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	05/27/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure wound care and management were implemented according to the facility's policy and procedure and national guidelines, for two of three residents reviewed (Residents 1 and 2), when:1.For Resident 1, the pressure injury (PI - a localized damage to the skin and underlying tissue caused by constant pressure, usually over a bony prominence) on the sacrococcyx (tail bone) area was not properly assessed. In addition, the treatment for Resident 2's PI on bilateral buttocks was not appropriate according to the facility's treatment protocol; and2.For Resident 2, infection control measures were not implemented while providing wound care. These failures had the potential for delayed wound healing and placed the resident at risk for further complications such as infection and worsening of the wound.Findings:On April 13,2026, at 9;15 a.m., an unannounced visit was conducted at the facility to investigate a quality-of-care issue.1.On April 13, 2026, Resident 1's record was reviewed. A review of Resident 1's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included heart failure and protein-calorie malnutrition (a potentially life-threatening condition caused by an inadequate intake of protein, calories (energy), or both).A review of Resident 1's care plan, dated March 2, 2026, indicated, .has actual impairment to skin integrity of the Sacrococcyx r/t (related to) admitted with unstageable pressure injury.Goal.The resident's (sic) will have no complications r/t unstageable pressure injury through the review date.Interventions.Follow facility protocols for treatment of injury.Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection.Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.A review of Resident 1's Skin Check, dated March 2, 2026, indicated a skin assessment to the sacrococcyx area (tail bone) with stage 3 pressure injury (a deep, crater-like wound that extends completely through the skin layers into the underlying fatty tissue), measuring 3 cm (centimeters - unit of measurement) by 4 cm by 0.1 cm.A review of Resident 1's Skin Check, dated March 2, 2026, indicated a skin assessment to the sacrococcyx area (tail bone) with unstageable pressure injury (PI - a severe wound where the true depth is hidden by dead tissue [slough or eschar]), measuring 5 by 5 by 0.1 cm, 100% slough, moderate exudate.A review of Resident 1's Skin Check, dated March 9, 2026, indicated the following skin assessments:- sacrococcyx area, unstageable PI, with measurement of 5 by 5 by 0.1 cm, 40% granulation, 30% slough, and 30% eschar;-left gluteus (buttocks), stage 2 PI (a shallow, open wound with a moist, shiny pink or red base, a blister or an abrasion/scrape), with measurement of 2 by 2 by 0.2 cm., pink wound base; and- right gluteus, stage 2 PI with measurement of 3 by 2 by 0.2 cm., pink wound bed.A review of Resident 1's Skin Check, dated March 17, 2026, indicated the following skin assessments:-right gluteus, stage 2 PI, with measurement of 2 by 2 by 0.1 cm, pink wound bed;-left gluteus, stage 2 PI, with measurement of 2 by 2 by 0.1 cm, pink wound bed; and-sacrococcyx, unstageable PI, with measurement of 6 by 6 by 3 cm. undermining (tissue destruction under the intact edges of a wound, creating a hidden pocket or cave beneath the skin) measuring 2 cm at 9 o'clock to 3 o'clock; 40% granulation, 20% slough (total of 70%).Further review of Resident 1's Skin Check, dated (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	March 17, 2026, indicated there was no description of the wound status of the 40% of the wound bed at the sacrococcyx unstageable wound.On April 13, 2026, at 10:45 a.m., during an interview with the Treatment Nurse (TN), the TN stated Resident 1 was admitted to the facility with an unstageable wound on the sacrococcyx area. The TN stated the wound care nurse practitioner (NP) assessed the sacrococcyx and the bilateral buttocks wounds as one wound.On April 13, 2026, at 1 p.m., during a concurrent interview and record review with the TN, the TN stated he does not stage the PI and waits for the wound care specialist to stage and assess the wounds, and he was not aware of what guidelines to follow when assessing the wound. The TN stated he should have assessed the wound on Resident 1's sacrococcyx area as Stage 4 (a severe, full-thickness wound where skin and underlying tissue are destroyed, exposing muscle, tendon, joint, or bone), when the wound presented with granulation tissue (a fresh, pink or dark red, moist, and slightly bumpy tissue that grows from the base of the wound for wound healing). The TN stated the skin assessment on Resident 1's sacrococcyx