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	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Springs Healthcare & Wellness Centre	82262 Valencia Avenue Indio, CA 92201

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure refrigerated medications and biologicals were stored at temperatures in accordance with facility policy and manufacturer's specifications, when one of two medication refrigerators was identified with documented temperature readings below the normal range on multiple days in September 2025. This failure had the potential for residents to receive ineffective medications which could result in the residents not receiving the full benefit of the medications, leading to further health complications.Findings:On September 15, 2025, at 11:28 a.m., during a concurrent observation and interview at nursing station 1 with Registered Nurse (RN), a medication refrigerator was inspected. The refrigerator temperature was observed on the thermometer to be 28 degrees Fahrenheit (F, a temperature measurement) and contained the following medications:- Afluria (influenza vaccine) injectable suspension;- Tuberculin PPD (test agent used in the diagnosis of tuberculosis [a respiratory disease]) vial; and- various types of insulin (injectable medication used to treat diabetes [abnormal blood sugar]) including insulin lispro, human insulin, and insulin glargine.On September 15, 2025, at 11:28 a.m., during a concurrent observation of the medication refrigerator and interview with the RN, she confirmed that 28 degrees F is within freezing range and that medications should be stored between 36 to 46 degrees F, according to the facility's policy and procedure. The RN noted the Afluria carton label stated, Do not freeze, and explained that medications stored at freezing temperatures are no longer viable and must be replaced.On September 15, 2025, at 11:45 a.m., during an interview and record review of the medication refrigerator temperature log for September 2025, the RN stated that evening (3 p.m. to 11 p.m.) and overnight (11 p.m. to 7 a.m.) nursing staff were expected to document the refrigerator temperature. The RN acknowledged the temperatures were documented as below 36 F (out of range) during the PM shift on the following dates: - September 1, 2025: 35 degrees F; - September 7, 2025: 31 degrees F; - September 8, 2025: 32 degrees F; - September 9, 2025: 32 degrees F; - September 10, 2025: 34 degrees F; and - On September 12, 2025: 34 degrees F.In a concurrent interview with the RN, the RN stated the nursing staff needed to adjust the thermostat inside the refrigerator and should report to maintenance if temperature had not returned to normal range when the medication refrigerator was out of range.On September 15, 2025, at 11:48 a.m., during a concurrent interview and record review, the RN reviewed the facility's maintenance log and stated there was no documented evidence the maintenance staff was contacted and no documented corrective actions were taken when the nursing station 1's medication refrigerator was below 36 degrees F (out of range) on the above dates.On September 15, 2025, at 11:49 a.m., during a concurrent observation of the nursing station 1 medication refrigerator and interview with the RN, the medication refrigerator temperature was observed on the thermometer to be 28 degrees F for the second time and the RN confirmed the temperature was still in the freezing range.On September 16, 2025, at 12:05 p.m., during a concurrent interview and record review of the medication refrigerator temperature logs and maintenance logs, for September 1 to 12, 2025, with the Director of Nursing (DON). The DON stated nursing staff were expected to check the medication (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refrigerator temperature twice a day during the PM shift and NOC shift. The DON stated the expected temperature range for the medication refrigerator should be between 36 to 46 degrees F and confirmed freezing temperature was 32 degrees F or less. The DON stated the expectation was for nursing staff to have adjusted the setting in the refrigerator, rechecked temperature after 15 minutes, and if the temperature was not corrected then nursing staff should have notified maintenance, if the medication refrigerator temperature was out of range. A review of the facility's policy and procedure titled, Medication Storage in the Facility, revised date February 2020, indicated, .Medications requiring refrigeration are kept in the refrigerator at temperatures between 2 degree C (36 degree F) and 8 degree C (46 degree F) with a thermometer to allow temperature monitoring . A review of the PI for Tuberculin PPD, dated October 2021, retrieved from DailyMed (a public