

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

Printed: 10/09/2026
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 07/09/2026
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure wound treatments ordered by a wound consultant were implemented in a timely manner for five of six residents reviewed for pressure injuries (PI - bed sore), Residents 1, 2, 3, 4, and 5. This failure resulted in the delay of the appropriate treatment as ordered by the wound consultant and contributed to the worsening of Residents 1 and 2's PI. In addition, this failure had the potential to contribute to the worsening of Residents 3, 4 and 5's PI. Findings: 1. A review of Resident 1's admission Record indicated that the resident was admitted to the facility on [DATE], with diagnoses which included fracture (break in the bone) of the right tibia. Resident 1 was transferred to the general acute hospital (GACH) due to hyperglycemia (high blood sugar) on May 24, 2026, and returned to the facility on May 25, 2026. A review of Resident 1's Progress Notes Type: N-Adv Skin Issues, on May 25, 2026, indicated the resident had a sacrococcyx (the area where a large triangular bone at the base of the spine [sacrum] connects to the tail bone [coccyx]) unstageable (UTD - a deep bedsore where the true depth of the damage is blocked by dead, hardened, or decaying tissue) pressure injury (PI - bedsore) measuring 7 centimeters (cm - a unit of measurement) in length (L - a unit of measurement) x 9 cm in width (W - a unit of measurement) with 100% epithelial cells (new layer of skin cells, white or light pink in color). On July 6, 2026, at 12:14 p.m., during a telephone interview with Resident 1's family member (FM 1), FM 1 stated she brought Resident 1 home on June 19, 2026, and the next day (June 20, 2026), the resident was taken to the GACH because her wound was bad. FM 1 stated Resident 1 was now back home under hospice care (specialized medical care for people with serious illness who are nearing the end of life). On July 6, 2026, at 12:42 p.m., during a concurrent interview and record review of Resident 1's medical record with Treatment Nurse (TN) 1, TN 1 stated the following: -On May 25, 2026, Resident 1 returned to the facility from the GACH with a sacrococcyx deep tissue pressure injury (DTPI - intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration), the treatment order was medical grade honey (MGH); -On May 26, 2026, the Wound Consultant (WMD) gave a verbal order of MGH for Resident 1's sacrococcyx DTPI; -On June 2, 2026, Resident 1's sacrococcyx DTPI declined to a stage 3 PI (a serious, full-thickness bedsore extending into the subcutaneous fatty layer) and measured 7 cm (L) x 9 cm (W) x 0.4 cm (D) with 50% granulation (pink to beefy-red tissue) and 50% eschar (a thick, dry, leathery layer of dead tissue) and the treatment ordered was Santyl (prescription medicine that removes dead tissue from wounds); -On June 9, 2026, Resident 1's stage 3 sacrococcyx PI was restaged to UTD that measured 7 cm (L) x 9 cm (L) x undetermined (D) with 25% granulation, with 75% eschar and the treatment ordered was Santyl; and -On June 16, 2026, Resident 1's UTD PI measured 6 cm (L) x 7 cm (W) x undetermined (D) with 25% granulation, 25% slough (a soft, moist, yellow, or white substance that forms in a wound) and 50% eschar, the treatment ordered was Santyl. A review of the facility document titled Wound Assessment (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	and Plan, documented by the WMD indicated the following: May 26, 2026, .Wound Location: Sacro-coccyx .DTPI .Treatment Order .Medical Honey Gel .; and June 2, 2026, Wound Location: Sacro-coccyx .3 (Full thickness .) Healing status: Declined .Treatment Order. Santyl .A review of Resident 1's, Order Details, indicated the MGH was not transcribed (entered in the medical record) until May 31, 2026 (five days after it was ordered) and the Santyl order was not transcribed until June 16, 2026 (14 days after it was ordered).On July 7, 2026, at 10:35 a.m., during a concurrent interview and record review of Resident 1's medical records, TN 1 stated she transcribed the MGH order on May 31, 2026, and the Santyl order on June 16, 2026, because she waited to receive the WMD's written notes. TN 1 stated that the WMD typically provides verbal treatment orders during wound rounds (a scheduled bedside evaluation where a team of nurses and/or physicians examines, measures, and discusses a resident's wounds). TN 1 stated that she normally carry out (transcribe) those verbal orders on the same day the orders were given. TN 1 further stated that the WMD's written notes were sometimes different from his verbal orders. On July 7, 2026, at 11:11 