

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  07/30/2025
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 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide a gastrostomy tube (g-tube, a tube inserted through the abdomen into the stomach, to deliver fluids and nutrition) stoma (opening) dressing change daily, for one of three residents reviewed (Resident 2). This failure had the potential to lead to skin breakdown or infection at/or around the stoma site. Findings: On July 28, 2025, at 1:10 p.m., an unannounced visit was made to the facility to investigate complaints related to quality of care. On July 29, 2025, at 8:44 a.m., an interview with the Treatment (Tx) Nurse was conducted. The Tx Nurse stated she was going to perform the dressing change on Resident 2's g-tube stoma site and that the dressing change is to be provided daily. A review of Resident 2's Resident Information, indicated resident was admitted to the facility on [DATE], with a diagnosis of stroke and dysphagia (difficulty swallowing). Resident 2 had a Brief Interview of Mental Status (BIMS-a cognitive assessment) score of 15 (cognitively intact). A review of Resident 2's physician orders, dated, June 13, 2022, at 2:07 p.m., indicated, . Cleanse stoma site with NS (Normal Saline), pat dry, and cover with dry split dressing every day shift for Peg tube (a type of g-tube) . On July 29, 2025, at 8:51 a.m., an interview with Resident 2 and a concurrent interview and observation of Resident 2's g-tube dressing change was conducted. Resident 2 stated her g-tube dressing change wasn't done yesterday. The Tx nurse stated the process to provide a dressing change includes verifying the physician orders, removing the prior dressing, assessing the site, applying the new dressing, then initialing the Treatment Administration Record (TAR), indicating the treatment has been provided. The Tx nurse was observed removing Resident 2's prior g-tube dressing. The dressing was noted to have a moderate amount of dried brown colored drainage on it. The Tx nurse acknowledged the dried drainage and stated, she was not sure if the drainage was from resident's g-tube nutrition or drainage from the site. The Tx nurse stated Resident 2's stoma site appeared red in color, and was cool to the touch. When she touched the site the resident stated, ouch. The Tx nurse stated the redness may be irritation from the site's drainage. The Tx nurse stated the site did not appear infected, but she was going to put a temporary cover on it and notify the physician of the red appearance. The Tx nurse then covered the site. A review of Resident 2's, July 2025 TAR, indicated, Resident 2's g-tube dressing change was initialed by the Tx Nurse on July 28, 2025, indicating the treatment had been provided. On July 29, 2025, at 9:01 a.m., an interview with the Tx nurse, and a record review of Resident 2's July 2025 TAR was conducted. The Tx nurse stated if a resident's treatment is not provided as ordered the process is to endorse the treatment to the next shift, do not initial the TAR, and notify the charge nurse. The Tx nurse stated she was the Tx nurse on July 28, 2025, and verified she did not provide Resident 2's g-tube dressing change as ordered by the physician. The Tx nurse stated she was busy doing rounds (assessing residents) with the wound doctor. The Tx nurse verified she initialed Resident 2's TAR on July 28, 2025, indicating the treatment had been provided. The Tx nurse stated she was not sure why she initialed resident's TAR when the treatment was not provided, but she should not have initialed it. The Tx nurse further stated she did not endorse Resident 2's g-tube dressing change to the next shift or notify the charge nurse. The Tx nurse further stated it is important to provide resident treatments as ordered to avoid the chance of infection. A review of Resident 2's Care Plan, titled, . (Resident 2) requires tube feeding . initiated June 10, 2022, indicated, an intervention of . Provide local care to g-Tube site as ordered and monitor for signs and symptoms of infection . On July 30, 2025, at 1:42 p.m., an interview was conducted with the Director of Nursing (DON) who stated she expects the Tx nurse to follow the physician orders. The TAR is to be initialed by the Tx nurse after the treatment has been provided, and initialing the TAR, when the treatment has not been provided, Is not a practice that we do here. The DON further stated, if the Tx nurse could not provide the treatment as ordered, they are to endorse to the next shift. The DON verified she was aware the Tx nurse had not provided Resident 2's g-tube stoma treatment as ordered on July 28, 2025, and the physician had already been notified. A facility Policy and Procedure titled, Pressure Injury and Skin Integrity Treatment, revised, August 12, 2016, indicated. Policy: Treatments will be provided as ordered by the physician . Treatments administered will be documented on the Treatment Administration Record.</p>		

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F 0692  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide enough food/fluids to maintain a resident's health.  (continued on next page)

