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	05/07/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain the kitchen environment in a clean and sanitary condition when:1. The kitchen sink and underneath the preparation counter were found to have black residue, dark build up, and areas of flaking and rusty-brown discoloration.2. The underside and bottom portion of the kitchen sink were coated with stains and spots of scattered yellow and brown food debris. 3. The kitchen sink's white funnel-shaped drainpipe contained debris, rust, and old food residue. These failures had the potential to expose residents to contaminants and increased the risk of food-borne illnesses.Findings:1. During an initial observation tour of the kitchen and interview on 5/4/26 at 7:52 AM with the Dietary Manager (DM), the area underneath the kitchen sink and preparation counter were found covered with dark residue and rust. The DM confirmed the presence of the black residue, dark build up, and areas of flaking and rusty-brown discoloration under the kitchen sink area.2. During a concurrent observation and interview on 5/4/26 at 7:52 AM with the DM, the underside and bottom portion of the kitchen sink were observed coated with stains and spots of scattered yellow and brown food debris and the kitchen sink's white funnel-shaped drainpipe contained debris, rust and old food residue. The DM confirmed that the bottom part and drainpipe of the kitchen sink were coated with stains and spots of scattered food debris and residue and acknowledged that the sink required cleaning.The following facility kitchen logs were reviewed: CNRC Weekly Deep Cleaning Chart for April Week 4 Food and Nutrition: Cleaning Log AM Cook, dated 4/6/26-4/12/26 Food and Nutrition: Cleaning Log PM Cook, dated 4/27/26-5/3/26 Cook's Cleaning Log, dated 4/20/26-4/25/26 Dishwasher/Dietary Aide Cleaning Log, 4/27/26 - 5/3/26The above logs did not include the area underneath the kitchen sink and preparation counter was cleaned daily.During a concurrent interview and record review on 5/5/26 at 4:28 PM with Registered Dietitian (RD), the facility's Policy & Procedure (P&P) titled, Cleaning Schedule with date of revision October 1, 2014, was reviewed. The P&P indicated, The dietary staff will maintain a sanitary environment in the dietary department by complying with the routine cleaning schedule developed by the Dietary Manager . The RD acknowledged that kitchen sink area required cleaning and replacement.During an interview on 5/6/26 at 7:19 AM with the DM, the findings underneath the kitchen sink and preparation area were verified. The DM acknowledged that the area required cleaning and replacement and affirmed responsibility for addressing these findings.

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

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	05/07/2026

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to ensure its Payroll Based Journal (a mandated reporting system used by the Centers for Medicare & Medicaid Services (CMS) to collect auditable, employee-level staffing data from long-term care facilities) was submitted for the first fiscal year quarter.This deficient practice resulted in the facility's failure to provide required information regarding staffing levels necessary to ensure the provision of safe and comprehensive care for all residents in accordance with federal regulations.Findings:During a review of the facility's PBJ Staffing Data Report for Fiscal Year Quarter 1, dated 4/26/26, the PBJ report indicated the facility failed to submit data for the fiscal year (FY) quarter 1 2026 (October 1-December 31). During an concurrent interview and record review, on 5/6/26 at 10:29 AM, with the Clinical Project Director (CPD), the CPD stated the PBJ staffing data submitted reflected a submission for quarter 2. The CPD stated the facility's CMS Submission Report dated 2/13/26 indicated, Fiscal Quarter 2 was reflected.During a record review of the State Operations Manual (SOM), dated 7/23/2025, the SOM indicates the facility is responsible for submitting staffing data through the CMS Payroll-Based Journal (PBJ) system. The facility's failure to submit PBJ data, as required, will be reflected on their CASPER report and result in a deficiency citation.

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	05/07/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care and services in accordance with professional standards of practice for three of five sampled residents (Resident 17, 1, and 39) when:Resident 17's respiratory bag was mislabeled, and respiratory supplies were not labeled changed as ordered.Resident 1's nasal cannula (NC- a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was not changed as ordered.Resident 39's respiratory supplies were unlabeled and kept in Resident 39's bedside for several days after the treatment was completed.Findings:1. A review of Resident 17's Face Sheet, (front page of the chart that contains a summary of basic information about the resident) dated 5/7/26, indicated Resident 17 was readmitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary ([COPD] - a progressive lung disease which blocks air flow making breathing difficult), and shortness of breath.A review of Resident 17's Order Summary Report, dated 5/7/26, indicated, Resident 17 had the following physician's orders dated:5/15/25 to Change nebulizer mask/tubing every Sunday Noc (night) shift or AS NEEDED every night shift every Sun (Sunday)10/31/25 for Albuterol Sulfate Inhalation Solution (a liquid medication turned into fine mist for inhalation used to open the airways) (2.5 MG [milligram] - metric unit of measurement, used for medication dosage and/or amount)/3 ML ([milliliter] - metric unit of measurement for volume of a liquid) 3 milliliter inhale orally via nebulizer every 6 hours as needed for SOB (Shortness of Breath)During a concurrent observation and interview on 5/4/26 at 10:24 AM, with the Licensed Vocational Nurse (LVN) 2, by Resident 17's doorway, LVN 2 removed the respiratory bag from Resident 17's bedside and stated he was asked to replace it. An inspection of the respiratory bag and label was conducted with LVN 2. The respiratory bag found at Resident 17's bedside indicated Name: [Name of Resident 1].Room: [Resident 1's room and bed number].Time: 6 AM.Date Issued: 3/30. LVN 2 confirmed that the respiratory bag contained a nebulizer tubing (flexible, hollow plastic tube that connects air compressor machine to the medication cup) that was not labeled with a date and the nebulizer mouthpiece (accessory part that delivers medication directly into the lungs through the mouth) had a date of 3/30. LVN 2 stated that the facility's expectation and practice was to change it every week and as needed. LVN 2 also stated that these should have been changed as bacteria can grow on it.During a concurrent observation and interview on 5/4/26 at 10:33 AM, in Resident 17's room, Resident 17 was alert, verbally responsive, and lying on his bed. Resident 17 was receiving oxygen via NC attached to an oxygen concentrator at a rate of 2 LPM (Liters Per Minute- unit of measure or dose). Resident 17 also stated that he received breathing treatments when needed.During a subsequent observation on 5/4/26 at 10:36 AM, LVN 2 placed a new respiratory bag with respiratory supplies at Resident 17's bedside.During a concurrent observation and interview on 5/4/26 at 12:20 PM with LVN 2, at Resident 17's bedside, the newly replaced respiratory bag containing respiratory supplies was inspected. The respiratory bag found at Resident 17's bedside had a new label which indicated, Name: [Name of Resident 1] .Date Issued: 5/4/26. LVN 2 acknowledged that the newly replaced respiratory bag containing respiratory supplies had the incorrect information and was labeled for Resident 1, instead of Resident 17. LVN 2 also stated he should have asked and verified Resident 17's name before replacing the respiratory bag to ensure the new respiratory bag and supplies would be labeled to the correct resident for use. 2. A review of Resident 1's Face Sheet, dated 5/7/26, indicated Resident 1 was readmitted to the facility on [DATE], with diagnoses that included COPD and pneumonia ([PNA]- an infection/inflammation in the lungs).A review of Resident 1's Order Summary Report, dated 5/7/26, indicated, Resident 1 had the following physician's orders dated:12/7/25 to Change O2 (oxygen) Tubing every night shift every Sun (Sunday)2/6/26 for Oxygen at 2 L (Liters)/min Via NC to keep O2 Sat (O2 Saturation - a measurement of how much oxygen the blood is carrying as a percentage) at/above 92% every shift for (continued on next page)

