

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 07/18/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview, and record review, the facility failed to treat two of four sampled residents, with dignity and respect when the Certified Nursing Assistants (CNA) did not sit at eye level while feeding the residents (Residents 40 and 43).</p> <p>This failure did not promote resident's dignity, did not allow social interaction, and had the potential promote more serious negative outcomes.</p> <p>Findings:</p> <p>On July 15, 2024, at 12:16 p.m., CNA 1 was observed wearing gloves, gown, and mask, and feeding Resident 40 while standing up. In a concurrent interview, CNA 1 stated he should be sitting down while feeding Resident 40.</p> <p>On July 15, 2024, at 12:23 p.m., during an interview with the Director of Staff Development (DSD), the DSD stated the CNA should be sitting down while feeding the resident.</p> <p>On July 15, 2024, at 12:34 p.m., the Restorative Nurse Assistant (RNA) was observed wearing a gown and gloves, and feeding Resident 43 while standing up. In a concurrent interview, the RNA stated she should be sitting down while feeding Resident 43 to have eye contact and communicate with the resident.</p> <p>On July 15, 2024, Resident 40's record was reviewed. Resident 40 was admitted on [DATE], with diagnoses which included, fracture of the lower left radius (a break in the long bones in the forearm), unspecified abnormality of gait and mobility (unusual walking pattern), and metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood).</p> <p>A review of Resident 40's Minimum Data Set (MDS - an assessment tool), dated April 19, 2024, indicated Resident 40 was severely impaired and needed extensive assistance with feeding.</p> <p>On July 15, 2024, Resident 43's record was reviewed. Resident 43 was admitted on [DATE], with diagnoses which included, hemiplegia (paralysis that affects only one side of the body), hemiparesis (one sided muscle weakness), cerebral infarction (disrupted blood flow to the brain), and dysphagia (difficulty swallowing).</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 43's Minimum Data Set, dated [DATE], indicated a BIMS (Brief Mental Status) score of 6 (severe cognitive impairment) and needed set up/limited assistance during meals.</p> <p>A review of the facility's policy and procedures titled, Resident Rights - Quality of Life, dated March 2017, indicated, .Each resident shall be cared for in a manner that promotes and enhance 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/her highest practicable well-being .</p> <p>A review of the facility's undated document titled, Feeding a Resident Competency Validation, indicated, .To protect resident's dignity and ensure that during assisting and/or feeding meals that you are seated at eye level of resident .Procedure .Sit down next to the resident .</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on interview and record review, the facility failed to ensure information regarding formulating an Advance Directives (AD- a written document that indicates a resident's medical wishes,) was provided to the resident or resident representative (RR), for three of six residents reviewed for AD, (Residents 6, 29, and 52).</p> <p>This failure had the potential for the resident/resident representative's current wishes for medical care not to be honored.</p> <p>Findings:</p> <p>1. On July 15, 2024, Resident 29's record was reviewed. Resident 29 was initially admitted to the facility on [DATE], with diagnoses which included end stage renal failure (a condition in which the kidneys lose the ability to remove waste and balance fluids), cognitive communications deficit (problems with a person's ability to think, learn, remember, use judgement, and make decisions), and dementia (condition characterized by progressive or persistent loss of intellectual functioning especially with impairment of memory and abstract thinking).</p> <p>A review of Resident 29's Advance Healthcare Directive (AHCD) Acknowledgement Form, dated June 2022, indicated Resident 29 signed that she received information regarding a right to make an AD.</p> <p>A review of Resident 29's Minimum Data Set (MDS - an assessment tool), dated July 10, 2023, indicated the resident had a Brief Interview for Mental Status (BIMS - a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long -term care facility) score of 6, indicating severe cognitive impairment.</p> <p>A review of Resident 29's History and Physical, dated September 10, 2023, indicated the resident was demented and did not have the capacity to make healthcare decisions.</p> <p>There was no documented evidence information regarding formulating an AD was provided to the resident representative (Family Member) when Resident 29 was not able to make healthcare decisions based on the MDS dated [DATE].</p> <p>A review of Resident 29's Minimum Data Set (MDS - an assessment tool), dated June 25, 2024, indicated the resident had a Brief Interview for Mental Status (BIMS - a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long -term care facility) score of 7, indicating severe cognitive impairment.</p> <p>The Social Service History and Initial assessment dated [DATE], indicated the resident did not have an AD, and did not have the capacity to make one.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On July 17, 2024, at 6:08 p.m., a concurrent interview and review of resident's record was conducted with the Activities Director (ACD). The ACD stated if a resident was not able to sign AD, the facility contacts the RR to review and sign the document. If the RR was not available, the facility would contact the Ombudsman. The ACD stated if the resident did not have the capacity to sign, then the RR should have been contacted. The ACD further stated Resident 29 should not have signed the AD.</p> <p>On July 18, 2024, 3:50 p.m., a concurrent interview and record review with the ACD was conducted. The ACD stated Resident 29 was not capable of making healthcare decisions and the RR was the family member who lived out of state. The ACD stated the AD form should have been acknowledged by the RR because Resident 29 was not capable of make decisions.</p> <p>On July 18, 2024, at 4:11 p.m., a concurrent interview and record review was conducted with the Case Manager (CM). The CM stated there was no documented evidence information was provided to the RR regarding formulating and AD. The CM stated the family representative should have been provided information regarding formulating an AD.</p> <p>On July 18, 2024, at 6:18 p. m., a concurrent interview and record review was conducted with the CM. The CM stated, the Annual Social Service Assessment, dated March 27, 2024, indicated there was no AD and there was no documented evidence information was provided to the RR regarding formulating an AD. The CM stated the RR should have been provided information regarding formulating and AD during the annual review in March 2024.</p> <p>2. On July 18, 2024, at 3:50 p.m., a concurrent interview and review of Resident 52's record was conducted with the ACD. Resident 52 was initially admitted on [DATE], with diagnoses which included hepatic encephalopathy (loss of brain function when the liver does not remove toxins from the blood), chronic kidney disease (gradual loss of kidney function), and diabetes mellitus (abnormal blood sugar).</p> <p>The ACD stated upon admission, it was her responsibility to interview the resident, ask if they had an AD, and give the information about formulating an AD to the resident. The ACD stated in order to determine if the resident was capable to make decision, they must have a BIMS score of 13-15. If the score was below 13, the representative would decide, and if there was not a representative, the Interdisciplinary Team (IDT - group of professionals all working together toward a common goal for the patient) would determine the care for the resident.</p> <p>The ACD stated Resident 52 had a BIMS score of 13 (cognitively intact) in the Minimum Data Set), dated May 24, 2024. The ACD stated The AD form was signed by Resident 52 on July 16, 2024 (two days into survey), when the ACD provided a copy of the AD information. The ACD was not able to find information that Resident 52 was provided information on how to formulate an AD upon admission. The ACD stated she should have provided information to the resident regarding formulating an AD upon admission.</p> <p>40988</p> <p>3. On July 16, 2024, at 12:13 p.m., Resident 6's record was reviewed. Resident 6 was admitted to the facility on [DATE]. The SNF HNP (Skilled Nursing Facility History and Physical), dated June 28, 2024, indicated Resident 6 had the capacity to make medical decisions.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 6's Advanced Healthcare Directive (AHCD) Acknowledgment Form, dated June 25, 2024, indicated an X mark on the line item indicating Resident 6 did not have an Advanced Directive. There was no documented evidence information on formulating an advance directive was provided to or received by Resident 6.