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to accurately monitor and document total fluid intake via gastrostomy tube (g-tube, tube inserted through the abdomen, into the stomach to administer medications, nutrition and hydration) and the output (I &amp;O) per physician orders, for two out of three residents (Residents 1 and 2). This failure had the potential to result in resident dehydration leading to other health complications such as decreased urine output, dizziness, rapid heart rate, and altered mental status. Findings: On July 28, 2025, at 1:10 p.m., an unannounced visit to the facility was made for a quality-of-care issue. 1. A review of Resident 1's Resident Information, indicated, resident was admitted to the facility on [DATE], with a diagnosis of dysphagia (difficulty swallowing), and g-tube. Resident 1 had a Brief Interview for Mental Status (BIMS-a cognitive assessment) score of 6 (severe cognitive impairment). A review of Resident 1's, Care Plan dated April 5, 2022, titled, (Resident 1) has an alteration in (g-tube) (related to) Dysphagia ., indicated an intervention of .Monitor intake and output . A review of Resident 1's, Order Summary, indicated following physician orders: - June 14, 2023, untimed, monitor intake and output every shift for (g-tube);- July 21, 2025, untimed, Bolus (all at once through g-tube) Osmolite (nutrition via g-tube), 237 ml (milliliters - a unit of measure), three times a day, via (G-tube) = 711 ml (per day); and- July 21, 2025, untimed, water flush 180 ml (before &amp; after) (nutrition) = 1080 mls (per day). On July 28, 2025, at 4:45 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1, who stated, when administering g-tube hydration and nutrition, she follows the physician orders. LVN 1 stated when monitoring a resident's intake the amounts are documented on the resident's Medication Administration Record (MAR) along with the nurses' initials. LVN 1 verified she was currently Resident 1's nurse and she had already administered resident's ordered nutrition and hydration for the night. A review of Resident 1's MAR for the Month of July 2025, indicated LVN 1 documented Resident 1's intake (I) as 186.5 (ml), and an output (O) as 50(ml), on the dates of July 1-3, 7-10, 13-16, 19-22, and 25-28, 2025. On July 28, 2025, at 5:19 p.m., a concurrent interview with LVN 1, and record review of Resident 1's physician orders, and July 2025 MAR was conducted. LVN 1 verified Resident 1 had physician orders for 180 ml of water before and after nutrition, and 237 ml of nutrition ordered daily on the evening shift. LVN 1 verified she did not add the total nutrition and hydration she administered to Resident 1 per physician orders, on the dates of July 1-3, 7- 10, 13-16, 19-22, and 25-28, 2025, and stated she should have. On July 30, 2025, at 1:42 p.m., a concurrent interview with the Director or Nursing, (DON), and record review of Resident 1's, g-tube orders, and July 2025 MAR was conducted. The DON stated she expects staff to monitor a resident's I&amp;O by adding up the total I&amp;Os for the shift, and document the totals on the resident's MAR. The DON stated she reviewed Resident 1's g-tube physician orders, and the MAR. The DON verified staff are inconsistently documenting I&amp;Os on the resident's MAR, as staff were not adding up the fluids and documenting them correctly as ordered by the physician. 2. A review of Resident 2's Resident Information, indicated Resident 2 was admitted to the facility on [DATE], with a diagnosis of stroke and dysphagia. Resident 2 had a BIMS score of 15 (cognitively intact). A review of Resident 2's Care Plan titled, (Resident 2) is at risk for dehydration ., initiated on January 22, 2025, indicated, an intervention of, . Monitor and document intake and output . A review of Resident 2's, physician orders, indicated the following: - December 6, 2024, untimed, 200 ml water flush, every 6 hours = 800 ml/(per) day; January 25, 2024, untimed, monitor intake and output every shift for (g-tube);- March 25, 2025, untimed, 1 Carton of (nutrition) five times per day = 1185 ml; and- August 17, 2023, 60 ml water flush before and after (nutrition) bolus, three times a day. On July 28, 2025, at 4:45 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1 who stated when administering g-tube hydration and nutrition, she follows the physician orders. LVN 1 stated when monitoring a resident's I&amp;O, the amounts are documented on the resident's MAR, along with the nurse's initials. LVN 1 verified she was Resident 2's nurse. A review of Resident 2's, Medication Administration Record (MAR), dated July 2025, indicated, . Monitor . every shift for (g-tube) intake . Further review indicated, LVN 1 documented 20 mls on the dates of, July 1, 2, 9 &amp; 16 and 30 mls, on the dates of July 3, 7, 8, 10, 13-15, 19-22, &amp; 25-28, 2025. On July 28, 2025, at 5:19 p.m., a concurrent interview with LVN 1, and record review of Resident 2's hydration orders, and the July 2025 MAR was conducted. LVN 1 verified Resident 2 had hydration orders for 200 ml water flush every 6 hours, nutrition orders for 1 Carton (five times per day) = 1185 ml, and orders to monitor Resident 2's I&amp;O via g-tube every shift. LVN 1 verified, she documented 20 mls on Resident 2's MAR (evening shift) on the dates of, July 1, 2, 9 &amp; 16, and 30 mls on the</p>		