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	05/07/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	COPD.During a concurrent observation and interview on 5/4/26 at 10:38 AM, with Resident 1, Resident 1 wheeled himself out of his room and stated he was late for activities. A NC dated 4/24/26 was observed on top of Resident 1's bed.During a concurrent observation and interview on 5/4/26 at 10:40 AM, with LVN 2, LVN 2 acknowledged that the label on the NC on top of Resident 1's bed was dated 4/24/26.3. A review of Resident 39's Face Sheet, dated 5/5/26, indicated Resident 39 was admitted to the facility on [DATE].A review of Resident 39's Physician's Order, dated 5/5/26, indicated, Resident 39 had the following telephone order dated for: 4/24/2026 for Ipratropium-Albuterol Solution (a liquid medication turned into fine mist for inhalation used to open the airways) 0.5-2.5 (3) MG/3 ML 1 vial inhale orally every 6 hours for PNA for 5 days.A review of Resident 39's Medication Administration Record, ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated from April 1, 2026 -April 30, 2026, indicated, Resident 39 received the last dose of Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3 ML 1 vial inhale orally every 6 hours for PNA on 4/29/26 at 6:00 AM.During an observation on 5/4/26 at 9:35 AM, inside Resident 39's room, Resident 39 was alert, verbally responsive, and wore a neck brace while lying on his bed. The nebulizer tubing and mouthpiece did not have a dated label and was left on top of the nebulizer machine at the bedside. The respiratory bag was dated 4/26/26.During a concurrent observation and interview on 5/4/26 at 9:53 AM, with LVN 8, LVN 8 acknowledged these findings and stated that Resident 39 had completed the ordered respiratory treatments. LVN 8 also stated that the nebulizer tubing and mouthpiece should have been labeled with a date and the respiratory supplies should have been removed from the resident's bedside after the last treatment was given on 4/29/26.During an interview on 5/5/26 at 1:01 PM, with the Registered Nurse Supervisor (RNS) 1, RNS 1 stated that staff were expected to keep respiratory supplies inside the respiratory bag when not in use. RNS 1 stated that these respiratory supplies such as NC, nebulizer tubing, and nebulizer mouthpiece should be labeled with a date and changed every week. RNS 1 verified that it was not acceptable for these supplies to be unlabeled and not changed as ordered by the physician. RNS 1 also stated that staff were expected to check and verify the resident's identity before labeling and placing the respiratory supplies at the resident's bedside. RNS 1 stated these actions were nursing standard of practice and for infection control purposes.During an interview on 5/6/26 at 1:01 PM, with the Infection Preventionist (IP), the IP stated staff were expected to remove these respiratory supplies and equipment from resident's bedside after the treatment had been completed. The IP also stated when these supplies were left and not changed as ordered by the physician, these had the potential for transmission of infections.A review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, with an effective date of 10/31/2025, indicated, POLICY: 1. Oxygen is administered under safe and sanitary conditions to meet resident needs. 2. Oxygen will be initiated with a provider order.II. Oxygen- Maintenance, and Safety A. Oxygen equipment shall be maintained as follows: 1. The tubing and mask should be changed at least every 7 days and labeled with the date of change.A review of the facility's policy and procedure (P&P) titled, Nebulizer (small volume), revised10/15/20, indicated, Procedure: I. Equipment A. Nebulizer machine.C. Physician ordered medication. D. Aerosol mask/mouthpiece.III. Assemble the necessary equipment needed for therapy. If new, label the set-up bag with Resident's name and date.XV. Place the nebulizer back into the Resident's set-up bag and leave the equipment at the bedside for further treatments. The small volume nebulizer set up, and filter will be changed every seven days and as needed.

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	05/07/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored properly and securely when a medication cart (Medication Cart 3) was left unlocked and not under direct observation by authorized staff.This had the potential to allow unauthorized access to medications and supplies which could cause undetected misuse, diversion (distribution, abuse, or use of drugs for purposes not intended by the prescriber), and unsafe use of medications. Findings:During an initial tour observation on 5/4/26, at 12:28 PM, in the facility hallway in front of room [ROOM NUMBER], Medication Cart 3's lock was not pushed in and was left unlocked and unattended. Staff and residents passed by the unlocked medication cart.During a concurrent observation and interview with the Licensed Vocational Nurse 4 (LVN 4), on 5/4/26, at 12:32 PM, LVN 4 acknowledged she was assigned to Medication Cart 3 and the medication cart was left unlocked and unattended. LVN 4 also stated that medication carts should be kept locked when unattended to prevent residents and other people from having access to medications.During an interview with LVN 5, on 5/5/26, at 12:02 PM, LVN 5 stated that Medication Cart 3 contained medications including narcotic drugs (a type of medication, specifically painkillers that is heavily regulated by the Federal Government and considered a controlled substance due to high addiction potential) and medical supplies for the residents of Rooms 24-35.During an interview with Registered Nurse Supervisor (RNS) 1 on 5/5/26, at 12:09 PM, RNS 1 stated the medication carts were to be kept organized and locked when not supervised. RNS 1 added that the importance of locking the medication cart when unattended was to prevent unauthorized access of medications from residents, staff, and visitors.During a concurrent interview and record review on 5/5/26 at 12:45 PM, with the Director of Nursing (DON), the DON reviewed the facility's policy and procedure (P&P) titled, MEDICATION STORAGE IN THE FACILITY, revised February 2020, the DON stated that it was her expectations from the staff to keep the medication cart locked at all times when staff were away from the cart. The DON also stated that this was important to prevent unauthorized access to residents' medications. The DON stated the facility's policy and procedure was not followed.A review of the facility's policy and procedure (P&P) titled, MEDICATION STORAGE IN THE FACILITY, revised February 2020, indicated, STORAGE OF MEDICATIONS Policy: Medications and biologicals are stored safely, securely, and properly. The medication supply is accessible only to licensed nursing personnel, pharmacist, or Pharmacy Nursing personnel. Procedures: . B. Only licensed nurses, pharmacist, medications are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access .