a.m., during an interview, the Director of Nursing (DON) stated physician verbal orders are implemented the same day, to avoid delays in treatment; and are clarified with the physician if there were questions. The DON stated she expected TN 1 to transcribe wound treatment orders for Resident 1 on the same day the orders were given.On July 7, 2026, at 4:23 p.m., during a telephone interview, the WMD stated he verbally would communicate treatment changes during weekly rounds and would expect those changes to be implemented the same day. The WMD stated he ordered MGH on May 26, 2026, and Santyl on June 2, 2026, and expected both treatments to be implemented the same day they were ordered for Resident 1.On July 9, 2026, at 3:42 p.m., during a telephone interview, the WMD stated he was unaware that the treatment orders for Resident 1 were not implemented on the same day they were ordered and the delays in initiating the treatments ordered could contribute to the worsening of Resident 1's PI.2. On July 6, 2026, at 11:35 a.m., during a concurrent observation and interview, Resident 2 was in her room, lying on an air mattress, with the head of bed elevated at 45 degrees, alert, awake, and there were two family members (FM) at the bedside. Resident 2 did not respond during the interview. Resident 2's FM (FM 2) stated Resident 2 only speaks Spanish. FM 2 stated Resident 2 has a big bed sore (PI - pressure injury) on her buttocks which developed in the facility.A review of Resident 2's admission Record indicated she was admitted to the facility on [DATE], with diagnoses which included stroke with right side weakness.A review of Resident 2's Progress Notes Type: N ADV Clinical Admission dated June 11, 2026, indicated there were no skin issues identified.A review of Resident 2's Progress Note Type: N Adv - Skin Check dated June 13, 2026, indicated the resident had a stage 2 (a damaged area of the skin that forms an open wound) coccyx PI and a left buttock open lesion that were present on admission.On July 6, 2026, at 12:42 p.m., during a concurrent interview and record review of Resident 2's medical record with Treatment Nurse (TN) 1, TN 1 stated the following:-On June 13, 2026, Resident 2 had a stage 2 coccyx PI that measured 5 cm (L) x 0.8 cm (W) and the treatment ordered was zinc barrier cream (helps rebuild damaged skin barrier);-On June 16, 2026, Resident 2 had a stage 2 right buttock PI that measured 2 cm (L) x 2 cm x (W) x 0.2 cm (D); Resident 2's stage 2 coccyx PI became a sacrococcyx DTPI that was dark red to maroon in color and measured 4 centimeters (cm- a unit of measurement) in length (L - a unit of measurement) x 3 cm in width (W - a unit of measurement) with 100% epithelial (thin tissues covering all the exposed surfaces of the body); the treatment ordered for both PIs was zinc barrier cream; -On June 23, 2026, Resident 2's stage 2 right buttock deteriorated to stage 3 PI that measured 7 cm (L) x 3.5 cm (W) x 0.3 cm (D) with 50% epithelial cells and 50% granulation tissue; Resident 2's sacrococcyx DTPI deteriorated to a stage 3 PI that measured 9 cm (L) x 4 cm (W) x 0.5 cm (D) with 50% epithelial and 50% granulation (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(D), with no changes in treatment; Resident 3's stage 3 right calf PI measured 1 cm (L) x 1 cm (W) x 0.2 cm (D) and the treatment order was changed to wound gel;-She (TN 1) transcribed the Santyl order on May 28, 2026 (16 days after it was ordered). She did not know why TN 2, who was with the wound consultant (WMD) during the wound rounds, did not transcribe the order on May 12, 2026;-She (TN 1) transcribed the MGH order for the left heel on June 28, 2026 (5 days after it was ordered on June 23, 2026) because she was waiting to receive the WMD's written notes; and-The wound gel ordered on June 30, 2026, was not transcribed because she (TN 1) only noticed it today.A review of Resident 3's Wound Assessment and Plan, documented by the WMD, indicated the following:May 12, 2026, .right posterior calf .Pressure Injury Stage Upon Completion of Visit: 3 (Full thickness) .Treatment Order .Santyl .; June 23, 2026, .Left heel .Pressure Injury Stage Upon Completion of Visit: 3 (Full thickness) .Treatment Order .Medical Honey Gel .; June 30, 2026, .right posterior calf .Pressure Injury Stage Upon Completion of Visit: 3 (Full thickness) .Treatment order .Wound gel . On July 7, 2026, at 3:40 p.m., during a concurrent observation and interview, Resident 3 was lying on an air mattress, eyes were closed, with steady breathing, with bilateral heel protectors. Resident 3 did not respond when her name was called. On July 7, 2026, at 4:24 p.m., during a telephone interview, the WMD stated he ordered Santyl