</p> <p>On July 18, 2024, at 3:52 p.m., a concurrent interview and review of Resident 6's record was conducted with the Director of Nursing (DON). The DON stated the AHCD Acknowledgment Form was completed by the licensed nurses upon admission. The X mark on the form indicated the licensed nurse would have asked Resident 6 if there was an Advanced Directive in place, and Resident 6 would have answered there was none. The facility process was, the Activities Director (ACD), who currently performs some Social Service functions, would follow up with the residents to provide information on AHCD and assist in the formulation of one, if the resident desired. The DON stated the absence of a mark on the line item indicating resident receipt of the information meant the ACD had not followed up with Resident 6, and should have.</p> <p>Further review of Resident 6's record indicated no documentation in the Social Services Assessment information regarding AD formulation was provided, as evidenced by the absence of a check mark regarding Advanced Directive item .Interested in Initiating Advance Directive/Information Provided ., or .Declined to formulate/reformulate . The .DNR (Do Not Resuscitate) . line item was checked.</p> <p>On July 18, 2024, at 4:49 p.m., a concurrent interview and review of Resident 6's record was conducted with the ACD. The ACD stated if she did not mark or sign Resident 6's AHCD Acknowledgment Form, then she did not provide information regarding AD formulation to Resident 6. The ACD further stated she marked the DNR on the Social Services Assessment after asking Resident 6 about her wishes, no information was given to Resident 6 due to items c and d not marked, and information should have been provided to Resident 6 regarding AD formulation.</p> <p>A review of the facility's policy and procedure titled, Advanced Directives, dated July 2018, indicated, .If a resident does not have an Advance Directive, the Facility will provide the resident and/or resident's next of kin with information about Advance Directives upon request .Upon admission, the Admissions Staff or designee will provide written information to the resident concerning his or her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives .During the Social Services Assessment process, the Director of Social Services or designee will also ask the resident whether he or she has a written advance directive .If the resident does not have an Advance Directive the Admissions Staff or designee will inform the resident that the Facility can provide the resident with a copy of the Advance Directive form .The Interdisciplinary Team will annually review the Advance Directives still reflects the wishes of the resident .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988</p> <p>48000</p> <p>Based on interview and record review, the facility failed to ensure a comprehensive care plan (specific interventions to provide effective and person-centered care to meet the resident's needs) was initiated for the use of apixaban (brand name Eliquis, an anti-coagulant, or blood thinning medication), for one of five residents reviewed for unnecessary medications (Resident 6).</p> <p>This failure had the potential to result in the delay in the care and treatment for Resident 6.</p> <p>Findings:</p> <p>On July 17, 2024, Resident 6's record was reviewed. Resident 6 was admitted on [DATE], with diagnoses which included atrial fibrillation (an irregular and often very rapid heart rhythm).</p> <p>A review of the Resident 6's telephone order, dated June 25, 2024, indicated, .Apixaban Oral Tablet 2.5 mg (mg - milligram, a unit of measurement) Give 1 (one) tablet by mouth two times a day for atrial fibrillation.</p> <p>In further review of Resident 6's record, there was no documented evidence a care plan was developed to address Resident 6's risk for bleeding regarding the use of apixaban medication.</p> <p>On July 17, 2024, at 5:38 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated there should be a care plan to monitor for the signs and symptoms of bleeding when Resident 6 was admitted with apixaban. The DON further stated the care plan needed to be completed within seven days of admission and the purpose of a care plan was to determine what care and monitoring would be needed for the resident. The DON acknowledged the care plan was not done within seven days and stated, it should have been completed.</p> <p>The facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, revised November 2018, was reviewed. The policy indicated, .To ensure that a comprehensive person-centered care plan is developed for each resident .It is the policy of this Facility to provide-person-centered, comprehensive and interdisciplinary care that reflects the best practices for meeting health, safety .needs of residents in order to maintain the highest physical .wellbeing. The policy also indicated .within 7 days from the completion of the comprehensive .assessment, the comprehensive care plan will be developed .</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview, and record review, the facility failed to ensure were provided the necessary level of assistance to meet their activities of daily living needs, for two of two sampled residents (Residents 30 and 29), when:</p> <ol style="list-style-type: none"> 1. Resident 30 was observed with lunch meal tray set up incomplete, with plastic covering/seal on food items and the milk carton was left unopened. Resident 30 was unable to remove the plastic covering nor able to open the milk carton; and 2. Resident 29 was observed with lunch meal tray set up incomplete, with plastic covering/seal on plated food items. Resident 29 was unable to remove the plastic covering on the plated food or reach her drinking cup. <p>These failures resulted in the residents not receiving direct necessary care and services needed at mealtime and had the potential to compromise the health and wellbeing of the residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On July 15, 2024, at 12:14 p.m., Resident 30 was observed with lunch meal tray set up incomplete, with plastic covering/seal on food items and the milk carton was left unopened. Resident 30 was unable to remove the plastic covering nor able to open the milk carton. <p>On July 15, 2024, at 12:14 p.m., during an interview with the Director of Staff Development, (DSD), the DSD stated it is the CNA's responsibility to open the food and set it up for the residents to eat.</p> <p>Resident's 30's record was reviewed and indicated the Resident was admitted on [DATE], with diagnoses which include chronic obstructive pulmonary disease (a group of lung diseases that block the airflow and make it difficult to breathe), dysphagia (difficulty swallowing), muscle weakness (decrease strength in muscles), and dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement).</p> <p>A review of Resident 30's Minimum Data Set (MDS - a standardized assessment and screening tool), dated May 27, 2024, indicated the resident had Brief Interview for Mental Status (BIMS - a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long -term care facility) with a score of 3 (severe cognitive impairment).</p> <p>A review of Resident 30's care plan indicated, the resident needed set-up or clean-up assistance. The helper sets up or cleans up prior to or following activity.</p> <ol style="list-style-type: none"> 2. On July 15, 2024, at 12:59 p.m., observed Resident 29's meal tray set up in the room in front of the resident. Resident 29's plated food had a seal/plastic covering food items in the bowls and the drink was not placed within her reach. In a concurrent interview, Resident 29 stated she needed help to get her drink. <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On July 15, 2024, at 1:02 p.m., an interview with Certified Nursing Assistant (CNA) 2. CNA 2 stated the plastic/seal should have been removed from the resident's plated food.</p> <p>On July 15, 2024, 1:07 p.m., CNA 3 was interviewed. CNA 3 stated the facility's process was the food was prepared, and the plastic seal removed and set up for the resident to eat. CNA 3 stated the plastic and set up the resident's food tray should have been removed.</p> <p>A review of Resident 29's record indicated the resident was admitted to the facility on [DATE], with diagnoses which included end stage heart failure (final severe stage of heart failure), dysphagia (difficulty swallowing), and dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement).</p> <p>A review of Resident 29's History and Physical, dated September 10, 2023, indicated the resident had muscular dystrophy, and severe arthritis of the wrist.</p> <p>A review of the facility's policy and procedure titled, .Feeding - Preparing Residents-Nursing Manual - Dietary & Dining, dated January 1, 2012, indicated, . Residents receiving feeding assistance will be properly prepared to eat before a meal .</p> <p>A review of the facility's policy and procedure titled, Dining Program- Nursing Manual - Dietary & Dining, dated January 12, 2012, indicated, .the facility's purpose is to provide residents with adequate supervision and/or assistance during mealtime .RNAs (restorative nurse assistant) /CNAs will work to provide assistance as needed to those residents who have difficulty or are unable to feed themselves and residents will be monitored by the RNAs/CNAs throughout their meal to ensure assistance is provided .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000</p> <p>Based on interview and record review, the facility failed to ensure the abnormal results of the chest x-ray (radiology procedure of the chest) was addressed by the physician timely, for one of three closed record reviewed (Resident 22). In addition, the physician's order for antibiotic to treat the abnormal chest x-ray was not administered timely.