area, on March 17, 2026, was incomplete as it did not indicate 40% of the remaining part of the wound bed.On April 13, 2026, at 2 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON stated the licensed nurses should be able to stage the PI, and not to wait for the wound care specialist to make the assessment. The DON stated she had to research what criteria or guidelines to use when staging wounds/P1. The DON stated the treatment of a barrier cream on Resident 1's stage 2 PI on bilateral buttocks was not appropriate as the resident is incontinent in urine and bowel.On April 20, 2026, at 11 a.m., the wound NP was interviewed. The wound NP stated the wound on Resident 1's sacrococcyx area should have been staged as 4 and not unstageable on March 17, 2026, as the muscle and bone were exposed to the wound. The wound NP stated the treatment for the stage 2 PI on bilateral buttocks should have been covered with a foam dressing instead of barrier cream and left open to air.A review of the facility's policy and procedure titled, Skin Integrity Management, revised June 27, 2024, indicated, .A Licensed Nurse will complete a skin evaluation then there is a change in skin integrity.A Licensed Nurse will complete the skin evaluation weekly.Consultation from a wound care physician may be obtained upon an order from the attending physician.Licensed Nurses will document the effectiveness of current treatment for skin integrity problems in the resident's medical record on a weekly basis.A review of the facility's document titled, Quick Reference - Topical Wound Care, indicated the following:-Stage 2 PI; wound treatment of Dermafilm (a transparent, flexible hydrocolloid [a flexible, moisture-retentive material which contains gel-forming agents) wound dressing used to treat non-infected, low-exuding wounds and shallow ulcers); and-Stage 4 PI; full thickness tissue loss with exposed bone, tendon or muscle, slough or eschar may be present on some parts of the wound bed.2.On April 13, 2026, at 11:15 p.m., an observation of wound care on Resident 2's wound on bilateral legs being provided by the TN. The TN was observed to do the following:-The TN applied gloves, cut off gauze bandage and removed xeroform dressing and left leg were directly placed on the pillow; no clean field was placed under the left leg;-cleansed the left leg with normal saline, removed gloves and performed hand hygiene and applied new gloves;-cut the new xeroform dressing with the same scissors used to remove the dirty bandage without disinfecting it; applied the dressing to the left leg wound and wrapped it with kerlix gauze (a type of stretchable, 100% woven cotton medical bandage featuring a unique crinkle-weave pattern);-removed the old gauze dressing from the right leg with the same scissors used for the left leg; and followed the same process of wound care on the left leg.A review of Resident 2's Face Sheet, record indicated the resident was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke).A review of Resident 2's Order Summary Report, included a physician's order, dated April 7, 2026, which indicated.Cleanse venous ulcers (a slow-healing sore typically found on the lower leg, usually near the ankle) to bilateral shins with normal saline, pat dry, apply xeroform to open areas, cover with non-stick gauze wrap with kerlix secure with tape.On April 13, 2026, at 1 p.m., during a concurrent interview and record review with the TN, the TN stated he should have provided a clean area for dressing removal and another for redressing the wounds when (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he performed wound care to Resident 2. The TN stated he should have disinfected the scissors before using it to a clean/sterile dressing.According to the web article titled, What does Infection Control and Prevention Mean in Wound Care? published by the Wound Care Education Institute, dated April 2, 2024, .Infection control practices are crucial to prevent complications in wounds. By following steps like these, you can reduce the risk of infection and promote successful wound healing.changing gloves after assessing a wound and before applying a clean dressing.moving from clean to dirty.Don't mix clean and dirty.Seeing patients with multiple wounds can quickly create a dirty, disheveled workspace.work areas should be free of used, dirty supplies and materials before place a clean, dry dressing.According to the web article titled, Infection Prevention During Wound Care, published by the California Department of Public Health, indicated, .Reusable wound care equipment should be cleaned and disinfected prior to reuse.Surfaces in the treatment area that may have been contaminated should be cleaned and disinfected.