an interview was conducted with a Licensed Vocational Nurse (LVN) 1. LVN 1 stated on September 25, 2024, CNA 4 was observed walking across the main lobby of the facility where Resident 1 was sitting and CNA 4 addressed Resident 1 as a pimp. LVN 1 stated that based on Resident 1's cognitive status, he may not have understood what was being said to him. LVN 1 further stated that addressing the resident in this manner had the potential to cause emotional distress for the resident and hurt his feelings. In addition, LVN 1 observed CNA 4 said, G--damn-it, and the name of Resident 2, and that was when she knew it was directed to Resident 2. LVN 2 stated there had been concerns from other residents due to use of harsh language by CNA 4. On October 3, 2024, at 10:07 a.m., an interview was conducted with Resident 1. Resident 1 was unable to recall CNA 4 or the incident on September 25, 2024. On October 3, 2024, at 11:54 a.m., an interview was conducted with the Receptionist (REC) at the facility. The REC stated on September 25, 2024, she observed CNA 4 addressing Resident 1 stating you look like a f*****g pig. The REC stated she reported her observation to the facility Administrator (ADM). On October 3, 2024, at 12:56 p.m., during interview, the Activity Assistant stated she called CNA 4 to assist Resident 2 and she heard the CNA said to Resident 2, I'm f---king tired of your sh-- (name of Resident 2), this is why you always fall. The Activity Assistant stated she immediately reported what she witnessed to the Administrator. A review of the facility policy and procedure titled, Resident Rights, revised January 1, 2012, indicated, . Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident's rights .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000 Based on observation, interview and record review, the facility failed to ensure the personal privacy of one of six sampled residents (Resident 4) when a visitor unknown to the resident was allowed into the resident's room. This failure caused emotional distress to Resident 4 and put the resident's safety at risk. Findings: On October 3, 2024, 5:05 a.m., an unannounced visit was conducted at the facility to investigate allegations of resident safety. A review of Resident 4's admission record indicated she was admitted to the facility on [DATE]. Resident 4's diagnoses which included fracture of right femur (the only bone in the thigh), repeated falls, difficulty walking. A review of Resident 4's Minimum Data Set (MDS - a standardized comprehensive assessment and care planning tool) dated October 2024, indicated Resident 4's BIMS (brief interview for mental status, ranges from 0 to 15) score was 15, which indicated the resident was cognitively intact. A review of Resident 4's History and Physical dated August 3, 2024, indicated Resident 4 had the capacity to understand and make decisions. On October 3, 2024, at 2:18 p.m., an interview with Resident 4 was conducted. Resident 4 stated Certified Nurse Aide (CNA) 12 let an unknown person have access to her. Resident 4 stated CNA 12 escorted an unknown female into her room and pointed her out to the stranger. Resident 4 stated the unknown female walked up to her, hugged her as if she knew her then sat down in the resident's room and began talking to her. Resident 4 stated she asked the unknown female who she was and what she was doing at the facility. Resident 4 stated the unknown female admitted to her that she lied to gain entrance saying she was Resident 4's sister. Resident 4 stated she informed the unknown female that she did not have a sister. Resident 4 stated she asked the unknown female what she wanted and she said she was there to find out about the facility. Resident 4 stated she did not know how the unknown female gained access to her as she did not know Resident 4's name. Resident 4 stated the encounter made her feel uncomfortable. On October 4, 2024, at 1:32 p.m., an interview was conducted with CNA 12 who stated while she was working, she noticed a female visitor approaching her. CNA 12 stated the female visitor said she was looking for her family member. CNA 12 stated the visitor did identify herself and CNA 12 did not ask the visitor's name. CNA 12 stated she escorted the visitor around the facility to Resident 4's room. CNA 12 stated the visitor entered Resident 4's room where she observed the female visitor hug Resident 4 and asked if Resident 4 was happy at the facility. CNA 12 stated she assumed the visitor and Resident 4 knew each other and left the room. CNA 12 stated she should have asked the visitor's name. CNA 12 stated the resident could have been scared if an unknown individual came into their room and started hugging and speaking to them. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 7, 2024, at 11:30 a.m., an interview with Registered Nurse (RN) 1 was conducted. RN 1 stated the process for visitors at the facility is they must check in at the front desk, sign their name and give details about their business at the facility. RN 1 stated visitors should be able to verbalize who they are visiting at the facility. RN 1 further stated obtaining visitor information is important because it is for the safety and privacy of the resident. RN 1 agreed that the resident could experience fear and stress if a person unknown to the resident was given access to them. October 7, 2024, at 3:42 p.m., an interview with the Director of Staff Development (DSD) was conducted. The DSD stated visitors must stop by the front desk, sign in, and state their business at the facility. If the visitor is at the facility to see a resident, they will see the nurse or nursing supervisor if they are allowed in. The DSD stated the resident could experience emotional distress and