</p> <p>These failures resulted in a delay in the care and treatment for Resident 22.</p> <p>Findings:</p> <p>On July 17, 2024, Resident 22's record was reviewed. Resident 22 was admitted to the facility on [DATE], with diagnoses which included aftercare for right femur (hip) fracture (broken bone) and malnutrition.</p> <p>A review of Resident 22's Progress Notes, indicated the following:</p> <ul style="list-style-type: none"> - May 10,2024, at 3:34 p.m., indicated, .reported to (name of physician) pt (patient) VS (vital signs) 132/70 (blood pressure) 99.8 (temperature) .102HR (heart rate) 40resp (respiratory rate) a minute .refusing to open her eyes and moans to painful stimuli .waiting for advice .; - May 10, 2024, at 4:38 p.m., indicated, .pt is ALOC (altered level of consciousness), hard to arouse. Does not respond verbally back to verbal stimuli, moans, responds to verbal stimuli by moaning .; - May 10, 2024, at 5:01 p.m., indicated, .CHEM PANEL (chemistry panel - laboratory test), CBC (complete blood count - laboratory test) AND CHEST X-RAY ORDERED . <p>A review of Resident 22's physician's notes, dated May 10, 2024, indicated, .Labs (laboratory) 5-8 (May 8, 2024) .u/a (urinalysis) with many wbcs (white blood cell count) .recheck cbc, cmp (complete metabolic panel - laboratory test to check electrolytes), u/a, u/c (urine culture). Will start on macrobid (medication to treat urinary tract infection) 100 bid (twice a day) .</p> <p>A review of Resident 22's Radiology Report, dated May 13, 2024, indicated, .Bilateral Infiltrates (a substance denser than air, such as pus, blood, or protein, which lingers within the lungs associated with pneumonia [lung infection]) .</p> <p>A review of Resident 22's Progress Notes, dated May 13, 2024, at 12:51 p.m., indicated, .pt is had to arouse, does not open eyes .Patient is not opening her mouth at meals, sleeping, moans at times . Recommendations: MD (physician) will come to facility to assess patient .</p> <p>A review of Resident 22's physician notes, dated May 13, 2024, indicated, .Pt seen groaning. Not communicating. Pt was confused on admission, continues to be confused. Started on abx (antibiotic) for possible uti (urinary tract infection) .xrays showed some patchy infiltrates .Will d/c (discontinue) macrobid and place on avelox (medication to treat lung infection) 400 daily x (times) 7 (seven) days .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 22's Progress Notes, dated May 15, 2024, at 8:07 a.m., indicated, .The patient's caregiver (name of caregiver) in facility and Patients (sic) son (name of son) is on the phone. The family asked what was ordered by the MD for the chest xray bilateral (both) infiltrates. The (sic) are aware no orders have been placed .Writer to follow up with MD .</p> <p>A review of Resident 22's Progress Notes, dated May 15, 2024, at 8:48 a.m., indicated, .spoke with MD (name of physician) to follow up with chest xray results bilateral infiltrates and he ordered atb (antibiotic) . Recommendation: MD ordered Moxifloxacin (avelox - brand name) 400 MG (milligram - unit of measurement) Give 1 (one) tablet by mouth one time a day for bilateral infiltrates on chest xray for 7 (seven) days .</p> <p>A review of Resident 22's Medication Administration Record (MAR), for May 2024, indicated moxifloxacin was signed out 9 on May 17 and 18, 2024. There was no documented evidence moxifloxacin was administered on May 15 and 16, 2024, as ordered by the physician on May 15, 2024.</p> <p>On July 17, 2024, at 4:06 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the chest xray result of bilateral infiltrates was received on May 13, 2024. The DON stated the bilateral infiltrates was referred to the physician on May 15, 2024 (2 days after the chest xray result was received) and the physician ordered for avelox. The DON stated there was a physician's progress notes dated May 13, 2024, which indicated to give avelox one time a day for seven days and discontinue the macrobid. The DON stated the licensed nurse should notify the physician for appropriate treatment within the day after a laboratory or xray result had come in. The DON stated the avelox was not signed out as 9 in the MAR on May 17 and 18, 2024. She stated 9 meant a progress note was created for the administration of the medication. She stated the progress notes indicated Resident 22 spit out avelox on May 17, 2024, and was unable to swallow the avelox on May 18, 2024.</p> <p>On July 17, 2024, at 4:49 p.m., a follow up concurrent interview and record review was conducted with the Infection Preventionist (IP). The IP stated the physician ordered for laboratory test and chest xray to be done on May 13, 2024. The IP stated the chest xray results of bilateral infiltrates was received on May 13, 2024, but was referred to the physician on May 15, 2024. The IP stated the physician's note dated May 13, 2024, indicated the physician assessed Resident 22 and ordered to discontinue Macrobid and change to Avelox. The IP stated the physician's order to d/c Macrobid and start on Avelox was not given by the physician on May 13, 2024, after he visited Resident 22. The IP stated the facility's process was for the physician to give the order to the licensed nurse during their visit in the facility. She stated this process was not done. The IP stated the licensed nurse should have followed up with the physician before he left the facility for any new orders. The IP stated avelox was not started not until May 17, 2024 (four days after the physician's visit). She stated the order for avelox should have been started on May 13, 2024, unless it was not available from the emergency medication supply.</p> <p>On July 18, 2024, at 9:31 a.m., a follow up interview was conducted with the DON. The DON stated when the physician comes in to assess the resident, the physician would either give a verbal order to the licensed nurse or would write down in a telephone order. The DON stated Resident 22's physician would either inform the licensed nurse or the DON or send the order electronically. The DON was unable to explain why the physician's order to d/c macrobid and change to avelox on May 13, 2024, was not communicated to the licensed nurse or to her.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On July 18, 2024, at 9:40 a.m., an interview was conducted with the Resident 22's MD (physician). The MD stated he assessed the resident during his visit in the facility and would communicate only to the DON for any new orders either verbally or through text message. The MD stated he would not give any orders to the licensed nurse because they are not always in the facility not like the DON who is on call 24/7 (24 hours/ 7 days a week) and knows the residents very well than the licensed nurses. He stated he would input his notes when he gets home and uploads it in the resident's record. The MD stated he saw Resident 22 on May 13, 2024 and uploaded his notes on May 15, 2024. The MD stated he could not remember if he informed the DON about the order for avelox on May 13, 2024 after his visit or why he uploaded his notes on May 15, 2024, and not on May 13, 2024. The MD stated he gave the order for avelox after the licensed nurse called him on May 15, 2024. He stated the medication avelox should have been administered within the day when it was ordered on May 15, 2024. The MD stated he should have given to the DON the order for the Avelox on May 13, 2024, when he visit Resident 22, or the licensed nurse should have called him on May 14, 2024 to follow up if there's any order for the bilateral infiltrates.</p> <p>On July 18, 2024, at 2:23 p.m., a follow up interview and record review was conducted with the DON. The DON stated the physician should have been notified of any abnormal laboratory or radiology result as within the day of receipt of results. The DON stated the order for the Avelox was placed on Resident 22's record the morning of May 15, 2024, and was discontinued by the physician electronically in the afternoon May 15, 2024. The DON stated she confirmed the order for canceled the order for Avelox on May 15, 2024 without indication of the reason for d/c. She stated the order was renewed on May 17, 2024, and that was the date it was first attempted to be administered. The DON stated the physician should indicate the reason for removing the order so the licensed nurse know why.</p> <p>A review of the facility's policy and procedure titled, Change of Condition Notification, dated April 1, 2015, indicated, .To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner .A Licensed Nurse will notify the resident's Attending Physician .when there is .A need to alter treatment significantly (e.g. based on lab/x-ray results .) .A Licensed Nurse will communicate critical test results and information pertinent to an emergency or significant change in condition to the Attending Physician immediately by telephone .</p>		