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	05/07/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care was provided in a dignified manner for one of 17 sampled residents (Resident 12) when a Certified Nursing Assistant (CNA) 1 fed Resident 12 while standing and not at eye level.This failure had the potential to have a negative impact on Resident 12's psychosocial well-being during dining. Findings: A review of Resident 12's Face Sheet (front page of the chart that contains a summary of basic information about the resident) dated 5/7/26, indicated the resident was admitted to the facility on [DATE]. A review of Resident 12's Minimum Data Set ([MDS] a federally mandated standardized assessment tool) dated 2/19/26 indicated Resident 12 required, partial/moderate assistance for eating. During an observation on 5/4/26 at 1:10 PM, in Resident 12's room, Resident 12 was seated in a wheelchair, while CNA 1 stood over Resident 12 and fed Resident 12 lunch. CNA 1 fed Resident 12 with a spoon and remained standing, above Resident 12's eye level throughout the interactionDuring an interview with CNA 1 on 5/4/26 at 1:10 PM, CNA 1 stated she preferred to stand while feeding and assisting Resident 12's with meals.During an interview with CNA 2 on 5/7/26 at 9:50 AM, CNA 2 stated staff should establish eye contact and sit at the residents' eye level while feeding to convey respect and ensure residents feel valued. CNA 2 further stated that these practices were covered during orientation and in-service training.During an interview with the Director of Staff Development (DSD) on 5/7/26 at 10:30 AM, the DSD stated staff received in- services regarding feeding residents at eye level and in a sitting position. Feeding residents while standing was discouraged to demonstrate respect and promote resident comfort. DSD further stated that CNA 1 should have fed the resident while seated.A review of the facility's policy and procedure (P&P) titled, Resident Rights - Quality of Life, revised March 2017 indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person centered manner as well as those that support the resident in attaining or maintaining his or her highest practicable well-being.

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	05/07/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an informed consent (a process providing the resident and/or resident representative information regarding risks, benefits, and potential side effects [unintended or adverse reactions caused by a medication] of treatment before agreement for treatment) was obtained prior to the administration of an increased dose of a psychotropic (medications affecting brain activities associated with mental processes and behaviors) medication for one of five sampled residents (Resident 16) reviewed for unnecessary medications.This failure had the potential for residents and/or resident representatives not fully informed regarding medication risks, benefits, and potential side effects before the resident received an increased dose of a psychotropic medication. Findings:A review of Resident 16's Face Sheet (front page of the chart that contains a summary of basic information about the resident) dated 5/7/26, indicated Resident 17 was readmitted to the facility on [DATE], with diagnoses including depression.A review of Resident 16's physician orders indicated the resident had been receiving sertraline (medication used to treat depression), in various doses, for depression manifested by verbalization of sadness and hopelessness.A review of Resident 16's physician orders indicated the following physician's orders dated:- On 9/5/25, Sertraline (a prescription medication used to treat depression, anxiety, and other mood disorders by increasing serotonin [a chemical in the brain that controls mood]) 25 mg (milligram - unit of measurement), with a direction to give one tablet by mouth one time a day for depression 'm/b (manifested by) verbalization of fe (feeling) hopeless,' discontinued.- On 9/5/25, Sertraline dose increased to 100 mg with a direction to give one tablet by mouth one time a day for depression m/b verbalization, 'I feel depressed.'- On 3/23/26, Sertraline 100 mg with a direction to give one tablet by mouth one time a day for 'depression manifested by verbalization being depressed,' discontinued.- On 3/23/26, Sertraline dose decreased to 50 mg with a direction to give one tablet by mouth one time for depression manifested by verbalization of feeling depressed.A review of Resident 16's Medication Administration Record, ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated from 9/25 through 3/26, indicated Resident 16 received sertraline 100 mg daily from 9/6/25 to 3/23/26.A review of Resident 16's Care Plan Report, (an individualized outline of specific care, interventions, and goals for a resident/patient) dated 1/8/25, indicated an Intervention for the use of an antidepressant medication was to .Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of Sertraline.During a concurrent interview and record review on 5/6/26 at 3:01 PM, with the Medical Record Director (MRD), the MRD reviewed Resident 16's medical record and stated the informed consent for Sertraline 100mg initiated on 9/5/25 could not be found.During a follow-up interview on 5/7/26 at 7:56 AM, with MRD, the MRD confirmed there was no informed consent for increased dose of Sertraline 100 mg initiated on 9/5/25 for Resident 16.During a concurrent interview and record review on 5/7/26 8:17 AM, with the Director of Nursing (DON), the DON stated the informed consent should have been obtained before the administration of the increased dose of Sertraline 100 mg, after the information regarding medication risks, benefits, and potential side effects to the resident and/or resident representative was provided.A review of the facility's policy and procedures (P&P) titled, NP67 Informed Consent, revised 12/21/2023, indicated: .Except in emergencies, informed consent must be obtained prior to the proposed treatment or procedure. Where possible, consent should be obtained sufficiently in advance to allow the resident or their surrogate decision-maker time to consider and make an informed decision.A review of the facility's P&P titled, P-NP67 Informed Consent, dated 1/30/2026, indicated, .D. The informed consent will be placed in the resident's medical record.A review of the facility's P&P titled, P-NP106 Behavior/Psychoactive Medication Management, dated 1/30/2026, indicated: .Facility must obtain a resident's written informed consent for treatment using psychoactive drugs.