website maintained by the U.S. Food and Drug Administration), indicated, Store at 2 to 8 degree C (35 to 46 degree F). Do not freeze. Discard product if exposed to freezing.A review of the PI for insulin lispro injection solution, dated September 2023, retrieved from DailyMed, indicated, Storage and Handling .Do not freeze and do not use if it has been frozen .Not In-Use (Unopened) Refrigerated (36 degree F to 46 degree F [2 to 8 degree C]).A review of the PI for human insulin injection solution, dated November 2022, retrieved from DailyMed, indicated, Storage and Handling .Do not freeze .Do not use if it has been frozen .Not In-Use (Unopened) Refrigerated (36 degree F to 46 degree F [2 to 8 degree C]).A review of the PI for insulin glargine injection solution, dated June 2023, retrieved from DailyMed, indicated, Store unused Insulin Glargine in a refrigerator between 36 degree F and 46 degree F (2 degree C and 8 degree C]. Do not freeze. Discard Insulin Glargine if it has been frozen.A review of an article titled Storage of Insulin, by the Institute for Safe Medication Practices (ISMP, a nationally recognized medication safety organization) dated 2025, indicated, Safety Tips for Storing Insulin.Do not keep insulin in places that freeze. Never store insulin products in a freezer. If insulin is frozen, do not use even after thawing. Freezing temperatures will breakdown the insulin and then it will not work well to lower your blood sugar.A review of the Prescribing Information (PI, manufacturer's instructions) for Afluria (flu vaccine) injectable suspension, dated March 2025, provided by the facility indicated, Store refrigerated at 2-8 degree Celsius [C, a temperature measurement] (36-46 degree F). Do not freeze. Discard if product has been frozen .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure clean linens (pillows) were handled and stored in a manner that prevented the spread of infection, when clean pillows were observed improperly stored in an area designated for soiled materials.This deficiency had the potential to cause harm by placing residents at risk for contamination from microorganisms.FindingsOn September 18, 2025, at 12:25 p.m., during a tour of the laundry area, multiple clean pillows wrapped in a clear plastic bag, were found stacked in the soiled area of the laundry. The plastic bag of clean pillows were observed tied in one knot but with open areas to escape in and out of the bag.On September 18, 2025, at 12:27 p.m., an interview was conducted with the Laundry Director (LD). The LD stated they did not have room to store the clean pillows. The LD acknowledged that keeping pillows in the soiled area of the laundry room could pose an infection control issue. On September 18, 2025, at 12:29 p.m. an interview was conducted with the Plant Manager (PM). The PM stated the pillows were not fully covered and could cause contamination. A review of the facilities policy and procedure titled, Laundry - Supply & Storage, dated January 1, 2012, indicated, .separate room for the storage of clean linen and soiled linen.separate linen carts labeled.Soiled or Clean Linen, constructed o f washable materials which shall be laundered or suitable cleaned as needed to maintain sanitation .A record review of the facilities policy and procedure titled, Soiled Laundry & Bedding, dated September 2016, indicated, .facility staff handle soiled laundry and bedding in a manner that prevents gross microbial contamination of the air and those handling the linen.washable pillows are laundered in hot water when soiled before exchange between residents.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record, the facility failed to ensure, for one out of one resident reviewed in the care planning process (Resident 7), was involved in the care planning process when Resident 7 was not notified of the gradual dose reduction (GDR - stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose of if the dose or medication can be discontinued) for the medication Depakote (medication used to treat bipolar disorder [mental health condition that causes extreme mood swings]).This failure resulted in Resident 7 feeling suppressed when changes were made to her plan of care without her knowledge, involvement, or consent. As a result, this violated Resident 7's right to be involved in her care and provide informed consent. Findings:On September 16, 2025, at 11:25 a.m., Resident 7 was interviewed. Resident 7 that her Depakote dosage was reduced from twice a day to once a day two weeks ago. Resident 7 stated she feels different and more suppressed since then. Resident 7 stated she did not know why no one asked her about how she was coping with the change.On September 18, 2025, Resident 7's medical