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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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview and record review, the facility failed to ensure interventions to prevent falls were implemented, for one of two residents (Resident 40) when 1:1 sitter was not provided to address impulsive behavior and falls.</p> <p>This failure had a potential to result in Resident 40 to have falls and sustain injury.</p> <p>Findings:</p> <p>On July 15, 2024, at 11:42 a.m., a concurrent observation and interview was conducted with Resident 40. Resident 40 was observed lying in bed awake. Two bumps were observed on Resident 40's forehead. The right side of her forehead had a nickel-size bump with a dark scab and the left side had a quarter size bump with red bruising. The Resident 40 stated she fell a couple of days ago and could not remember how. Resident 40 stated staff helped her to eat as she was blind.</p> <p>On July 15, 2024, at 3:42 p.m., observed Resident 40 in her room alone, sitting at the edge of her wheelchair trying to get up, Resident 40 almost slipped out of the chair. A Certified Nursing Assistant (CNA) was called to assist resident.</p> <p>A review of Resident 40's record was conducted. Resident 40 was admitted to the facility on [DATE], with diagnoses which include fracture of the left radius (one of the two long bones in the forearm - breaks close to the wrist), unspecified abnormality of gait and mobility (unusual walking pattern), and metabolic encephalopathy (problem in the brain, caused by a chemical imbalance in the blood).</p> <p>A review of Resident 40's History and Physical, dated April 13, 2024, indicated the resident would benefit in the future for FWW (front wheel walker) or wheelchair for assistance at home.</p> <p>A review of Resident 40's Minimum Data Set (MDS - a standardized assessment and screening tool), dated April 19, 2024, indicated the resident had severely impaired cognitive status.</p> <p>The care plan initiated on April 12, 2024, indicated, .The resident is high risk for falls related to confusion, gait/balance problems, incontinence, unaware of safety needs, and Alzheimer's dementia .Review information on past falls and attempt to determine cause of falls. Record possible root causes .</p> <p>The care plan initiated on April 13, 2024, indicated, .The resident has had an actual fall with no injury r/t (related to) impulsive behavior, confusion, Unsteady gait .</p> <p>A review of Resident 40's Progress Notes, dated June 26, 2024, at 10 a.m., indicated, .Res (resident) found slouched forward to the left side at EOB (edge of bed) with face touching floor .Res positioned back in bed noted with raised area to left forehead .states she bumped her head on floor as she slouched forward to left side .Bed kept in lowest position .</p> <p>(continued on next page)</p>		

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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 40's Progress Notes, dated July 7, 2024, at 4:08 a.m., indicated, .This nurse is at the nurse station across from the resident room when I heard a loud noise, upon entering the room the resident was naked and standing on the corner holding on the bedside drawer. I turn the headlight on and while talking to the resident I notice a raised area on left forehead with small amt (amount) of blood and bluish discoloration to right forehead, resident gets aggressive to the staff and wanted to open the door .</p> <p>A review of Resident 40's care plan, revised on July 15, 2024, indicated, The resident has had an actual fall with raised area to left forehead r/t impulsive behavior .Does not want to follow instructions from the staff, blind .Interventions .1:1 sitter (date initiated: 07/15/2024 July 15, 2024) .</p> <p>On July 18, 2024, a review of Resident 40's progress notes dated July 15, 2024, at 5:12 p.m., titled, IDT Progress Notes-Falls indicated, . Resident will have a 1:1 sitter .</p> <p>On July 18, 2024, at 10:42 a.m., a concurrent interview and record review was conducted with the Licensed Vocational Nurse (LVN) 1. LVN 1 created a risk management on June 26, 2024, at 10:00 a. m. because she found resident slouched over to her left side and observed a raised light red quarter size bump on the resident's left forehead. The LVN stated Resident 40 had another fall on July 7, 2024, with injury. Stated resident is visually impaired. LVN 1 further stated the resident did not have a 1:1 sitter in June or July 2024, and was not scheduled for frequent checks. LVN 1 stated Resident 40 should have been on frequent monitoring and should probably have had a bed alarm.</p> <p>On July 18, 2024, at 11:46 a. m., a concurrent interview and record review with the Director of Nursing (DON) was conducted. The DON stated on April 13, 2024, there was an unwitnessed fall at 7:30 p.m. in Resident 40's room. The DON stated she found Resident 40 on the floor. The DON stated the resident was blind and was not listed in the frequent check logbook because Resident 40's room is close to the nurse station. The DON acknowledge that Resident 40 was not visible from the nurse's station. The DON stated the Resident had another fall on July 7, 2024, at 3:15 a.m. Stated she heard a loud noise from Resident 40's room and the resident was found standing at the door naked. Resident 40 stated said she fell . The DON observed a raised area to the left forehead with minimum amount of blood. Stated she cleaned the area, put the resident to bed, and notified the doctor.</p> <p>The DON stated previous interventions were not effective and Resident 40's plan of care should have been re-evaluated to reflect the needs of the resident. The DON stated the current plan of care was also, ineffective. Stated a care plan for 1:1 sitter was created for behavior. A concurrent observation of Resident 40 was conducted with the DON. Resident 40 was lying down asleep, call light hanging on a hook behind the resident's bed, not within reach. There was currently no 1:1 sitter in the room. The DON stated the call light should be within the resident reach and acknowledged there was not a 1:1 sitter present and there should have been a 1:1 sitter.</p> <p>A review of the facility policy and procedures titled, Fall Management Program-Nursing Manual-Falls, dated March 13, 2021, indicated, .The facility will implement a Fall Management Program that supports providing an environment free from fall hazards .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 .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48000</p> <p>Based on interview and record review, the facility failed to ensure accurate accountability of controlled medications (those with high potential for abuse and addiction) for one of four residents (Resident 62) when a random controlled medication audit did not reconcile. The controlled medication was signed out of the Individual Narcotic Record (a controlled drug record, an inventory sheet that keeps record of the usage of controlled medications) but not documented on the Medication Administration Records (MAR) to indicate it was administered to Resident 62.</p> <p>This failure resulted in inaccurate accountability of controlled medications, which had the potential for misuse or diversion.</p> <p>Findings:</p> <p>The Individual Narcotic Record for controlled medications for four random residents receiving controlled medications were requested for review during the survey and indicated the following:</p> <p>A review of Resident 62's facility medical record indicated Resident 62 had a physician's order, dated June 19, 2024, for .Norco (hydrocodone-acetaminophen, a potent controlled medication for pain) 5/325 milligram (mg - unit of measurement) tablet, 1 tablet by mouth every 6 hours. Entered as needed for pain .</p> <p>On July 15, 2024, at 3:52 p.m., during a concurrent interview and record review with Licensed Vocational Nurse (LVN) 2, a review of Resident 62's Individual Narcotic Record for May, June, and July 2024, indicated the nursing staff signed out one tablet of Norco 5/325 mg on the following dates and times but did not document the administration on the MAR of Resident 62:</p> <ul style="list-style-type: none"> - June 24, 2024, at 2300 (11 p.m.); and - July 1, 2024, at 1700 (5:00 p.m.). <p>In a concurrent interview, LVN 2 acknowledged one Norco 5/325 mg tablet for Resident 62 was unaccounted in June 2024 and one Norco 5/325 mg tablet was unaccounted in July 2024. LVN 2 stated both Norco 5/325 mg tablets should have been documented in the MAR at the dates and times listed above.</p> <p>On July 16, 2024, at 2:50 p.m., during an interview with the Director of Nursing (DON), the DON stated the facility's process of controlled medication administration as follows:</p> <ul style="list-style-type: none"> - When a controlled medication is received from the pharmacy, the medication is logged in the facility's individual narcotic record book; - Nursing staff complete assessment of the resident's pain; - The controlled medication is pulled from the medication cart and administered to the resident; and <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- The administration of the medication documented in the resident's chart on the MAR immediately.</p> <p>The DON acknowledged the discrepancies and the missing documentation in the MAR for June 24, 2024, and July 1, 2024, at the times listed above for Resident 62.</p> <p>During a review of the facility's policy and procedure titled Medication Administration, dated January 1, 2012, indicated, .The Licensed Nurse will chart the drug, time administered and his/her name with each medication administration and signed full name and title on each page of the Medication Administration Record (MAR) . The policy also indicated .The time and dose of the drug or treatment administered to the patient will be recorded in the patient's individual medication record by the person who administers the drug or treatment . Recording the date, time and the dosage of the medication or type of treatment .