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	05/07/2026

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely completion of the comprehensive admission Minimum Data Set ([MDS] - a federally mandated resident assessment tool) assessments for one of 17 sampled residents (Resident 76).This deficient practice had the potential to delay the care planning process to meet Resident 76's comprehensive and individualized care needs.Findings:A review of Resident 76's Face Sheet, (front page of the chart that contains a summary of basic information about the resident) dated 5/6/26, indicated Resident 76 was readmitted to the facility on [DATE], with diagnoses that included encounter for palliative care (specialized medical care focused on providing relief from pain, and stress from serious illness), chronic obstructive pulmonary ([COPD] - a progressive lung disease which blocks air flow making breathing difficult) , and immunodeficiency (a state in which a person's ability to fight infections is compromised or entirely absent).A review of Resident 76's Comprehensive admission MDS Assessment, with an Assessment Reference Date ([ARD] - a specific date that serves as the end point of the look back or observation period for capturing a resident's clinical condition) of 4/11/26, indicated, Section (Sec.) A1600 [Entry Date]: 3/30/36. Sec. B (Hearing, Speech and Vision), Sec. GG (Functional Abilities), Sec. H (Bladder and Bowel), Sec. J (Health Conditions), Sec. K (Swallowing/Nutrition Status), Sec. L- (Oral/Dental Status), Sec. M (Skin Conditions), Sec. N (Medications), Sec. O (Special Treatments, Procedures, and Programs), Sec. V. (Care Area Assessment Summary, Sec. Z0500 A (Signature of [Registered Nurse] RN Assessment Coordinator Verifying Assessment Completion and Sec. Z0500B (Date RN Assessment Coordinator signed assessment as complete) were all left blank.During a concurrent interview and record review on 5/6/26 at 1:33 PM with the MDS Coordinator (MDS-C), the MDS-C reviewed Resident 76's Comprehensive admission MDS Assessment, with an ARD of 4/11/26 via PCC (PointClickCare- cloud-based electronic health record). The MDS-C stated that the assessment was not completed yet. The MDS-C also stated Resident 76's Comprehensive admission MDS Assessment should have been completed within 14 days of admission and should have been completed on 4/12/26 (24 days overdue). The MDS-C stated this was not acceptable because there will be no baseline assessment of the resident that was needed to develop comprehensive and individualized care plan for the resident.During an interview on 5/6/26 at 2:01 PM with the Director of Nursing (DON), the DON stated the MDS must be completed in a timely manner to avoid delays in the development of the residents' care plans.The Centers for Medicare & Medicaid Services (CMS)'s Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2025, indicated Chapter 5: Submission and Correction of the MDS Assessments.5.2 Timeliness Criteria. Completion Timing: .For the admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days, after the Entry Date (A1600).

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	05/07/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary nail care services and personal hygiene for one of two sampled residents (Resident 97) by failing to ensure Resident 97's fingernails were cleaned and trimmed.This failure resulted in Resident 97 having overgrown and untrimmed fingernails, which placed Resident 97 at risk for discomfort, impaired hygiene, skin breakdown and infection.Findings:During an initial tour observation and interview on 5/4/26 at 9:12 AM, inside Resident 97's room, Resident 97 was awake, verbally responsive, and lying in bed. Resident 97's fingernails on both hands were extending beyond the fingertip. There was a build-up of yellow substance at the base of the fingernails, and the fingernail tips had black residue underneath. Resident 97 stated he wanted his fingernails cleaned and trimmed but no one had done it since he was admitted .A review of Resident 97's Face Sheet (front page of the chart that contains a summary of basic information about the resident) dated 5/6/26, indicated the resident was admitted to the facility on [DATE].During a concurrent observation and interview on 5/5/26 at 4:35 PM, inside Resident 97's room with Licensed Vocational Nurse 3 (LVN 3), LVN 3 acknowledged Resident 97's fingernails on both hands were long and had dirt underneath. LVN 3 also stated it needed to be cleaned and trimmed for it may cause skin tears and infections.During a subsequent observation and interview on 5/5/26 at 4:46 PM, inside Resident 97's room with Director of Staff Development (DSD), the DSD acknowledged that Resident 97's fingernails on both hands were long and had black residues underneath. DSD stated it had to be cleaned and trimmed. The DSD also stated that the Certified Nursing Assistants (CNA) were primarily responsible for cleaning and trimming the fingernails and the licensed nurses were responsible for the oversight to ensure residents were well groomed.A review of Resident 97's Care Plan Report, initiated on 4/28/26, indicated, Focus: The resident has potential impairment to skin integrity related to (r/t) fragile skin and immobility.Goal: The resident will maintain or develop clean and intact skin.Interventions: Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short .A review of the facility's CNA's Job Description, undated indicated, .GENERAL DUTIES AND RESPONSIBILITIES.Provide assigned personal hygiene care in accordance with facility procedures, including.nail care.to maintain resident cleanliness, dignity, and comfort.A review of the facility's LVN's Staff Nurse Job Description, undated indicated, .General Duties and Responsibilities.CLINICAL.Conducts daily resident rounds to observe the resident's physical and emotional status. Supervise CNAs. SUPERVISION.Make resident rounds to ensure appropriate care is being rendered, identifying, and making corrections as necessary.A review of the facility's policy and procedure (P&P) titled, Grooming, revised on 1/1/12, indicated, .Policy: The facility will work with residents to improve their ability to groom him/herself to promote independence, hygiene, comfort, self-esteem, and dignity.Procedure: IV. F. Nail Care.ii. Many residents find soaking to be soothing but the main advantage of soaking is softening and loosening of dirt particles lodged under the nails. Iii. A nailbrush can be used to gently remove any remaining dirty particles under the nails.

