

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/17/2026
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 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** Based on observation, interview, and record review, the facility failed to immediately respond to a Wander Guard alarm (A bracelet that triggers an alarm when the resident attempts to exit the facility - elopement) for one of three residents reviewed (Resident 1). This failure resulted in Resident 1's elopement from the facility. Resident 1 experienced a fall outside of the facility and was transported to the General Acute Care Hospital (GACH) for evaluation and treatment. Findings: On May 28, 2026, at 11:00 a.m., a concurrent observation and interview was conducted with Resident 1 who stated on May 22, 2026, he walked out of the facility. He stated Nobody was around .so I left . Resident 1 did not know what time he left the facility. Resident 1 stated after leaving the facility he fell and was taken to the hospital. Resident 1 was observed to have two scabs on his left knee, one scab on his right knee, and a small laceration (cut) on the left side of his forehead just above his eye, with three intact sutures. Resident 1 stated he was fine and was not in pain. Further observation indicated Resident 1 was wearing a Wander Guard on his left wrist. A review of Resident 1's Progress Notes, dated May 23, 2026, at 12:15 a.m., indicated, . After change of shift, during rounds CNA noticed patient (Resident 1) was not in bed. CNA reported to nurse. All staff in the building immediately went from room to room and outside looking for patient. PM (3-11 shift) nurse was called to see if patient was OOP (out on pass) or sent to the hospital. DON (Director of Nursing) was called and nurse was instructed to call 911 (emergency services) and report elopement. Nurse called 911, gave dispatcher patient name and was informed patient was found on the street at 2230 (10:30 pm) and taken to (name of GACH). Family was notified by DON. A review of Resident 1's, Resident Information, indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis of Hemiplegia (partial or total paralysis) of his right side, with muscle weakness and unsteadiness on his feet. A review of Resident 1's, Brief Interview for Mental Status (A cognitive assessment), dated, March 19, 2026, indicated a score of four out of fifteen, severely cognitively impaired. A review of Resident 1's, Elopement Evaluation, dated, March 19, 2026, indicated resident had a history of wandering the facility, and elopement attempts prior to admission to the facility. A review of Resident 1's, Doctor's orders, dated May 5, 2026, at 9:56 a.m., indicated . Wander guard . to right wrist for safety/elopement risk . On May 28, 2026, at 1:55 p.m., an interview was conducted with CNA 1 who stated when the facility exit door alarms, the process is to immediately go to the door alarming and assess the situation; check inside and outside of the facility for the resident who may have triggered the alarm or exited the facility; alert all staff on the radio the exit alarm was going off; and check the facility to ensure all residents are present. CNA 1 stated on the night of May 22, 2026, at approximately 10:15 p.m., she was doing rounds on the residents when she heard the front door alarm. CNA 1 stated the alarm was on for approximately four to five minutes. CNA 1 stated she walked over to the front door and she didn't see any residents within the immediate area. She turned off the alarm, looked out the window, cracked open the front door, and she did not see any residents. CNA 1 verified she did not walk outside to make sure a resident didn't exit the facility unsupervised. CNA 1 further stated she did not see any staff around the area to ask about the alarm, she did not speak to other staff regarding the alarm, and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 056428	If continuation sheet Page 1 of 2

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she did not report the incident to any staff members or the charge nurse. CNA 1 further stated she should have walked outside and looked around the facility to check if a resident was present, and she should have reported the alarm to other staff members including the charge nurse. On May 28, 2026, at 2:50 p.m., an interview was conducted with the DON who stated when the exit door alarms go off staff are to check right away, and if they do not initially see a resident present in the area, staff should look outside of the facility to ensure a resident did not exit unattended. She expected staff to do a head count, of residents when the alarm is going off and there are no residents around. The DON stated on May 23, 2026, after she was notified Resident 1 was missing, she called the GACH and was informed Resident 1 had fallen and sustained a laceration to his left forehead, and skin scrapes to both knees. The DON stated she was informed Resident 1 was found and picked up by the police at 10:30 p.m., and arrived at the GACH at 10:50 p.m. (May 22, 2026). A review of Resident 1's Progress Notes, dated, March 23, 2026, at 8:56 a.m., indicated Resident 1 returned to the facility unable to give details of why he was out of the facility or at the hospital.		