</p> <p>During a review of the facility's policy and procedure titled Medication Storage In The Facility .Controlled Substance Storage, revised June 2016 indicated .A controlled substance accountability record is prepared by the pharmacy/facility .current controlled substance accountability records are kept in the MAR .</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000</p> <p>Based on interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities during monthly medication regimen review (MRR), four of five residents reviewed for unnecessary medications (Residents 9, 6, 40, and 52), when: and three residents (Resident 6, 40, 52) on anticoagulation (medications also referred to as blood thinners) did not have monitoring for signs of bleeding:</p> <ol style="list-style-type: none"> 1. Resident 9 was administered aripiprazole (an anti-psychotic medication for schizophrenia and bipolar depression) without adequate behavioral monitoring documented during use of aripiprazole; and 2. Residents 6, 40, and 52 were not monitored for signs and symptoms of adverse effects related to the use of anti-coagulants (blood thinners). <p>These failures had the potential for medications not being optimized for the best possible health outcome, and unnecessary or prolonged use of medications which could lead to medication adverse effects for the residents.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. During a review of Resident 9's facility medical record, the facility's Admission Record (a document in the resident's medical record that summarizes important details about the resident's admission), indicated Resident 9 was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions). <p>A review of Resident 9's facility medical record indicated Resident 9 had a physician's order, dated July 25, 2023, .Aripiprazole Oral Tablet 5mg (mg - milligram, a unit of measurement) .Give 1 tablet by mouth in the morning for Schizoaffective disorder M/B (manifested by) hallucinations .</p> <p>There was no documented evidence the target behavior of hallucinations related to the use of aripiprazole was being monitored.</p> <p>On July 17, 2024, at 1 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON acknowledged the facility was not monitoring for target behavior of visual hallucinations while Resident 9 was receiving aripiprazole since July 2023 (approximately one year) and should have been monitored.</p> <p>On July 17, 2024, at 5:32 p.m., during a follow-up interview with the DON, the DON confirmed Resident 9's records confirmed no additional information was found in the chart or records related to target behavior monitoring for visual hallucinations while taking aripiprazole.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On July 17, 2024, at 6:07 p.m., during an interview with the DON, the MMR reports for resident 40 were reviewed from July 1, 2023, to June 30, 2024, and no CP recommendations were indicated in the records. The DON was asked if the CP should have identified the need for monitoring the resident while taking aripiprazole, the DON stated it should have been identified.</p> <p>A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for aripiprazole tablets, dated February 2024, retrieved from DailyMed (a website operated by the U.S. National Library of Medicine to publish up-to-date and accurate drug labels to health care providers and the general public) was reviewed. The contents of DailyMed is provided and updated daily by the U.S. Food and Drug Administration. The aripiprazole tablet PI indicated, Most common adverse reactions . nausea, vomiting, constipation, headache, dizziness, akathisia (an inability to remain still), anxiety, insomnia, and restlessness .</p> <p>During a review of the facility's policy and procedure, titled Behavior/Psychoactive Drug Management, dated November 2018, the facility's policy and procedure did not mention behavioral monitoring.</p> <p>2a. A review of Resident 6's Admission Record indicated Resident 6 was admitted to the facility on [DATE], with diagnoses including diabetes (abnormal blood sugars), hypertension (high blood pressure), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>A review of Resident 6's facility medical record indicated Resident 6 had a physician's order, dated June 25, 2024, indicated, .Apixaban Oral Tablet 2.5 MG (mg - milligram, a unit of measurement) .Give 1 tablet by mouth two times per day for Atrial Fibrillation .</p> <p>On July 17, 2024, at 5:38 p.m., during a concurrent interview and record review with the DON, the DON acknowledged Resident 6 was not monitored for signs and symptoms of bleeding during apixaban use from June 25, 2024, to July 15, 2024. The DON further stated there was no CP recommendations on the monthly MRR for the monitoring for adverse effects while Resident 6 was taking apixaban.</p> <p>2b. A review of Resident 40's Admission Record indicated, Resident 40 was admitted to the facility on [DATE], with diagnoses including atrial fibrillation.</p> <p>A review of Resident 40's facility medical record indicated Resident 40 had a physician's order, dated April 12, 2024, which indicated, .Apixaban Oral Tablet 2.5 MG (mg - milligram, a unit of measurement) .Give 1 tablet by mouth two times per day for Atrial Fibrillation .</p> <p>On July 17, 2024, at 5:38 p.m., during a concurrent interview and record review with the DON, the DON stated the purpose of a care plan is to determine what care is needed and what monitoring is needed for the resident. The DON acknowledged potential adverse effects were not monitored during apixaban use. The DON verified that there was no monitoring for signs and symptoms of bleeding while Resident 40 was on apixaban and stated, adverse effects should have been monitored.</p> <p>On July 17, 2024, at 6:11 p.m., during an interview with the DON, the DON was asked if the CP should have identified the need for monitoring the resident while taking apixaban, the DON stated it should have been identified.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the PI for apixaban tablets, dated June 2021, retrieved from DailyMed, the apixaban tablet PI indicated, .Indications and usage .to reduce the risk of stroke .in patients with nonvalvular [not related to heart valve] atrial fibrillation [irregular heart rhythm], for the prophylaxis [prevention] of deep vein thrombosis (DVT) for the treatment of DVT and PE .Warnings and precautions .Apixaban tablets increases the risk of bleeding and can cause serious, potentially fatal, bleeding .</p> <p>2c. A review of Resident 52's Admission Record indicated, Resident 52 was admitted to the facility on [DATE], with diagnosis which included diabetes (abnormal blood sugar), hypertension (elevated blood pressure) and a history of falling.</p> <p>A review of Resident 52's facility medical record indicated Resident 52 had a physician's order, dated May 8, 2024, which indicated, .Lovenox (blood thinner) Injection Solution Prefilled Syringe 40 MG/0.4ml (ml - milliliter, a unit of measurement) .Inject 1 syringe subcutaneously (beneath the skin) at bedtime .</p> <p>On July 17, 2024, at 5:55 p.m., during a concurrent interview and record review with the DON, the DON stated the purpose of a care plan is to determine what care and monitoring is needed for the resident. The DON acknowledged potential adverse effects were not monitored during Lovenox use. The DON verified that there was no monitoring for signs and symptoms of bleeding while Resident 52 was on Lovenox and stated, adverse effects should have been monitored.</p> <p>On July 17, 2024, at 6:11 p.m., during an interview with the DON, the DON was asked if the consultant pharmacist should have identified the need for monitoring the resident while taking Lovenox, the DON stated it should have been identified.</p> <p>A review of PI for Lovenox injection, dated January 2022, retrieved from DailyMed, the Lovenox injection PI indicated, .Indications and usage .for the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE). PI also indicated Adverse Reactions .spinal/epidural (the space between the wall of the spinal canal and the covering of the spinal cord) hematomas (an abnormal collection of blood outside of a blood vessel) .Increased Risk of Hemorrhage (an acute loss of blood from a damaged blood vessel) and Thrombocytopenia (a deficiency of platelets in the blood) .</p> <p>A review of the CP's monthly MRRs for Residents 6 and 40 from April 1, 2024, to June 30, 2024, indicated there were no recommendations from the CP related to the need for monitoring adverse effects for Residents 6 and 40 during apixaban use.</p> <p>A review of the CP's monthly MRRs for Resident 52 from May 1, 2024, to June 30, 2024, indicated there were no recommendations from the CP related to the need for monitoring adverse effects for Resident 52 during Lovenox use.</p> <p>On July 17, 2024, at 6:54 p.m., during an interview and concurrent record review with the facility Administrator (ADM), the ADM stated the facility did not have a policy and procedure for anticoagulant medications and verified the facility's policy and procedure titled Medication Monitoring and Management, dated October 2012 did not mention medications apixaban or Lovenox.