record was reviewed. Resident 7 was admitted to the facility on [DATE], with diagnoses including bipolar disorder and major depressive disorder (mental illness).A review of Resident 7's Minimum Data Set (MDS - a clinical assessment tool), dated July 14, 2025, indicated Resident 7 had a BIMS (Brief Interview for Mental Status) score of 13 (cognitively intact).A review of Resident 7's IDT (interdisciplinary team - a group of healthcare professionals) PROGRESS NOTES - BEHAVIOR MANAGEMENT, dated August 30, 2025, indicated Resident 7 was recommended for GDR of Depakote to give .Divalproex Sodium Tablet Delayed Release 250 MG (milligram - unit of measurement) Give 1 tablet by mouth in the morning for Bipolar .Resident 7's Medical Orders were also reviewed. Resident 7's previous order of Depakote was discontinued on August 30, 2025, and indicated .Divalproex Sodium Tablet Delayed Release 250 MG Give 1 tablet by mouth two times a day for Bipolar .On September 18, 2025, at 2 p.m., Resident 7 was interviewed. Resident 7 stated her plan of care was not clear and that she was not involved in meetings regarding dose reduction or changes in the Depakote. Resident 7 stated she was not aware of the change in Depakote and that the staff could not explain why her second daily dose Depakote was discontinued. Resident 7 stated that she has been asking when her psychiatrist would come see her.On September 18, 2025, at 3:07 p.m., the Director of Nursing (DON) was interviewed. The DON stated that the GDR of Depakote for Resident 7 was recommended by the IDT as they were trying to wean her off the medication. The DON stated that she did not mention the change in Depakote to Resident 7. The DON stated the IDT would discuss a plan for GDR of certain medications and they would implement the plan and interventions if the resident agreed. The DON stated that Resident 7 should have been involved in her plan of care and notified of the change. The DON stated. The DON stated that she was not aware that Resident 7 had been asking about the psychiatrist. The DON acknowledged that Resident 7 should have been involved in her care plan, and her rights were violated due to not being notified of the changes made.A review of facility's policy and procedure titled, Comprehensive Person-Centered Care Planning, revised November 2018, indicated, .Each resident and/or resident representative will actively remain engaged in his or her care planning process through the resident's rights to participate in the development of, and be informed in advance of changes in the plan of care .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a copy of the Advance Directive (AD - written instruction for the provision of care and services when unable to make decisions for oneself) was readily available in the chart, for one of 13 residents reviewed for Advance Directives (Resident 4). This failure had the potential for Resident 4's wishes for health care services not to be honored.Findings: On September 17, 2025, Resident 4's record was reviewed. Resident 4 was admitted to the facility on [DATE], with diagnoses which included rhabdomyolysis (a serious medical condition that occurs when muscle tissue breaks down, releasing harmful substances into the bloodstream).A review of Resident 4's Minimum Data Set (MDS- a clinical assessment tool), dated July 2, 2025, indicated Resident 4 had a Brief Interview for Mental Status score of 11 (mild cognitive impairment).A review of Resident 4's Social Services Assessment, dated June 26, 2025, indicated Resident 4 had an AD but was not on file, and a copy was requested from the resident/resident representative.Further review of Resident 4's record indicated there was no copy of Resident 4's AD in the electronic or paper record.On September 18, 2025, at 4:16 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON stated that Resident 4's record did not have a copy of the AD, which the Social Service Director (SSD) had not yet obtained. The DON confirmed that a copy should be in Resident 4's record and the SSD's AD binder.A review of the facility's policy and procedure titled, Advance Directive, dated July 25, 2024, indicated, .An Advance Directive is defined as a resident's written preference regarding treatment options.During the Social Services Assessment process, the Director of Social Services or Designee will also ask the resident if they have a written advance directive.If the resident has an Advance Directive, the Facility shall request a copy of the document from the family or resident's representative.If a copy is provided by the resident or resident representative, it will be placed in the medical record.