on May 12, 2026, MGH on June 23, 2026, and wound gel on June 30, 2026, for Resident 3 and he expected the treatments to be implemented the same day they were ordered. On July 9, 2026, at 3:42 p.m., during a telephone interview, the WMD stated he was unaware the treatment orders for Resident 3 were not implemented on the same day it was ordered and the delay in initiating out the treatment orders could worsen Resident 3's Pls. 4. A review of Resident 4's medical record indicated the resident was re-admitted to the facility on [DATE], with diagnoses which included sacrococcyx (the area where a large triangular bone at the base of the spine [sacrum] connects to the tail bone [coccyx]) stage 4 (full thickness skin and tissue loss with exposed or palpable fascia (connective tissue), muscle .bone in the ulcer) PI.A review of Resident 4's H & P dated April 24, 2026, indicated the resident can make needs known but cannot make medical decisions.A review of Resident 4's Braden Scale dated May 14, 2026, indicated the resident has a moderate risk of developing Pls.A review of Resident 4's Treatment Administration Record for the month of July 2026, indicated the resident has a sacral stage 4 PI and the treatment was a wound vacuum (wound vac - an advanced wound treatment that promotes healing through controlled suction) to be changed every Tuesday, Thursday and Friday.On July 7, 2026, at 2:03 p.m., during a concurrent interview and record review of Resident 4's medical record with Treatment Nurse (TN) 1, TN 1 stated the following:-Resident 4 was transferred out to the GACH due to a deteriorating stage 3 sacrococcyx PI on April 16, 2026;-Resident 4 was re-admitted to the facility on [DATE], with a stage 4 coccyx PI;-On April 24, 2026, Resident 4's stage 4 coccyx PI measured 3.4 centimeters (cm - a unit of measurement) in length (L - a unit in measurement) x 3 cm (W) x 2.5 cm (D) and the treatment was Santyl (prescription medicine that removes dead tissue from wounds);-On May 5, 2026, Resident 4's stage 4 coccyx PI measured 4.4 cm (L) x 2 cm x 2.5 cm with 90% granulation (pink to beefy-red tissue) and 20% slough (a soft, moist, yellow, or white substance that forms in a wound) with no changes in treatment;-On May 12, 2026, Resident 4's stage 4 coccyx PI declined and measured 4 cm (L) x 2 cm (W) x 2.5 cm (D) and the treatment order was changed to wound vac;-The wound vac was started on May 19, 2026 (seven days after it was ordered) because that was when she received the wound vac. TN 1 stated while they were waiting for the wound vac, they continued to apply Santyl to Resident 4's PI; and-She documented on May 20, 2026, that on May 12, 2026, the WMD gave orders for a moist to dry dressing until the wound vac arrives.A review of Resident 4's Wound Assessment and Plan, documented by WMD, dated May 12, 2026, indicated, .Wound location: sacrum .Pressure Injury Stage (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	upon completion of visit: 4 (Full thickness: Exposed underlying structure) .Treatment Order .Negative Pressure Wound Therapy .A review of Resident 4's Treatment Administration Record for the month of May 2026, indicated the resident continued to receive Santyl on May 12 to 19, 2026 and orders for MGH moist to dry dressing was implemented on May 20 to 22, 2026. Further review of the TAR did not indicate an order to continue Santyl while awaiting the wound vac.On June 7, 2026, at 3:50 p.m., during a concurrent observation and interview, Resident 4 was in her room, lying on an air mattress, alert and awake, with wound vac at bedside. Resident 4 stated she has a bed sore on her bottom and when asked about the wound vacuum, Resident 4 responded it's getting better and do not worry about it.On June 7, 2026, at 4:23 p.m., during an interview, the wound consultant (WMD) stated he ordered the wound vac for Resident 4 on May 12, 2026, and it usually takes a day for the facility to have a wound vac. The WMD stated he was not notified that the facility did not have a wound vac for several days and that facility usually notifies him if they do not have it. The WMD stated the delay in starting the wound vac could potentially contribute to worsening of Resident 4's PI.On June 7, 2026, at 6:09 p.m., during an interview, the Director of Nursing (DON) stated they usually have a wound vac available in house and if it was available, it should be placed right away. The DON stated for Resident 4, TN 1 should have called and followed up with the vendor providing the wound vac, if they still have not received the wound vac, they should have an alternative treatment of wet to dry dressing in place.5. On July 9, 2026, at 9:29 a.m., during a concurrent observation and interview, Resident 