they could feel unsafe in the facility because someone had access to them without their permission. On October 7, 2024, at 5:40 p.m., an interview with the facility Administrator (ADM) was conducted. The ADM stated allowing visitors unknown to the resident could have the potential for abuse and could cause emotional distress. The ADM further stated it could make the resident feel uncomfortable and it is a violation of the resident's privacy. A review of the facility policy and procedure (P&P) titled Visitation Rights, dated January 16, 2020, indicated the purpose was .To ensure that residents are able to exercise their rights with regard to visitation . The P&P also indicated . The Facility permits residents to receive visitors subject to the resident's wishes . The P&P further indicated . When a resident chooses to refuse visitation from a particular individual, the name of that person and the date of refusal will be documented in the resident's medical record and Care Plan to ensure that Facility Staff is aware of the restriction .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000 Based on interview and record review, the facility failed to ensure an alleged abuse involving two of six sampled residents reviewed (Residents 1 and 2) were reported to the California Department of Public Health (CDPH) immediately or within two hours of the facility being aware of the alleged abuse. This failure had the potential to result in a delayed investigation of the alleged abuse causing a delay in implementation of corrective actions which placed the residents at risk for further abuse. Findings: On October 3, 2024, 5:05 a.m., an unannounced visit was conducted at the facility to investigate allegations of potential abuse and resident rights. A review of Resident 1's admission record indicated Resident 1 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Resident 1's diagnoses included a disorder of the brain, altered mental status (disorders and injuries that affect brain function), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar). A review of Resident 1's Minimum Data Set (MDS - a standardized comprehensive assessment and care planning tool) dated July 8, 2024, indicated Resident 1's BIMS (brief interview for mental status, ranges from 0 to 15) score was 8, which indicated moderate cognitive impairment. A review of Resident 1's History and Physical dated February 16, 2024, indicated Resident 1 could make his needs known but did not have the capacity to make medical decisions. A review of Resident 1 ' s progress note, dated September 25, 2024, at 11:00 a.m., indicated, .Staff reported that she heard staff use inappropriate words to the resident. Staff reported to Administrator .Left voicemail to [resident's representative] to return call. Will continue to monitor well-being. A review of Resident 2's admission record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included cerebral infarction (stroke), major depressive disorder (continuously depressed mood or loss of interest in activities, causing significant impairment in daily life), dysarthria (weakness in the muscles used for speech, which often causes slowed or slurred speech), and anarthria (a motor disorder that causes a complete or partial loss of speech due to severe impairment of the muscles used for speaking). A review of Resident 2's Minimum Data Set (MDS - a standardized comprehensive assessment and care planning tool) dated September 8, 2024, indicated Resident 2's BIMS (brief interview for mental status, ranges from 0 to 15) score was 9, which indicated moderate cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's History and Physical dated February 6, 2024, indicated Resident 2 could make her needs known but did not have the capacity to make medical decisions. A review of Resident 2"s progress note dated September 25, 2024, at 7:24 p.m., indicated, .Staff reported that she heard staff use inappropriate words to the resident .Resident continue to be roaming around in the hallway in her wheelchair as her regular routine. Notified [resident's representative]. Will continue to monitor health status . On October 7, 2024, at 2:12 p.m., during an interview with Certified Nurse Aide (CNA) 4, he stated he was placed on suspension while an allegation was being investigated but stated he was in the facility for a meeting with the Administrator (ADM). CNA 4 stated he received training on abuse and resident rights in May of 2024. CNA 4 stated on September 25, 2024, he referred to Resident 1 as a, pimp, and stated the words, G*d d**n you, in the presence of Resident 2. CNA 4 stated the allegations occurred at approximately 8:45 a.m. on September 25, 2024. On October 7, 2024, at 2:55 p.m., an interview was conducted with the ADM. The ADM stated he became aware of the allegations on September 25, 2024, at approximately 9:00 a.m. The ADM stated the allegations should have been reported to CDPH within two hours. The ADM further stated that not reporting the allegations within two hours could result in CNA staff not being suspended from the facility in time and the abuse could continue and put the resident at risk for more emotional distress. A review of Resident 1 and Resident 2's facility report facsimile confirmation (sent simultaneously), the confirmation indicated the facility reported the incident to CDPH on September 25, 2024, at 7:02 p.m. A review of the facility's Policy & Procedure, titled, Abuse - Reporting & Investigations, revised March 2018 was reviewed. The P&P indicated .Notification of Outside Agencies of Allegations of Abuse .Administrator or designed representative will .notify the LTC [long-term care] Ombudsman, and CDPH by telephone and in writing .within two (2) hours of initial report.

