STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555084	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Springs Healthcare & Wellness Centre	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47832 Based on interview and record review, the facility failed to assess the interventions for revisions to address multiple incidents of falls for two of three sampled residents (Residents 7 and 8). This failure had the potential to result in unmet needs and a potential for falls with possible injury. Findings: On December 26, 2024, at 9:13 a.m., an unannounced visit was conducted at the facility to investigate nursing services and accidents issue. A review of Resident 7's admission record indicated Resident 7 was admitted to the facility on [DATE]. Resident 7 was admitted with diagnoses which included cellulitis (bacterial skin infection) of left lower limb, hypertension (force of blood against the artery walls is too high), anxiety disorder (a mental health disorder of worry, or fear that are strong enough to interfere with one's daily activities), difficultly walking and dementia (a group of conditions with impairment of at least two brain functions, such as memory loss and judgement). A review of Resident 7's Minimum Data Set (MDS- a standardized comprehensive assessment and care planning tool), dated December 28, 2024, indicated the following: - Resident 7 had a Brief interview for Mental Status (BIMS -a tool used to screen and identify cognitive condition of residents) score of 8 (moderate cognitive impairment); and - Resident 7 was maximum assistance to dependent with ADL's (activities of daily living includes bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet and eating). A review of Resident 7's Progress Notes titled Fall Risk Evaluation, dated November 21, 2024, indicated a score of 12 (a score of 10 or greater, considered at high risk for potential falls). (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan, developed on November 21, 2024, indicated, The resident is at high risk for falls r/t (related to) left bka (below knee amputation), decreased mobility pad .Goal .will be free of falls through the review date .Interventions/Tasks .Anticipate and meet the resident's needs .The resident's call light is within reach and encourage the resident to use it for assistance as needed .The resident needs prompt response to all requests for assistance .Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility .Follow facility protocol .PT (physical therapy) evaluate and treat as ordered or PRN (as needed). Further review of Resident 7's medical records indicated resident had multiple falls dated November 23, 2024, December 7, 2024, and December 17, 2024. A review of the care plans after the actual falls on December 7 and 17, 2024, did not indicate new interventions were added to the care plan. A review of Resident 7's Interdisciplinary Team (IDT-staff from different health care disciplines discuss to help people receive the care they need) Notes, dated December 9, 2024, for fall on December 7, 2024, indicated, to attend activities as needed, which was not included in the care plan post fall. A review of Resident 8's admission record indicated Resident 8 was admitted to the facility on [DATE], with diagnoses which included atrial fibrillation (a rapid heart rate that can cause poor blood flow), repeated falls, hydrocephalous (a build up of fluid in the cavities within the brain), hypertension ((force of blood against the artery walls is too high), diabetes (long term condition in which the body has trouble controlling blood sugar and using it for energy), chronic kidney disease (long standing disease of kidneys leading to renal failure), and chronic obstructive pulmonary disease (a group pf lung diseases that block airflow and make it difficult to breathe). A review of Resident 8's Minimum Data Set (MDS- a standardized comprehensive assessment and care planning tool), dated November 20, 2024, indicated the following: - Reside 8 had a Brief interview for Mental Status (BIMS -a tool used to screen and identify cognitive condition of residents) score of 9 (moderate cognitive impairment); and - Resident 8 required moderate to maximum assistance to dependent with ADL's (activities of daily living includes bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet and eating). A review of Resident 8's Progress Notes titled Fall Risk Evaluation, dated November 11, 2024, indicated a score of 17 (a score of 10 or greater, considered at high risk for potential falls). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plan, developed on November 11, 2024, indicated, The resident is at high risk for falls r/t (related to) Gait/balance problems, increased weakness, hx (history) of multiple falls at home and fall with left hip fracture .Goal .Will be free of falls through the review date .Interventions .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance .encourage the resident to participate in activities that promote exercise, physical activity fir strengthening and improved mobility .Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair) .PT (physical therapy) evaluate and trat as ordered or PRN .The resident needs a safe environment with even floors free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, the bed in low position; personal items within reach .The resident needs to be evaluated and supplied appropriate adaptive equipment or LPN (licensed practical nurse) devices as needed. Further review of Resident 8's medical records indicated resident had multiple falls December 7, 2024, December 16, 2024, and December 18, 2024. A review of the care plan after the actual fall on December 7, 2024, indicated no new interventions were added to the care plan after the fall. A review of Resident 8's Interdisciplinary Team (IDT-staff from different health care disciplines discuss to help people receive the care they need) Notes, dated December 24, 2024, for fall on December 18, 2024, recommended every one-hour check, which was not included in the care plan post fall. On December 26, 2024, at 2:05 p.m., during a concurrent interview and record review the Registered Nurse (RN) stated for Resident 7 the initial fall risk score was 12. The RN stated there were no new interventions added to the care plan after the falls on December 7 and December 17, 2024. The RN stated an IDT meeting was held on December 9, 2024, for the fall that occurred on December 7, 2024, and it was recommended for resident to attend activities as needed but that was not added to the care plan post fall. The RN further stated interventions should have been updated and discussed to evaluate the need for 1:1 monitoring or to send resident to activities to prevent further falls. The RN stated for Resident 8 there was no change in intervention from the initial care plan after the fall on December 7, 2024. The RN stated an IDT meeting was held on December 24, 2024, for fall on December 18, 2024, and was recommended for every one-hour check, which was not added to the care plan post fall. The RN stated it was important to update interventions to see if that could help a resident and prevent recurring falls. A review of facility's policy and procedure titled, Fall Management Program with a revision date of March 13, 2021, indicated, .if a fall risk factor is identified, document interventions on the Resident's care plan. Document interventions for every Resident regardless of fall risk evaluation score .The Interdisciplinary Team (IDT) and/or the licensed nurse will develop a care plan according to the identified risk factors and root cause(s) per Care Area Assessment (CAA) guidelines. The IDT will initiate, review and update the Resident's fall risk status and care plan at the following intervals: on admission .upon significant change of condition, post fall and as needed. The licensed nurse will evaluate the Resident's response to the interventions on the Weekly Summary and update the Resident's care plan as necessary .Once the Post-FALL Huddle is completed the licensed nurse will immediately update the care plan with recommendations .The Resident's care plans will be updated with the IDT recommendations.