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	05/07/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure needed treatment and services were provided to maintain range of motion (ROM- full movement potential of a joint) for one of three sampled residents (Resident 4) when Resident 4's Restorative Nursing Program (a nursing-driven service in long-term care settings that helps residents maintain or improve their functional abilities to their highest possible level) orders were not followed and in accordance with Resident 4's plan of care.These failures had the potential to cause further decline in functional mobility, ROM, and quality of life for Resident 4.Findings:During an initial tour observation on 5/4/26 at 3:47 PM, inside Resident 4's room, Resident 4 was awake, verbally responsive, and lying in bed. Resident 4 had a left arm sling and was observed with limited movement in the arms and legs.A review of Resident 4's Face Sheet (front page of the chart that contains a summary of basic information about the resident) dated 5/7/26, indicated the resident was readmitted to the facility on [DATE] with diagnosis that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke- loss of blood flow to a part of the brain) affecting left non-dominant side, muscle weakness, and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion).A review of Resident 4's Minimum Data Set, ([MDS] a federally mandated resident assessment tool) with an Assessment Reference Date ([ARD] a specific date that serves as the end point of the look back or observation period for capturing a resident's clinical condition) of 2/16/26, indicated, R4's Brief Interview for Mental Status (BIMS) score was 7 (severely impaired). The MDS assessment also indicated that Resident 4 was dependent on eating, toileting hygiene, and personal hygiene.A review of Resident 4's Order Summary Report, dated 5/7/26, indicated, Resident 4 had the following order: RNA (Restorative Nursing Assistant) services for RUE AAROM (Right Upper Extremity [limb] Assisted Active Range of Motion) exercises, frequency QD (Daily) 3x/wk (three times per week), or as tolerated and as needed order date: 3/30/2026 .A review of Resident 4's Documentation Survey Report, (legal document used to track RNA services provided) dated 4/1/26 to 5/7/26, indicated RNA services for RUE AAROM exercises, frequency QD 3x/wk or as tolerated and as needed. However, there were no documented evidence indicating these services were provided on 4/2/26, 4/7/26, 4/9/26, 4/14/26, and 4/18/26, as the boxes in the Documentation Survey Report were left blank.During an interview on 5/7/26 at 9:58 AM, with the RNA, the RNA stated that Resident 4 is on an RNA program. The RNA also stated that RNAs were expected to document the services provided to Resident 4 via PCC (PointClickCare- cloud-based electronic health record) right after the treatment was given.During a concurrent interview and record review on 5/7/26 at 10:18 AM, with the RNA, the RNA reviewed Resident 4's Documentation Survey Report dated 4/1/26 to 5/7/26. The RNA stated that RNA services were usually done on Tuesdays, Thursdays, and Saturdays. RNA also stated that the blank boxes in Resident 4's Documentation Survey Report, on 4/2/26, 4/7/26, 4/9/26, 4/14/26, and 4/18/26 indicated that the treatment was not provided.During a concurrent interview and record review on 5/7/26 at 10:27 AM, with the Registered Nurse Supervisor (RNS) 1, RNS 1 reviewed Resident 4's Documentation Survey Report dated 4/1/26 to 5/7/26. RNS 1stated that it was her expectations for staff to follow doctor's orders and document after the services were provided because if it was not documented, it meant it was not done.A review of Resident 4's Care Plan Report, undated, indicated Resident has self-care performance deficit r/t (related to) LEFT SHOULDER, HAND AND ELBOW CONTRACTURES AND BILATERAL ANKLES.Goal: The resident will maintain current level of function.Interventions. RUE AAROM exercises, frequency QD 3x/wk or as tolerated and as needed.During a concurrent interview and record review on 5/7/26 at 2:55 PM, with the Director of Nursing (DON), the DON reviewed Resident 4's Documentation Survey Report dated 4/1/26 to 5/7/26. The DON acknowledged that RNA (continued on next page)

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	05/07/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services for RUE AAROM exercises, frequency QD 3x/wk or as tolerated and as needed on 4/2/26, 4/7/26, 4/9/26, 4/14/26, and 4/18/26, were left blank. The DON stated that there was no documented evidence that these services were rendered to Resident 4 on those dates. The DON also stated that it was her expectations for staff to follow the doctor's order. The DON stated Resident 4's plan of care and the facility's policy and procedure were not followed.A review of the facility's P&P titled RESTORATIVE NURSING PROGRAM GUIDELINES, effective January 30, 2026, indicated I. Implementation of a restorative nursing program.B. Frequency of the RNA program will be determined by the medical necessity and Provider order.V. The RNA carries out the restorative program according to the Care Plan. VI. The RNA documents the amount of time the Resident spent in the activity and their tolerance to the program.

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	05/07/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure accurate accountability of controlled substances (CS - medications with high potential for abuse and addiction) for two of six randomly selected residents (Residents 45 and 51) who were reviewed for controlled substance accountability when:Resident 45's Tramadol (an opioid medication used to treat moderate to moderately severe pain) Individual Narcotic Record (inventory records used to document receipt, use, and count of controlled substances [medications with potential for abuse and dependence]) did not match the Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident).Resident 51's Percocet (an opioid medication used to treat severe pain) Individual Narcotic Record did not match the MAR.These failures resulted in an inaccurate accountability of controlled substances and had the potential for diversion (controlled substances used by someone other than the resident for whom the medication was prescribed), or misuse of controlled substances and compromised residents' medication therapy and safety.Findings:1. During a concurrent interview, record review, and inspection of Medication Cart 2A on 5/5/26 at 10:13 AM, with Licensed Vocational Nurse (LVN), the following facility items and records were reviewed:Resident 45's Blister Card (a type of medicine packaging where individual doses of medication are sealed in small, clear plastic bubbles (blisters) and attached to a rigid card or foil backing) for Tramadol 50 mg (milligram - unit of measurement) was inspected with LVN 7. Resident 45's physician's telephone order, dated 3/21/26, indicated an order for Tramadol 50 mg, give 1 tablet by mouth every 6 hours as needed for severe excruciating pain (scale: 8-10 [pain scale]).Resident 45's Individual Narcotic Record dated from 3/16/26 - 5/4/26 indicated, Tramadol 50 mg one tablet was removed from the blister card and signed out by a licensed staff on 4/6/26 at 0500 (5:00 AM) and 5/2/26 at 0900 (9:00 AM).Review of Resident 45's MAR, for April 2026 through May 2026, indicated there was no corresponding documentation of administration and pain assessments on the Resident 45's MAR. LVN 7 confirmed the above findings and stated there were discrepancies between Resident 45's Individual Narcotic Record dated 3/16/26-5/4/26 and Resident 45's MAR dated April 2026 through May 2026. LVN 7 confirmed and verified Resident 45's records did not match.2. During a concurrent interview, record review, and inspection of Medication Cart 3 on 5/5/26 at 11:13 AM, with LVN 5, the following facility items and records were reviewed:Resident 51's Blister Card, for Percocet 10/325 mg (brand name medication containing oxycodone [narcotic medication] and acetaminophen used for pain) was inspected with LVN 5.Resident 51's Physician's Telephone Order, dated 3/16/26, indicated an order for, Percocet 10-325mg (oxycodone with acetaminophen), ?give 1 tablet by mouth every 4 hours as needed for severe-excruciating pain' (scale: 8-10).Resident 51's Individual Narcotic Record dated from 4/26/26 - 5/5/26 indicated, Percocet 10/325 mg one tablet was removed from Resident 51's Blister Card and signed out by a licensed staff on 4/26/26 at 1330 (1:30 PM), 4/29/26 at 0700 (7:00 AM), 1400 (2:00 PM) and at 2050 (8:50 PM).Review of Resident 51's MAR, for April 2026 indicated there was no documentation of Resident 51 received Percocet 10/325 mg on the following dates and times:4/26/26 at 1:30 PM4/29/26 at 7:00 AM and 8:50 PM LVN 5 confirmed the above findings and stated staff should have documented the administration of Resident 51's Percocet 10/325 mg one tablet in Resident 51's MAR at the time the medication was signed out of Resident 51's Individual Narcotic Record.During a concurrent interview and record review on 5/5/26 at 11:50 AM, with the Director of Nursing (DON), the DON confirmed discrepancies between the Individual Narcotic Records and the MARs for Resident 45 and 51. The DON stated the nursing staff were expected to document in the resident's Individual Narcotic Record and MAR when the controlled medication is removed and administered to the resident.A review of the facility's policy and procedures (P&P) titled, Medication - Administration, dated 8/19/25, indicated: .The Licensed Nurse will .Right documentation: Immediately document after administration .Documentation: The time (continued on next page)

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	05/07/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and dose of the medication or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the medication or treatment .A review of the facility's P&P titled, Medication Storage in the Facility - ID2: Controlled Substance Storage, dated June 2016, indicated: .Controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR) and Form 12: INDIVIDUAL RESIDENT'S CONTROLLED SUBSTANCE RECORD .