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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** 48000 Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 3) was supervised and interventions were put in placed to prevent elopement (leaving the facility without the staff's knowledge). This failure resulted in Resident 1 eloping from the facility and had the potential to cause injury and harm to the resident. Findings: On October 3, 2024, 5:05 a.m., an unannounced visit was conducted at the facility to investigate the elopement of a resident. A review of Resident 3's facility admission record indicated Resident 3 was admitted to the facility on [DATE], at 6:25 p.m. with a diagnosis of lumbar fracture (a break in the lower back spine that can cause moderate to severe back pain). There was no photograph of the resident on the admission record. A review of Resident 3's medical record titled Elopement Evaluation, dated October 1, 2024, at 8:22 p.m. indicated the resident had verbally expressed the desire to go home. A review of Resident 3's care plan for risk of wandering/elopement identified. created October 1, 2024, indicated, Clearly identify Resident's room and bathroom; Implement a scheduled toileting program, Implement hydration A review of Resident 3's progress notes dated October 1, 2024, at 8:30 p.m. indicated .Patient arrived at the facility around 1825 (unit of time - 6:25 p.m.) via stretcher . Admitting diagnosis L 1 FX (fracture) from fall and acute pain. HX (history) of falls, ETOH (alcohol abuse), ALOC (altered level of consciousness), anxiety. A&Ox3 (alert and oriented to person, place, and situation) with forgetful. Can make needs known .High risk for falls. Ambulatory (able to walk), but requires frequent reminders of utilizing FWW (front-wheeled walker) and call light due to unsteady gait (the pattern of walking) . On October 4, 2024, at 12:02 p.m., an interview was conducted with Housekeeper (HK) 1. HK1 stated she worked at the facility morning of October 2, 2024, and saw a male unknown to her leaving the facility at approximately 7:00 a.m. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 7, 2024, 11:30 a.m., an interview was conducted with Registered Nurse (RN) 1. RN 1 stated she worked at the facility on October 1, 2024, from 3:00 p.m. to 11:00 p.m. RN 1 stated she completed Resident 3's admission assessment. RN 1 stated Resident 3 was alert and oriented but could not state the current year; however, Resident 3 was able to state that he was in the facility because of the lumbar fracture. RN 1 stated Resident 3 did not want to stay at the facility because a family member was in a local skilled nursing facility and about to be discharged . RN 1 stated there was no photograph taken of the resident because he was admitted after hours. RN 1 stated that Resident 3 was a fall risk and could be injured. RN 1 stated the facility was on a main street and Resident 3 eloping from the facility could have resulted in the resident falling or being struck by a car. On October 7, 2024, 3:23 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 6. LVN 6 stated she was unsure of the hours of the front entrance reception desk and she further stated she was unsure if the front entrance door was locked the night of October 1, 2024. LVN 6 stated that Resident 3 leaving the facility without staff's knowledge could have resulted in him falling or being hit by a car. On October 7, 2024, at 1:17 p.m., an interview was conducted with Certified Nurse Aide (CNA) 9. CNA 9 stated she was scheduled to work at the facility on October 2, 2024, from 7:00 a.m. to 3:00 p.m. CNA 9 stated she arrived at the facility to work at approximately 6:40 a.m. and the front entrance was unlocked when she entered and there was no one at the reception desk. CNA 9 stated she was assigned to provide care for Resident 3, a new admission from the previous night. CNA 9 stated she looked inside the room and the bed assigned to Resident 3 was unoccupied. CNA 9 stated she went to pass out breakfast trays to the residents assigned to her and once she completed that task at approximately 7:30 a.m., she returned to Resident 3's room to take his vital signs. CNA 9 stated Resident 3 was not in the room and could not be located. CNA 9 stated there was no picture of the resident because he arrived late evening the day before. A review of the facility policy and procedure titled, Wandering and Elopement, dated February 10, 2023, indicated, . Residents .assessed to be at risk for elopement, will have a photograph maintained in their medical record .If the facility staff observed a resident leaving the premises unaccompanied or without having followed proper procedures, he/she may: a. Try to prevent the departure in a courteous manner. b. Get help from other Facility Staff in the immediate vicinity, if necessary .