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedures, titled Consultant Pharmacist Reports, dated October 2012, indicated, The consultant pharmacist performs a comprehensive review of each resident's medication regimen (MRR) at least monthly .The consultant pharmacist identifies irregularities .The consultant pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the following .Resident is monitored for adverse consequences .Side effects, adverse reactions, interactions .are evaluated and modifications or alternatives are considered . The policy and procedure also indicated .Resident-specific irregularities and/or clinically significant risk resulting from or associated with medications are documented in the residents [active record] .</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000</p> <p>Based on interview and record review, the facility failed to ensure three of four sampled residents (Residents 6, 40 and 52) were free from unnecessary medications when:</p> <ol style="list-style-type: none"> 1. Resident 6 received apixaban (brand name Eliquis, an anti-coagulant, or blood thinning medication) without monitoring for signs and symptoms of adverse effects related to the use of apixaban; 2. Resident 40 received apixaban without monitoring for signs and symptoms of adverse effects related to the use of apixaban; and 3. Resident 52 received enoxaparin (brand name Lovenox, an anti-coagulant, or blood thinning medication) without monitoring for signs and symptoms of adverse effects related to the use of enoxaparin. <p>These failures had the potential to result in unnecessary use of medications for Residents 6, 40 and 52 and had the potential for side effects of this medication (such as bleeding, excessive bruising, etc.) to go undetected or recognized for timely intervention.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. During a review of Resident 6's Admission Record, it indicated Resident 6 was admitted to the facility on [DATE], with diagnoses including atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). <p>During a review of Resident 6's facility medical record it indicated Resident 6 had a physician's order, dated June 25, 2024, which indicated, .Apixaban Oral Tablet 2.5 mg (mg - milligram, a unit of measurement) .Give 1 tablet by mouth two times per day for Atrial Fibrillation .</p> <p>On July 17, 2024, at 5:38 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON acknowledged Resident 6 was not monitored for signs and symptoms of bleeding during apixaban use from June 25, 2024, to July 15, 2024. The DON stated Resident 6 should have been monitored for bleeding while being on apixaban.</p> <p>A review of the PI (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for apixaban tablets, dated June 2021, retrieved from DailyMed (a website operated by the U.S. National Library of Medicine to publish up-to-date and accurate drug labels to health care providers and the general public), the apixaban tablet PI indicated, Warnings and precautions .Apixaban tablets increases the risk of bleeding and can cause serious, potentially fatal, bleeding .</p> <ol style="list-style-type: none"> 2. A review of Resident 40's Admission Record indicated, Resident 40 was admitted to the facility on [DATE], with diagnoses including atrial fibrillation. <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 40's facility medical record indicated Resident 40 had a physician's order, dated April 12, 2024, at 6:17 p.m., for apixaban. The order indicated, .Apixaban Oral Tablet 2.5 mg .Give 1 tablet by mouth two times per day for Atrial Fibrillation .</p> <p>On July 17, 2024, at 5:55 p.m., during a concurrent interview and record review with the DON, the DON confirmed there was no monitoring for signs and symptoms of bleeding while Resident 40 was on apixaban from April 13, 2024, to July 17, 2024 and stated, adverse effects should have been monitored.</p> <p>3. A review of Resident 52's Admission Record indicated, Resident 52 was admitted to the facility on [DATE], with diagnosis which included diabetes (abnormal blood sugar), hypertension (elevated blood sugar), and a history of falling.</p> <p>A review of Resident 52's facility medical record indicated Resident 52 had a physician's order, dated April 30, 2024, which indicated, .Lovenox Injection Solution Prefilled Syringe 40 mg/0.4 milliliter (ml, a unit of measurement) .Inject 1 syringe subcutaneously (beneath the skin) at bedtime .</p> <p>On July 17, 2024, at 5:46 p.m., during a concurrent interview and record review with the DON, the DON verified there was no monitoring for signs and symptoms of bleeding while Resident 52 was on Lovenox and stated, adverse effects should have been monitored.</p> <p>A review of PI for Lovenox injection, dated January 2022, retrieved from DailyMed. the Lovenox injection PI indicated, Adverse Reactions . hematomas (an abnormal collection of blood outside of a blood vessel) . Increased Risk of Hemorrhage (an acute loss of blood from a damaged blood vessel) and Thrombocytopenia (a deficiency of platelets in the blood) .</p> <p>On July 17, 2024, at 6:54 p.m., during an interview and concurrent record review with the facility Administrator (ADM), the ADM stated the facility did not have a policy and procedure for anticoagulant medications and verified the facility's policy and procedure titled Medication Monitoring and Management, dated October 2012, did not mention apixaban or Lovenox.</p> <p>During a review the facility's policy and procedure titled Medication Monitoring and Management, dated October 2012, indicated .Facility staff monitor the resident for possible medication-related adverse consequences .</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000</p> <p>Based on interview and record review, the facility failed to ensure was free from unnecessary psychotropic (drugs that affects brain activities associated with mental processes and behavior) medications, for one of five residents reviewed for unnecessary medications (Resident 9), when Resident 9 was administered aripiprazole (brand name Abilify, an anti-psychotic medication for schizophrenia and bipolar disorder) without adequate behavioral monitoring documented during use of aripiprazole.</p> <p>This failure had the potential to result in unnecessary use of medications for Resident 9, which increased the potential for medication interactions, adverse reactions, and unidentified risks associated with the use of psychotropic medications that included but not limited to sedation, respiratory depression, constipation, anxiety, agitation, and memory loss.</p> <p>Findings:</p> <p>During a review of Resident 9's Admission Record indicated, Resident 9 was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE], with diagnoses that included schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions).</p> <p>A review of Resident 9's MDS (Minimum Data Set - an assessment tool) dated July 11, 2024, indicated Resident 9 had a BIMS (brief interview for mental status) score of 5, which indicates Resident 9 had severe cognitive impairment.</p> <p>A review of Resident 9's facility medical record indicated Resident 9 had a physician's order, dated July 19, 2023, which indicated, .Aripiprazole Oral Tablet 5 milligram (mg, a unit of measurement) .Give 1 tablet by mouth in the morning for Schizoaffective disorder M/B (manifested by) hallucinations .</p> <p>On July 17, 2024, at 1 p.m., during a concurrent interview and record review with the Director of Nursing (DON), Resident 9's medical records were reviewed including the physician's order list above and the Medication Administration Records (MARs) dated July 2023 through July 2024. The DON acknowledged the facility was not monitoring for target behavior of visual hallucinations while Resident 9 was receiving aripiprazole since July 19, 2023, to July 16, 2024, and stated it should have been monitored.</p> <p>On July 17, 2024, at 5:32 p.m., during a follow-up interview with the DON, the DON confirmed, no additional information was found in Resident 9's medical records related to target behavior monitoring for visual hallucinations while taking aripiprazole from July 19, 2023, to July 16, 2024 (approximately one year).</p> <p>A review of the facility's policy and procedure titled, Behavior/Psychoactive Drug Management, dated November 2018, was reviewed. The facility's policy and procedure did not mention behavioral monitoring.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988</p> <p>Based on observation, interview, and record review, the facility failed to follow the menu during tray line (food preparation and assembly at the steam table) observation on July 17, 2024, for three of 68 residents who consumed food in the facility (Residents 9, 45 and 35).</p> <p>This failure had the potential to negatively impact the residents' nutritional status and further compromise the residents' medical status.</p> <p>Findings:</p> <p>On July 17, 2024, at 9:15 a.m., the facility's Summer Menu for Week 3, Wednesday, was reviewed. The document indicated the lunch menu for the day included:</p> <ul style="list-style-type: none"> - Taco Casserole - Seasoned Fresh Zucchini - Fiesta Salad; and - Tangy Glazed Fresh Fruit. <p>On July 17, 2024, beginning at 11:35 a.m., a tray line observation was conducted. The following were observed:</p> <p>a. Resident 9's tray was assembled first due to a dialysis (removal of waste products and excess body fluids from the body via the blood due to kidney failure) appointment after lunch. Resident 9's diet, as written on the Order Listing Report (Physician's Order), indicated a Renal Diet (a special diet for patients with kidney disease) -80 gram (gm- unit of measurement) protein diet .