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	05/07/2026

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adequately monitor one of 17 sampled residents (Resident 34) for side effects (secondary, often predictable, unintended effects of a medication that can be beneficial, neutral, or harmful) and adverse drug reactions (strictly unintended, harmful, and unexpected reaction of a medication, usually requiring intervention) for the use an anticoagulant (medication that thins the blood to prevent blood clots) medication per facility's policy.This failure had the potential to result in adverse outcomes, including bleeding complications, bruising, hemorrhage, hospitalization, or other medication related complications associated with anticoagulant use.Findings:During an initial tour observation on 5/4/26, at 3:45 PM, inside resident's room, Resident 34 was lying in bed, awake, and watching TV.A review of Resident 34's Face Sheet (front page of the chart that contains a summary of basic information about the resident) dated 5/7/26, indicated Resident 34 was admitted to the facility on [DATE].A review of Resident 34's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated April 2026, indicated Resident 34 was on Heparin Sodium (Porcine) Solution 5000 unit/ml. Inject 1 ml subcutaneously (SQ- between the skin and muscle) two times a day for Deep Vein Thrombosis (DVT is a serious medical condition where a blood clot (thrombus) forms in a deep vein, most commonly in the legs or pelvis) prophylaxis (a medical term for preventive care) with a start date of 4/18/26.Further review of Resident 34's MAR dated May 2026 indicated Resident 34 was administered Heparin from 5/1/26-5/7/26.During a concurrent interview and record review with the Registered Nurse Supervisor (RNS) 1 on 5/7/26, at 9:14 AM, RNS 1 reviewed Resident 34's MAR for the months of April and May 2026. RNS 1 stated that there was no documented evidence in the MAR monitoring for adverse reactions that was completed for Resident 34 for the use of Heparin. RNS 1 also stated when a resident is on Heparin, the resident should be monitored for bruising, bleeding and side and adverse effects of the medication.A review of the facility's policy and procedure (P&P) titled, Adverse Drug Reactions, dated 8/19/25 indicated, The facility will monitor, promptly identify, document, report, and appropriately address adverse drug reactions in accordance with federal and state laws and facility policy and procedures.Adverse Drug Reaction (ADR): An unintended and harmful reaction resulting from the use of medication at normal doses for prophylaxis.1. Identification of Adverse Drug Reaction (ADR).a. Nursing staff shall observe for any changes in condition that may be associated with medications, including but not limited to: .v. Bleeding. 2. Evaluation a. The licensed nurse must evaluate the resident, document findings in the medical record and notify the physician. 3. Documentation a. Document the following in the medical record: i. Description of the reaction.

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	05/07/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with physician orders when a medication error rate of 8% was identified, with two medication errors out of 25 medication administration opportunities, during medication administration observations for one of four residents observed (Resident 39).These failures included the administration of an incorrect dose and an incorrect dosage form of medications, which had the potential to compromise the resident's medication therapy and safety.Findings:During a medication administration observation for Resident 39 on 5/4/26 at 8:58 AM, Licensed Vocational Nurse (LVN) 4 prepared and administered 17 medications, including two tablets of Senna (medication used to treat constipation) 8.6 mg (milligram - unit of measurement) and one tablet of OxyContin CR (controlled-release narcotic pain medication designed to release slowly over time) 10 mg.A review of Resident 39's Physician's Orders indicated the following physician's orders dated: 4/6/26, Senna Oral Tablet (Sennosides [active ingredient in senna used to treat constipation]), give 8.6 mg by mouth one time a day for constipation. 4/15/26, Oxycodone (a medication used to manage severe pain that requires round-the-clock, long-term treatment) HCl (hydrochloride - chemical salt form of medication) Tablet 10 mg (oxycodone HCl), give 1 tablet by mouth two times a day for pain management.During a concurrent interview and record review on 5/4/26 at 11:49 AM, with LVN 4, LVN 4 confirmed the Resident 39's Physician's Order, for Senna indicated one tablet, but LVN 4 administered two tablets. LVN 4 stated she should have administered one tablet of Senna per the physician's order. LVN 4 also confirmed the Resident 39's Blister Card, (a type of medicine packaging where individual doses of medication are sealed in small, clear plastic bubbles (blisters) and attached to a rigid card or foil backing) label and Individual Narcotic Record (inventory records used to document receipt, use, and count of controlled substances [medications with potential for abuse and dependence]) dated 4/15/26-4/20/26, indicated OxyContin CR 10 mg ER 12hrs, while the Physician's Order, indicated, Oxycodone 10mg tablet. LVN 4 stated ER meant extended release but stated she did not know the meaning of CR and needed to look up the meaning.During a record review on 5/5/26 at 9:38 AM, Resident 39's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 4/1/26-4/30/26 and 5/1/26-5/31/26, indicated staff documented the administration of oxycodone 10 mg twice daily from 4/15/26 through 5/4/26. Concurrent review of the Individual Narcotic Records dated 4/15/26-4/20/26 and pharmacy Packing Slips (delivery receipts) dated 4/16/26, indicated the facility received and administered OxyContin ER/CR 10 mg during that period.During an interview on 5/5/26 at 10:22 AM, with the Primary Physician (MD 1), MD 1 stated the intended order was oxycodone immediate-release (IR - medication designed to release immediately after administration) 10 mg twice daily, not controlled-release (CR) formulation.During a concurrent interview and record review on 5/5/26 at 11:50 AM, with the Director of Nursing (DON), the DON stated nursing staff were expected to verify correct medication, correct dose, and correct dosage form before administration. The DON stated discrepancies between immediate-release (IR) and controlled-release (CR) dosage forms should have been clarified with the physician or pharmacy prior to medication administration.A review of the facility's policy and procedures (P&P) titled, Medication - Administration, dated 8/19/25, indicated: .All medications shall be administered by licensed using staff according to physician orders .The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner .The Licensed Nurse will verify.before administering the medication using the 6 rights of medication administration .Right Medication: Verify against the MAR and pharmacy label .Right Dose: Ensure accuracy based on provider order .A review of the facility's P&P titled, Medication Orders - IB2: Controlled Substance Prescriptions, dated October 2012, indicated: .Elements of a controlled substance prescription .dosage form .The prescriber is contacted to verify or clarify a prescription when needed .If changes to a controlled substance prescription are necessary, the prescriber (or (continued on next page)

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	05/07/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescriber's employee) must communicate the new order to the facility nursing staff for documentation in the chart and communicate or transmit the new prescription to the pharmacy prior to dispensing .