5 was in her room, lying on an air mattress, alert and awake, with a wound vacuum (wound vac - an advanced wound treatment that promotes healing through controlled suction) next to her. Resident 5 stated she is quadriplegic (a person affected by paralysis that impacts both arms and both legs, as well as the torso) and when she was transferred to the facility, she already had a wound on her bottom which worsened due to lack of care from the staff.A review of Resident 5's medical record indicated Resident 5 was initially admitted to the facility on [DATE], with diagnoses which included fracture of the neck and stage 4 (full thickness skin and tissue loss with exposed dermis, adipose, and various underlying structures) sacral PI.A review of Resident 5's Braden Scale dated April 23, 2026, indicated the resident is at moderate risk for developing PI.On June 9, 2026, at 11:32 a.m., during a concurrent interview and record review of Resident 5's medical record with TN 1, TN 1 stated the following:-Resident 5 was sent out to the general acute hospital (GACH) on April 13, 2026, because the resident's stage 4 coccyx PI developed a foul odor and increased in size. The treatment at the time was a wound vac with changes every Monday, Wednesday and Friday;-Resident 5 returned to the facility on April 23, 2026, with multiple PIs including stage 4 sacral PI which was being treated with wound vac and UTD right lateral malleolus (the bony prominence located on the outer side of the ankle) PI which was being treated with Santyl (prescription medicine that removes dead tissue from wounds);-On May 26, 2026, Resident 5's UTD right lateral malleolus PI was restaged to stage 3 PI and there were no changes in treatment order;-On June 9, 2026, the treatment order for the stage 3 right lateral malleolus was changed to medical grade honey (MGH); however, it was not applied due to delayed written notes from the WMD and lack of verbal communication; and-Resident 5 continued to receive Santyl on his stage 3 right lateral malleolus from May 12 to June 15, 2026.On July 9, 2026, at 5:10 p.m., during an interview, the Director of Nursing (DON) stated, for Resident 5, the orders given by the WMD should be implemented on the same day it was ordered; if the nurses are unsure of the orders, they can clarify the orders with the WMD.A review of the facility's policy and procedure titled Physician Orders dated November 16, 2022, indicated .The licensed nurse receiving the telephone/verbal order will transcribe the order in the resident medical record at the time the order is taken .A review of the facility's policy and procedure titled Skin Integrity Management dated July 31, (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct and review planned quality improvement monitoring activities and audits to determine whether corrective actions were effective for the problems identified for pressure injuries (PI). This failure resulted in wound treatment orders recommended by the wound consultant (WMD) not being implemented in a timely manner, for five of six residents reviewed for PIs. (Cross refer F-686) Findings: A review of the facility document titled, QAPI (Quality Assurance and Performance Improvement) Plan dated [DATE], indicated the improvement plan required weekly wound reports, monitoring of implementation of wound treatment orders, and presentation of audit findings to the QAPI Committee for review and recommendations monthly for three months. A review of the facility's QAPI Meeting Minutes from January to May 2026 did not include any documentation of wound treatment audits, monitoring tools or evidence that audit findings were reviewed by the QAPI Committee to evaluate the effectiveness of corrective actions. On July 9, 2026, at 1:55 p.m., during an interview with the Director of Nursing and Administrator (ADM), the ADM stated the facility conducts QAPI meetings monthly and quarterly to discuss areas needing improvement and to assess if the facility is improving. The ADM stated wounds and skin integrity had been a focus since December 2025. On July 9, 2026, at 4:37 p.m. during an interview with the Regional Quality Management Consultant (RQMC), the RQMC stated the Treatment Nurse should review the audit tool, report her findings to the DON so that it can be present to the QAPI Committee for review and recommendations. A review of the facility's policy and procedure titled, Quality Assurance and Performance Improvement (QAPI) Program dated June 4, 2024, indicated the facility implements and maintains an ongoing, facility wide Quality Assurance and Performance Improvement (QAPI) Program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality of care and resolve identified issues .		