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, for two of five residents (Resident 5 and 10) were free from unnecessary psychotropic (drugs that affects brain activities associated with mental processes and behavior) medications when:1. Resident 10 was administered Aripiprazole (medication to treat mental illness) without potential adverse effect monitoring documented during use of risperidone; and2. Resident 5 was given quetiapine (medication to treat mental illness) without following the manufacturer's monitoring guidelines.These failures could have led to unnecessary medications for Residents 5 and 10, increasing the risk of medication interactions, adverse reactions, and side effects such as dyslipidemia (an abnormal balance of lipids or fats in the bloodstream), sedation, respiratory depression, constipation, anxiety, agitation, and memory loss.Findings:1. On September 17, 2025, Resident 10's record was reviewed. A review of Resident 10's admission Record, indicated the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including schizoaffective disorder (mental health condition characterized by psychotic symptoms like hallucinations/delusions and mood episodes like mania or depression).A review of Resident 10's medical record indicated the resident had been receiving Aripiprazole in various doses since July 2023. Resident 10's current Order Summary Report, included a physician's order, date ordered September 11, 2025, which indicated, Aripiprazole 2 mg (milligram, unit of measurement), give one tablet by mouth in the morning for Schizophrenia (mental illness) m/b (manifested by) visual hallucination AEB (as evidenced by) seeing people not there.A review of Resident 10's Care Plan Report, dated June 15, 2025, indicated, At risk for adverse side effects of psychotropic medications Aripiprazole r/t (related to dx (diagnosis) of Schizophrenia with interventions that included, Administer Psychotropic medication as ordered by physician. Monitor for side effects and effectiveness Q (every)- shift.Monitor/document/report PRN (as needed) any adverse reactions of Psychotropic medications.A review of Resident 10's medical record on September 17, 2025, indicated there was no physician's order to monitor side effects related to use of aripiprazole.A review of Resident 10's Medication Administration Record (MAR), dated June 16, 2025 through September 16, 2025, indicated Resident 10 was administered aripiprazole as ordered. There was no documented evidence in Resident 10's medical record that the side effects were monitored and documented by nursing staff during the use of aripiprazole between June 16, 2025, to September 16, 2025.On September 17, 2025, at 12:05 p.m., during an interview and record review, the Director of Nursing (DON) confirmed that nursing staff did not monitor or document side effects during the administration of aripiprazole. The DON acknowledged this should have been done according to the facility's psychotropic and antipsychotic monitoring process. The DON stated monitoring is crucial to ensure residents do not experience negative effects on daily living or discomfort. The DON emphasized the importance of evaluating residents for movement disorders or other side effects to determine if medication adjustments are needed. A review of the Prescribing Information (PI, manufacturer's instructions) for aripiprazole tablet, dated May 2023, retrieved from DailyMed (a public website maintained by the U.S. Food and Drug Administration), indicated, Adverse Reactions.Stroke. Neuroleptic Malignant Syndrome (NMS, rare life-threatening reaction that causes high fever, severe muscle stiffness, confusion). Tardive Dyskinesia (TD, uncontrolled movements of the face and body).Falls.Seizures. Cognitive and Motor Impairment.nausea, vomiting, constipation, headache, dizziness, akathisia (restlessness), anxiety, insomnia (difficulty sleeping). 2. On September 17, 2025, a review of Resident 5's admission Record, indicated Resident 5 was initially admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including bipolar disorder (a mental health condition that causes extreme mood swings), psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality), dementia (memory loss), (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Parkinsonism (a brain condition that cause slowed movements, rigidity, and tremors), and depression. A review of Resident 5's medical record indicated the resident had been receiving quetiapine in various doses since June 2023. Resident 5's current Order Summary Report, indicated the following physician's orders:- Quetiapine 200 mg, give one tablet by mouth at bedtime for Schizoaffective d/o (disorder) AEB (as evidenced by) angry outbursts, date ordered July 14, 2025; and- Monitor for side effects of antipsychotic medication due to use of