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	05/07/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 81) reviewed for unnecessary medications was free from a significant medication error when, Resident 81 did not receive phenobarbital (a controlled substance used to control seizures [a sudden, uncontrolled electrical disturbance in the brain that may cause involuntary jerking movements, staring spells, and/or loss of consciousness] by stabilizing electrical activity in the brain) as ordered by the physician for five consecutive days. The facility failed to ensure the physician was notified of the missed doses and failed to follow-up on the status of the medication with the facility's contracted pharmacy.This failure resulted in missed doses of anticonvulsant (seizure-control) medication and had the potential for decreased medication levels in the body and increased risk for seizure activity.Findings:A review of Resident 81's Face Sheet, (front page of the chart that contains a summary of basic information about the resident) dated 5/7/26 indicated Resident 81 was admitted to the facility on [DATE], with diagnoses including epilepsy (a disorder characterized by recurrent seizures caused by abnormal electrical activity in the brain).A review of Resident 81's Physician's Orders, dated 4/14/26, indicated an order for Phenobarbital oral tablet 30 mg (milligram - unit of measurement), give 3 tablets by mouth one time a day for seizures.A review of Resident 81's Care Plan Report, dated 4/15/26, indicated, a Focus area for Resident 81 the resident has a seizure disorder r/t (related to) disease process. and had Interventions for an action to, Give medications as ordered.A review of the pharmacy delivery receipt titled Packing Slip, dated 4/14/26, indicated the facility received 45 tablets of phenobarbital 30 mg on 4/14/26.A review of Resident 81's Individual Narcotic Record, (inventory records used to document receipt, use, and count of controlled substances [medications with potential for abuse and dependence]) and Medication Administration Record, ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments administered given to a resident) dated April 2026 - May 2026, indicated phenobarbital administration began on 4/15/26 with removal of 3 tablets daily through 4/29/26. The last documented removal of phenobarbital on the Individual Narcotic Record, occurred on 4/29/26, which indicated Resident 81 received all 45 tablets during this period, with no remaining supply available after 4/29/26. Further review of Resident 81's Individual Narcotic Record indicated there was no documentation the phenobarbital medication was available and administered to Resident 81 from 4/30/26 through 5/4/26.A review of Resident 81's MAR, dated April 2026 - May 2026, indicated the nursing staff documented phenobarbital with chart code 9 - see progress notes on 4/30/26, 5/1/26, and 5/2/26. A review of Resident 81's Progress Notes (a formal, often daily, record documenting a resident's clinical status, medical necessity, and response to treatment) dated 4/30/26-5/2/26, indicated an Administration Note dated 4/30/26 for Phenobarbital Oral Tablet 30 mg.medication pending refill delivery from pharmacy. Further review of Resident 81's Progress Notes dated 5/1/26-5/2/26, indicated there was no documentation of the medication status, no follow-up with the pharmacy on the availability of the medication, and no notification to the physician regarding the unavailable medication and missed doses for Resident 81. A review of the pharmacy delivery receipt titled Packing Slip, dated 5/5/26, indicated the facility received 45 tablets of phenobarbital 30 mg on 5/5/26.During an interview on 5/7/26 at 8:38 AM with Pharmacy Technician (PT), the PT stated the pharmacy did not receive a refill request from the facility for phenobarbital between 4/30/26 and 5/4/26, and no communication occurred between the facility and the pharmacy regarding the medication during this timeframe.Further review of Resident 81's MAR, dated for May 2026, indicated Resident 81 received and was administered phenobarbital on 5/3/26 and 5/4/26, despite the unavailability of the medication.During a concurrent interview and record review on 5/7/26 at 8:56 AM, with the Director of Nursing (DON), the DON confirmed no documented evidence showed nursing staff notified the physician or followed up with the pharmacy regarding the unavailability of (continued on next page)

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	05/07/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phenobarbital from 4/30/26 through 5/4/26. The DON reviewed Resident 81's MAR, dated May 2026 and confirmed licensed nursing staff documented the phenobarbital was administered to Resident 81 in Resident 81's MAR on 5/3/26 and 5/4/26, when Resident 81's Individual Narcotic Record, indicated no remaining supply was available after 4/29/26. The DON stated the licensed nursing staff should have requested a refill from the pharmacy prior to depletion of medication supply and should have notified the physician regarding the unavailable medication for further instruction or guidance.A review of the facility's Policy and Procedures (P&P) titled, Miscellaneous Special Situations - IF11: Unavailable Medications, dated October 2012, indicated: .The facility must make every effort to ensure that medications are available to meet the needs of each resident.B. Nursing staff shall 1). Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for order and/or direction.A review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy - IC4: Receiving Controlled Substances, dated October 2012, indicated: .Controlled substances are reordered when a five day supply remains to allow for transmittal of the required written prescription to the pharmacist.

