

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/09/2024
NAME OF PROVIDER OR SUPPLIER  Desert Springs Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 82262 Valencia Avenue Indio, CA 92201	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40988</p> <p>Based on interview and record review, the facility failed to ensure a safe environment was provided, for one of three residents reviewed (Resident 1), when the outside patio had an open sunken area of dirt, approximately 2 inches below the level of surrounding concrete pavement.</p> <p>This failure resulted in Resident 1 being stuck in the dirt between a tree and the edge of the concrete pavement.</p> <p>Findings:</p> <p>On August 7, 2024, at 1:37 p.m. an unannounced visit was conducted at the facility to investigate two complaints.</p> <p>A request for facility policies and procedures, including those regarding Accidents and/or Accident Prevention was made. The Director of Nursing (DON) stated per her consultant, the facility did not have any, unless it pertained to a specific incident or condition that involved an accident.</p> <p>Resident 1's record was reviewed. The resident was admitted to the facility on [DATE], with diagnoses which included right femur fracture, history of falling, high blood pressure, and muscle wasting and atrophy (decrease in muscle mass and strength).</p> <p>A review of Resident 1's History and Physical Examination, dated April 9, 2024, indicated Resident 1 had the capacity to understand and make decisions.</p> <p>A review of Resident 1's Minimum Data Set (MDS- an assessment tool), dated July 12, 2024, indicated Resident 1 had a BIMS score of six (Brief Interview for Mental Status- a score of zero to seven meant severe cognitive impairment); but had the ability to wheel at least 50 feet and make two turns using a manual wheelchair, as well as wheel at least 150 feet in a corridor or similar space using the same.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Progress Notes, dated July 20, 2024, at 2 p.m., written by the Licensed Vocational Nurse (LVN), included a change in condition report indicating unresponsiveness but with stable vital signs (clinical measures including pulse, respiratory rate, blood pressure, and temperature). The narrative notes indicated, .resident was found unresponsive outside on patio. resident sitting on w/c (wheelchair) with right side of head and right shoulder leaning on gate .had eyes closed and not responding to verbal or painful stimuli. resident was wheeled inside therapy room, while this nurse called 911 another nurse was at bedside. resident stared (sic) talking and answering questions. resident was sent out via 911 . The LVN followed up later with the hospital and was informed Resident 1 was admitted there due to syncope (brief loss of consciousness when blood flow to the brain suddenly changes, people who experience syncope usually go limp and then quickly recover) and elevated d-dimer levels (protein in the blood that is released when blood clots break down).</p> <p>On August 9, 2024, at 11:05 a.m., a follow up onsite visit was conducted at the facility.</p> <p>On August 9, 2024, at 12:22 p.m., a concurrent observation and interview was conducted with the LVN. The LVN showed the outside patio where Resident 1 was found on July 20, 2024. The LVN stated Resident 1 finished his lunch meal at the dining room around 1:10 p.m. on July 20, 2024, and was brought to his room by a Certified Nursing Assistant (CNA), and Resident 1 asked for his hat indicating he wanted to go about the facility in his wheelchair. The LVN stated at around 1:30 p.m., another resident who was in the rehabilitation therapy gym, saw Resident 1 through the glass door (which was facing the outside patio), struggling with his wheelchair and appeared stuck. The LVN stated the other resident walked from the therapy gym via the hallway inside the building, past the nurses ' station, through another hallway to the side door beside the Medical Records room. This door led to the outside patio. The LVN stated upon opening the door, the other resident saw Resident 1 slumped in his wheelchair and appeared unresponsive, so he returned quickly to the nurse ' s station and notified the LVN about what he saw. The LVN stated she immediately made her way to the outside patio, and upon opening the side door, the LVN saw Resident 1 slumped in his wheelchair facing the tree trunk and away from her, and his wheelchair was back towards her and the door. The LVN stated Resident 1 ' s head was leaning to his right and resting on the fence. The LVN stated the wheelchair was on the dirt where a tree was planted, which was approximately two inches lower than the concrete pavement. The LVN stated all four wheels of the wheelchair were in the space between the trunk and roots of the tree and the edge of the concrete pavement. The LVN stated she was assisted by another staff member in bringing Resident 1 past the expanse of the patio and through the glass doors, into the rehabilitation therapy gym (which was across his previous location). The LVN stated she conducted a head to toe assessment and found bruising on a finger of Resident 1 ' s right hand, as well as redness on the right ear. The LVN stated Resident 1 was sent out to the hospital for further evaluation, and was later on admitted to the hospital due to syncope and elevated D-dimer levels. No other details were provided to them by the hospital.</p> <p>On August 9, 2024, at 1:25 p.m., a concurrent interview with the Administrator (ADM) and DON was conducted. The ADM stated the area where Resident 1 was found stuck, was frequented by other residents as well. The ADM further stated, it was the first incident of that nature to have happened, it was unfortunate that it happened to Resident 1, and they did not anticipate that it would happen.</p>		