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	03/09/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to administer the resident's morning medications and notify the doctor (Dr) on February 20, 2026, for one of three residents reviewed (Resident 1).This failure had the potential for Resident 1 to experience adverse effects from not receiving their morning medications as ordered.Findings:On March 9, 2026, an unannounced visit was made to the facility for a Quality-of-Care issue.A review of Resident 1's, Resident Information, indicated, the resident was admitted to the facility on [DATE], with a diagnosis of Pulmonary Embolism (A blood clot in the lungs).Further record review indicated Resident 1 had a Brief Interview of Mental Status (BIMS-a cognitive assessment) score of 15, no cognitive impairment.On March 9, 2026, at 11:15 a.m., an interview was conducted with Resident 1 who stated she did not receive her morning (9:00 a.m.) medications on February 20, 2026. Resident 1 stated she did not experience any adverse side effects from missing her morning medications on February 20, 2026.A review of Resident 1's Doctor's (Drs) Orders, indicated Resident 1 had the following medications ordered for the morning of February 20, 2026: Eliquis (Blood thinner) 5 mg (Milligrams-a unit of measure); andHydrochlorothiazide (Anti-diuretic-helps to eliminate excess fluid and swelling of legs) 25 mg.A review of Resident 1's Medication Administration Record (MAR), dated February 20, 2026, indicated Resident 1's morning medications were not administered by Licensed Vocational Nurse (LVN) 1.A review of Resident 1's Progress Notes, dated February 20, 2026, indicated no documentation explaining why Resident 1 did not receive her morning medications. A review of Resident 1's Care Plan titled, Resident (1) has edema (fluid retention), initiated January 24, 2024, indicated the intervention of . Administer Hydrochlorothiazide as ordered . Further review of Resident 1's Care Plan titled, Resident (1) is on (an) anticoagulant (blood thinner) therapy Eliquis, indicated the intervention of, . Administer ANTICOAGULANT medications as ordered by (the Dr) .On March 5, 2026, at 2:17 p.m., a concurrent interview with the Director of Nursing (DON) and review of Resident 1's February 2026 MAR and documentation was conducted. The DON stated it's the facility's policy medications can be administered one hour before to one hour after, the ordered/scheduled times. The DON further stated that when medications are not administered as ordered, she expects the medication nurse to notify the Dr, follow the Drs orders if any, and document. The DON verified LVN 1 was Resident 1's medication nurse on February 20, 2026, and the resident's MAR indicated Resident 1 did not receive their morning medications as ordered. The DON further verified there was no documentation on February 20, 2026, provided by LVN 1 explaining why Resident 1 did not receive her medications or notification to the Dr.On March 9, 2025, at 3:35 p.m., an interview was conducted with LVN 1, who stated it is the facility policy that medications can be administered between one hour before and one hour after the ordered medication times. LVN 1 stated when she does not administer a resident's scheduled medications, she will notify the Dr and document a progress note.On March 12, 2026, at 2:10 p.m., a concurrent interview with LVN 1 and record review of Resident 1's February 2026 MAR and documentation was conducted. The LVN stated when a resident is scheduled to go out on a pass, the nurse should administer their scheduled medications prior to the resident leaving the facility. LVN 1 verified she was Resident 1's medication nurse the morning of February 20, 2026, and she did not (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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(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	administer Resident 1's morning medications that day. LVN stated she could not remember why she did not administer Resident 1's medications, but she may have thought resident was out of the facility on a day pass. LVN 1 further verified she did not notify the Dr or document a progress note explaining why Resident 1 did not receive her medications the morning of February 20, 2026, stating she should have. LVN 1 stated Resident 1 did not report any signs or symptoms of side effects from not receiving her morning medications February 20, 2026.A facility policy titled, Medication Administration, with an effective date of August 19, 2025, indicated, .Policy . All medications shall be administered . according to physician's (Drs) orders.The facility shall ensure residents receive the correct medication in a timely, safe and documented manner.Process .Administration of Medications.Medications must be administered within one hour before or one hour after the scheduled time.Holding Medications .Whenever a medication is held of any reason, it must be documented along with reason and the prescribing (Dr) will be notified.