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	05/07/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control and prevention measures when:1. The sharps container (a puncture-resistant, leak-proof receptacle designed for the safe disposal of medical sharps to prevent injury and infection) on one of three medication carts (Medication Cart 2) was filled beyond the fill line indicator.2. The Certified Nurse Assistant (CNA) 1 failed to follow the facility's policy for Enhanced Barrier Precautions ([EBP] - an infection control prevention designed to reduce the transmission of multi-drug-resistant organisms (MDROs) in healthcare settings, particularly nursing homes) when CNA 1 did not wear a gown while providing incontinent care to Resident 60.These failures had the potential for increased risk of infection which can compromise the health and wellbeing of residents, staff, and visitors.Findings:1. During a concurrent observation and interview on 5/4/26 at 11:16 AM, with License Vocational Nurse (LVN) 1, LVN 1 was observed pushing Medication Cart 2. The sharps container attached to the side of the medication cart was filled past the fill line indicator. LVN 1 confirmed the finding and stated that the sharps container should have been replaced.During an interview on 5/7/26 at 9:34 AM, with Registered Nurse Supervisor (RNS) 1, RNS 1 stated that a full sharps container had an indicator line, and the disposal and replacement of the container was needed once the line was reached. RNS 1 stated the importance of changing the sharps container was to prevent accidental needle stick injuries. RNS 1 confirmed Medication Cart 2's sharps container was over the fill line and needed to be replaced.During an interview on 5/7/26 at 10:05 AM, with Infection Preventionist (IP), the IP stated the staff member assigned to the medication cart was responsible for ensuring the sharps container was replaced when the indicator line was reached. The IP confirmed that the container exceeded the fill line and required replacement.During a review of the facility's policy and procedure (P&P) titled, Sharps Disposal, revised January 1, 2012, indicated, .Nursing staff discard contaminated sharps into designated containers .Procedure .III .C. The infection control coordinator or designee is responsible for sealing and replacing containers when they are 75% to 80% full to protect Nursing Staff from punctures and/or needlesticks when attempting to push sharps into the container.2. A review of Resident 60's Face Sheet, (front page of the chart that contains a summary of basic information about the resident) dated 5/7/26, indicated Resident 60 was admitted to the facility on [DATE] and included a diagnosis of Gastrostomy (a medical procedure used to create an opening through the skin directly into the stomach, usually to insert a feeding tube. This allows for nutrition, fluids, and medication to be delivered directly to the stomach).A review of Resident 60's History and Physical, (H&P) dated 2/5/26, indicated under Physical Findings.Abdominal.+ (positive) PEG ([percutaneous endoscopic gastrostomy] a feeding tube placed directly into the stomach through a small incision in the skin of the belly) and Resident 60's .Current diagnosis, status post (s/p - a medical term meaning after, following, or condition after a specific event, procedure, or treatment) PEG.During an observation on 5/4/26 at 9:45 AM, a sign at the entrance to Resident 60's room indicated EBP - Enhanced Barrier Precaution. CNA 1 was observed changing Resident 60's incontinence brief without wearing a gown.During an interview on 5/4/26 at 10:00 AM, with CNA 1, CNA 1 stated Resident 60 was on EBP. CNA 1 stated that as per EBP sign and the facility's policy gloves and a gown must be worn when changing a resident's incontinence brief and providing direct care for a resident on EBP. CNA 1 confirmed she did not wear a gown when providing direct care and when changing Resident 60's incontinence brief.During an interview on 5/7/26 at 9:40 AM, with LVN 2, LVN 2 confirmed Resident 60 was on EBP because Resident 60 had a feeding tube. LVN 2 further stated that CNA 1 should have worn a gown while providing direct care to Resident 60.During an interview on 5/7/26 at 9:55 AM, with RNS 1 verified Resident 60 was on EBP and stated CNAs, LVNs, and RNs were required to wear gloves and gown during high contact care activities (applies to activities that involve high-touch contact with a resident's body or environment including direct care services).A review of (continued on next page)

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	05/07/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's policy and procedure titled Enhanced Barrier Precautions, revised 10/15/24, indicated .Process.2. For residents for whom EBP are indicated, EBP is employed when performing the following high contact resident care activities for those at risk of transmission or acquisition of MDROs: .f. changing briefs or assisting with toileting g. device care or use.feeding tube. h. Wound care: any skin opening requiring a dressing.9.a.i. Gown and gloves are to be donned before each high contact task.10.Table: Summary of Personal Protective Equipment (PPE) use an .Applies to .EBP, all residents with any of the following: wounds and or indwelling medical devices (e.g., feeding tube).

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	05/07/2026

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of five sampled residents (Residents 17 and 52) reviewed for immunizations, were offered the COVID-19 (contagious respiratory illness caused by the SARS-CoV-2 virus) vaccine and failed to maintain documentation of vaccine education, refusals, or acceptance.These failures had the potential for Residents 17 and 52 to be unprotected against COVID-19, increased the risk of serious illness, delayed identification of vaccine status, and missed opportunities to prevent the spread of infection within the facility.Findings:A review of Resident 17's admission Record, (a document showing a summary of the resident's information) dated 5/24/23, indicated Resident 17 was readmitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary ([COPD] - a progressive lung disease which blocks air flow making breathing difficult), shortness of breath, and muscle weakness.A review of Resident 52's Face Sheet, (front page of the chart that contains a summary of basic information about the resident) dated 5/24/23, indicated Resident 52 was readmitted to the facility on [DATE], with diagnoses that included pulmonary fibrosis (a chronic, and progressive lung disease which makes it difficult for oxygen to enter the bloodstream), essential hypertension ([HTN] -high blood pressure), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity).During a concurrent interview and record review on 5/6/26 at 10:08 AM, with the Infection Preventionist (IP), the IP stated that COVID-19 vaccine was offered to residents annually. The IP reviewed Resident 17 and 52's medical records via PCC (PointClickCare- cloud-based electronic health record) and immunization log. The IP stated there were no documented evidence that COVID-19 vaccine was offered and informed consent was obtained by staff from Residents 17 and 52 or their representative for over a year.During an interview on 5/7/26 at 8:37 AM, with Medical Records Director (MRD), the MRD stated that after review of Resident 17 and Resident 52's medical records, the MRD confirmed that there were no recent documented evidence of COVID-19 informed consent and vaccination were kept for these residents.During a subsequent interview on 5/7/26 at 8:40 AM, with the IP, the IP stated that after further review of Resident 17 and Resident 52's records and the facility's infection and control program records, the IP acknowledged that there were no documented evidence of the COVID-19 vaccination and no documentation of vaccine education, refusals, or acceptance for these two residents. The IP also stated that the expectation at the facility was for informed consent be obtained and the COVID-19 vaccine to be offered annually to all residents.During an interview on 5/7/26 at 10:15 AM, with the Director of Nursing (DON), the DON stated that it was the facility's policy to annually offer the COVID-19 vaccine to residents and informed consents be obtained so that the vaccine benefits and risks can be explained.A review of the facility's P&P titled IPC406 Management of COVID-19, effective 10/28/2022, indicated .Purpose: To prevent the development and transmission of COVID-19.Education: 31. Provide COVID-19 education as indicated to employees, patients, and visitors.Vaccination.37. Residents are encouraged to receive COVID-19 vaccination and boosters. 38. The facility will maintain documentation of resident and staff vaccination status.