</p> <p>The [NAME] placed one soft taco on the plate, scooped one oz. (ounce- unit of measurement) of ground meat onto the taco, folded the taco, poured one cup of regular zucchini in a small bowl and placed it on the plate, covered the plate, and placed the covered plate on Resident 9's meal tray.</p> <p>The menu spreadsheet (which contained the portion sizes for the food items) was reviewed with the Dietary Supervisor (DS). The DS stated for Resident 9, there should be two tacos with one and a half oz. ground meat in each taco, so there should be two tacos on the plate. The DS proceeded to obtain a red scoop and stated the [NAME] should have used this red scoop, which was equivalent to the one and a half oz portion of ground meat, instead of the yellow ladle which measured only one oz., to measure the ground meat for each taco.</p> <p>On July 18, 2024, beginning at 6:09 p.m., Resident 9's record was reviewed. Resident 9 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease, dependence on dialysis, diabetes mellitus (abnormal blood sugar), protein-calorie malnutrition, and dementia (a brain disease characterized by progressive memory loss).</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 9's Care Plans included a care plan with a .Focus .potential nutritional problem ., initiated July 17, 2023, which included the intervention, .Provide, serve diet as ordered .80 g (gram- a unit of measurement) Pro (protein) .</p> <p>b. Resident 45's diet, as written on the Order Listing Report, indicated renal diet, large portion. The menu spreadsheet was reviewed with the DS, who stated they followed the 60 gm protein Renal diet (two soft tacos which required one oz ground meat for each soft taco) for Resident 45.</p> <p>The [NAME] assembled two soft tacos with one oz. ground meat for each taco, scooped one cup of regular zucchini in a small bowl, placed it on the plate, covered the plate, and placed the plate on Resident 45's meal tray.</p> <p>The menu spreadsheet was reviewed with the DS, and when asked what the portion size was for a large portion for renal diet, the DS stated she would ask the Registered Dietitian (RD) who was currently in the kitchen, since the spreadsheet did not provide the information for a large portion renal diet. After consulting with the RD, the KS stated she was advised to serve the 2 tacos and ask Resident 45 later if he wanted more (Resident 45 was served only a regular portion for lunch).</p> <p>On July 17, 2024, beginning at 5:30 p.m., Resident 45's record was reviewed. Resident 45 was admitted to the facility on [DATE], with diagnoses which included end-stage renal disease, dependence on dialysis, diabetes mellitus, and protein-calorie malnutrition.</p> <p>The Minimum Data Set (MDS- an assessment tool), dated June 25, 2024, indicated Resident 45 had a weight loss of five % (percent- a unit of measurement) in the past month or loss of 10 % in the last six months.</p> <p>Resident 45's Care Plans included a care plan with a .Focus .risk for malnutrition ., initiated December 29, 2023, which included the intervention, .Provide and serve diet as ordered .</p> <p>c. Resident 35's diet, as written on the Order Listing report, indicated a regular large portion diet, pureed texture (very smooth, crushed or blended food resembling applesauce or mashed potatoes)</p> <p>The [NAME] portioned one #6 scoop (number 6- green scoop equivalent to a two-third cup portion) pureed tuna casserole onto a plate, then portioned a level #12 scoop (green scoop equivalent to one-third cup) of pureed zucchini onto the plate, covered the plate, and placed the plate on Resident 35's meal tray.</p> <p>The menu spreadsheet was reviewed with the DS, who stated the large portion of pureed taco casserole required a one cup portion size. The DS proceed to take a grey scoop and stated the [NAME] should have used this scoop, since it was equivalent to a one cup portion size, to measure the pureed tuna casserole.</p> <p>On July 18, 2024, beginning at 6:09 p.m., Resident 35's record was reviewed. Resident 35 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's dementia (a type of dementia), and dysphagia (difficulty swallowing).</p> <p>The MDS, dated [DATE], indicated Resident 35 had severe cognitive impairment, and had weight loss of five % or more in the last month or 10% or more in the last 6 months.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 35's Care Plans included a care plan with a .Focus .risk for malnutrition/significant weight change ., initiated January 14, 2022, which included the intervention, .Provide and serve diet as ordered .</p> <p>On July 18, 2024, at 10:45 a.m., the RD was interviewed. The RD stated serving less than the required portions will lead to weight loss and it starts off at tray line sometimes, errors have to be caught to avoid low calories going out from the kitchen to the residents. The RD stated she expected the kitchen staff to follow the menu, and that the menu should have been followed.</p> <p>A review of the facility policy and procedure titled, Menus, dated April 14, 2014, indicated, .Purpose .To ensure that the Facility provides meals to residents that meet the requirements of the Food and nutrition Board of the National Research Council of the National Academy of Sciences .Food served should adhere to the written menu .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988</p> <p>Based on observation, interview, and record review, the facility failed to ensure Infection Prevention and Control practices were properly implemented when:</p> <ol style="list-style-type: none"> The direct care staff were not aware which patients were on Enhanced Barrier Precautions (EBP- a type of infection prevention measure requiring the use of gowns and gloves during high contact resident care); Certified Nursing Assistant (CNA) 1 observed EBP while feeding Resident 40. Resident 40 was not on the list for EBP; Cohorting (placing residents in the same room) guidelines for EBP were not observed for Residents 6 and 117. <p>These failures had the potential to spread infection throughout the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> On July 16, 2024, at 10:22 a.m., signs for EBP were observed posted on the door of room [ROOM NUMBER], where Residents 117 and 6 were roomed. <p>On July 16, 2024, at 10:32 a.m., Certified Nursing Assistant (CNA) 1 was interviewed and stated the EBP was for Resident 117 when she had her IV (intravenous- access through the vein for delivering fluids or medication) the prior week.</p> <p>On July 16, 2024, at 11:10 a.m., CNA 2 was interviewed and stated the EBP was for Resident 117, due to the resident having an IV central line catheter (a longer intravenous tube that goes all the way up to a vein near the heart or just inside the heart) and was on IV antibiotics (medication to treat an infection) on admission, but has since been discontinued.</p> <p>On July 16, 2024, at 11:32 a.m., Licensed Vocational Nurse (LVN) 3 was interviewed and stated the EBP was for both residents in room [ROOM NUMBER], as listed on the huddle sheet that was at the nurses' station, for which she also had a copy. The document was concurrently reviewed with LVN 3, LVN 3 stated Resident 117 was on EBP for ESBL (extended spectrum beta lactamase- enzymes produced by some bacteria that make them resistant to some antibiotics) in the urine, as well as for the presence of a dialysis catheter.</p> <p>LVN 3 stated Resident 6 was on EBP due to C. diff (Clostridium Difficile - highly contagious spore forming bacteria causing diarrhea and/or inflammation of the large intestines), and was on vancomycin (a type of antibiotic used against resistant strains of bacteria).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The direct care staff responses regarding the reason for the observance of EBP for room [ROOM NUMBER] were discussed with LVN 1. LVN 1 stated she was not sure why they did not know the right reasons for EBP for room [ROOM NUMBER]. When asked if it was important for the direct care staff to know the exact reason for the EBP for both residents, LVN 1 stated it was important for them to know the reasons for EBP for both residents, so that they can observe proper precautions for each resident. LVN 1 further stated it was more concerning for her that EBP should be observed more strictly for Resident 117 due to C. Diff.</p> <p>On July 16, 2024, at 3:20 p.m., Resident 6's record was reviewed. Resident 6 was admitted to the facility on [DATE], with diagnoses including enterocolitis (inflammation of the small and large intestines) due to C. diff, and kidney disease.</p> <p>A review of Resident 6's care plan titled, .The resident has C. Difficile ., initiated on June 25, 2024, included an intervention for EBP.</p> <p>On July 16, 2204, Resident 117's record was reviewed. Resident 117 was admitted to the facility on [DATE], with diagnoses which included urinary tract infection, end stage renal disease (ESRD), dependence on dialysis and diabetes mellitus (abnormal blood sugar).</p> <p>A review of Resident 117's care plan titled, .The resident needs Hemo dialysis r/t (related to) renal failure. Resident has Dialysis Catheter at Right Subclavian (right upper chest) and AV Fistula (abnormal connection between artery and vein, surgically created for dialysis patients for use during dialysis treatments) to left wrist (Non-use) ., initiated July 9, 2024, included an intervention for EBP.</p> <p>On July 16, 2024, at 3:37 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON) and Infection Preventionist (IP). The above observation and interviews were discussed and the IP stated it was unfortunate that the staff did not know the reasons for EBP for Residents 6 and 117, since the EBP was in place weeks before Resident 117 was admitted to room [ROOM NUMBER]. The IP stated they should have known, in order for proper precautions to be observed for both residents.</p> <p>2. On July 15, 2024, at 12:16 p.m.; CNA 1 was observed wearing gloves, gown, and mask, while feeding Resident 40.</p> <p>On July 15, 2020, at 12:20 p.m., during an interview with the Infection Preventionist (IP), she stated Residents 30 and 25 were to be placed on EBP. The IP stated Resident 40 did not require EBP, and CNA 1 should not need to wear PPE while providing direct care.</p> <p>3. On July 16, 2024, at 3:37 p.m., a concurrent interview and record review was conducted with the DON and the IP. The IP stated Resident 6 was admitted to the facility on [DATE], due to C. Diff but was colonized (infectious organism exists in the body but does not make you sick), had no active diarrhea, was already on oral vancomycin, and was placed on EBP. The IP stated Resident 117 was admitted on [DATE], with diagnosis of ESRD, requiring hemodialysis (removal of toxins and excess fluids from the blood due to inability of the kidney to do its function).</p> <p>When asked why Resident 117 was placed in the same room as Resident 6 who had a diagnosis of C. Diff, although colonized, the DON and IP were not able to provide an answer.</p> <p>(continued on next page)</p>		

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 07/18/2024
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.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On July 16, 2024, at 6:30 p.m., a concurrent follow up interview was conducted with the DON and the IP in the presence of the Administrator (ADM).</p> <p>The IP stated Resident 117 was considered a high risk patient due to ESRD requiring hemodialysis, and the presence of a dialysis catheter. A high risk patient may be prone to acquiring other infections. The IP stated Resident 117 was admitted in the afternoon, she did not know Resident 117 had a dialysis catheter, and the facility had a full census at that time. The IP stated she should have looked at the documentation from the hospital, and should have placed Resident 117 in a different room.</p> <p>The facility's policy and procedure titled, .Enhanced Barrier Precautions, revised June 7, 2024, was reviewed. The policy indicated, .Purpose .to reduce the risk of transmission of epidemiologically (pertaining to the study of diseases) important microorganisms by direct or indirect contact .Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities (i.e., nursing homes), contributing to substantial resident morbidity and mortality and increased healthcare costs .Many residents at nursing homes are at increased risk of becoming colonized and developing infections with MDROs .Perform risk assessment to determine need for Enhanced Barrier vs. Transmission based Precautions with a targeted MDRO resident .When cohorting residents with the same MDRO is not possible, place MDRO residents in rooms with other residents who are at low risk for acquisitions of MDROs and associated adverse outcomes from infection .Implementing strategies to help minimize transmission between roommates including . Choosing roommate candidates who are at low risk of acquisition .</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000</p> <p>Based on interview and record review, the facility failed to ensure the antibiotics were prescribed and administered to the residents under the guidance of their antibiotic stewardship program, for one of three residents reviewed for closed record (Resident 22), when:</p> <ul style="list-style-type: none"> - Resident 22's condition did not meet the McGeer's criteria (a set of specific definitions to identify true infections in long term nursing facilities) for the use of antibiotic for UTI (Urinary Tract Infection); and - The physician's order to discontinue Macrobid (a medication to treat UTI) was not carried out as ordered. <p>These failures had the potential for antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria.</p> <p>Findings:</p> <p>On July 17, 2024, Resident 22's record was reviewed. Resident 22 was admitted to the facility on [DATE], with diagnoses which included aftercare for right femur (hip) fracture (broken bone) and malnutrition.</p> <p>A review of Resident 22's Progress Notes, indicated the following:</p> <ul style="list-style-type: none"> - May 10,2024, at 3:34 p.m., indicated, .reported to (name of physician) pt (patient) VS (vital signs) 132/70 (blood pressure) 99.8 (temperature) .102HR (heart rate) 40resp (respiratory rate) a minute .refusing to open her eyes and moans to painful stimuli .waiting for advice .; - May 10, 2024, at 4:38 p.m., indicated, .pt is ALOC (altered level of consciousness), hard to arouse. Does not respond verbally back to verbal stimuli, moans, responds to verbal stimuli by moaning .; - May 10, 2024, at 5:01 p.m., indicated, .CHEM PANEL (chemistry panel - laboratory test), CBC (complete blood count - laboratory test) AND CHEST X-RAY ORDERED . <p>A review of Resident 22's physician's notes, dated May 10, 2024, indicated, .Labs (laboratory) 5-8 (May 8, 2024) .u/a (urinalysis) with many wbcs (white blood cell count) .recheck cbc, cmp (complete metabolic panel - laboratory test to check electrolytes), u/a, u/c (urine culture). Will start on macrobid (medication to treat urinary tract infection) 100 bid (twice a day) .</p> <p>A review of Resident 22's Order Summary Report, included a physician's order which indicated, .Macrobid Oral Capsule 100 MG (milligram - unit of measurement) .Give 1 (one) capsule by mouth tow times a day for Possible UTI until 05/17/2024 (May 17, 2024) .</p> <p>(continued on next page)</p>		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>A review of Resident 22's urinalysis and urine culture results, dated May 13, 2024, indicated > (more than) 100,000 Escherlichia coli (a bacteria that is commonly found in the lower intestine of warm-blooded organisms).</p> <p>A review of Resident 22's Progress Notes, dated May 13, 2024, at 12:51 p.m., indicated, .pt is had to arouse, does not open eyes .Patient is not opening her mouth at meals, sleeping, moans at times . Recommendations: MD (physician) will come to facility to assess patient .</p> <p>A review of Resident 22's physician notes, dated May 13, 2024, indicated, .Pt seen groaning. Not communicating. Pt was confused on admission, continues to be confused. Started on abx (antibiotic) for possible uti (urinary tract infection) .xrays showed some patchy infiltrates .Will d/c (discontinue) macrobid and place on avelox (medication to treat lung infection) 400 daily x (times) 7 (seven) days .</p> <p>A review of Resident 22's Medication Administration Record (MAR), for May 2024, indicated Macrobid was administered on May 11, 2024, until May 17, 2024, with episodes of Resident 22's refusal.</p> <p>A review of facility document titled,Surveillance Data Collection Form, Attachment C, dated May 20, 2024, indicated, Resident 22's use of Macrobid did not meet the criteria for UTI as Resident 22 did not have symptoms of UTI.</p> <p>On July 17, 2024, at 4:49 p.m., a concurrent interview and record review was conducted with the Infection Preventionist (IP). The IP stated she would check the dashboard to check which resident was ordered for antibiotic. The IP stated she would assess the resident if she meets the McGeer's criteria for a specific infection. She stated if the criteria of an infection was not met, she would notify the physician. The IP stated the facility implements a 3-day antibiotic time out where the resident is being monitored for side effects while the resident continues to get the antibiotic. The IP stated Resident 22's condition did not meet the criteria for UTI and the physician should have been notified when the resident did not meet the criteria for UTI and should have the Macrobid use be reevaluated. The IP stated the physician notes dated May 13, 2024, indicated a physician's recommendation to discontinue Macrobid and change to Avelox. The IP stated the physician's order was not carried out as ordered and Macrobid was administered to Resident 22 from May 11 to 17, 2024, even though Resident 22 did not meet the criteria for UTI.</p> <p>A review of the facility's policy and procedure titled, Antibiotic Stewardship, dated May 20, 2021, indicated, . To optimize use of antibiotics by improving prescribing practices and reduce inappropriate antibiotic use . The Facility will implement an Antibiotic Stewardship Program (ASP) to promote appropriate use of antibiotics optimizing the treatment of infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and improve outcomes for Residents .The Facility has chosen to use Revisited McGeer's Criteria (2012) for surveillance .Antibiotic time-outs (ATO) will be utilized when appropriate .An antibiotic time-out (ATO) is a review process for all antibiotics prescribed in the Facility. ATOs prompt clinicians to reassess the ongoing need for an antibiotic after culture results are available .The IP is responsible for tracking the following antibiotic stewardship processes .Whether or not the Resident's condition met McGeer's Criteria when the antibiotic was ordered .</p>		