Seroquel (brand name for quetiapine) every shift, dated May 13, 2025.A review of Resident 5's MARs, dated May 13, 2025, through September 16, 2025, indicated Resident 5 was administered quetiapine as ordered. On September 17, 2025, at 12:59 p.m., during a concurrent interview and record review, the DON confirmed Resident 5 had been on quetiapine since June 2023. The DON could not find documentation for lipid monitoring as per manufacturer's instructions and emphasized its importance to avoid complications.A review of the PI for quetiapine tablet, dated January 2025, retrieved from DailyMed, indicated, Warnings and Precautions.Dyslipidemia: Undesirable alterations have been observed.Appropriate clinical monitoring.including fasting blood lipid testing at the beginning of, and periodically, during treatment.A review of the facility's policy and procedure titled, Behavior/Psychoactive Medication Management, revised date April 24, 2025, indicated, .Monitoring and Reporting for Side Effects.The resident will be observed and/or monitored for side effects, and adverse consequences.All complications and side effects should be reported to the Healthcare practitioner.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a clinical assessment tool) was accurately coded, for one of three residents reviewed for nutrition (Resident 41).This failure resulted in an inaccurate MDS assessment to be submitted to CMS (Centers for Medicare and Medicaid Services).Findings: On September 18, 2025, Resident 41's record was reviewed. Resident 41 was admitted to the facility on [DATE], with diagnoses which included senile degeneration of the brain (progressive decline in cognitive function that interferes with daily life), Alzheimer's dementia (memory loss), and palliative care (comfort care).A review of Resident 41's Weights and Vitals Summary, indicated the following weights:-155 lbs. (pounds - unit of measurement); June 2, 2025; and-139 lbs.; July 2, 2025; weight loss of 12.58% in a month (significant weight loss is 5% or more).A review of Resident 41's MDS, dated [DATE], Section K for nutrition assessment, indicated no weight loss in the last month.On September 18, 2025, at 5:23 p.m., the Director of Nursing (DON) stated that the previous MDS coordinator incorrectly coded a weight loss. The DON stated the weight loss exceeded 5% in 30 days and should have been coded in the MDS. The DON expects accurate completion of MDS assessments. The DON stated that the facility followed the RAI Manual guidelines for MDS assessments, without a specific policy on their accuracy.A review of the facility's policy and procedure titled, Evaluation of Weight and Nutritional Status, dated January 30, 2025, indicated, Definitions.Weight Loss.Unplanned weight loss in a resident. Significant weight loss (5%& (and)/or 5lb in one month, 7.5% in three months, or 10% in six months), as well as unplanned weight loss that occurs over time that does not meet the guidelines for significant weight loss and does not trigger review of the Nutritional Status CAA (care area assessment).A review of the RAI manual, dated October 2024, indicated, .Weight loss can result in debility and adversely affect health, safety, and quality of life.Coding instructions.Code 2, yes, not on physician -prescribed weight-loss regimen: if the resident has experienced weight loss of 5% or more in the past 30 days.and the weight loss was not planned and prescribed by a physician.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities during the monthly medication regimen review (MRR), for two of five sampled residents (Resident 5 and 10) when: 1. Resident 10 was administered aripiprazole (an antipsychotic medication for mental illness) without potential adverse effect monitoring documented during use of aripiprazole; and 2. Resident 5 was given quetiapine (an antipsychotic medication for mental illness, depression, and schizophrenia) without following the manufacturer's monitoring guidelines. These failures had the potential for medications not being optimized for best possible health outcome, and increased risk for adverse effects for Resident 5 and 10.Findings:1. On September 17, 2025, Resident 10's record was reviewed. A review of Resident 10's admission Record, indicated the resident was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including schizoaffective disorder (mental health condition characterized by psychotic symptoms like hallucinations/delusions and mood episodes like mania or depression).A review of Resident 10's medical record indicated the resident had been receiving Aripiprazole in various doses since July 2023. Resident 10's current Order Summary Report, included a physician's order, date ordered September 11, 2025, which indicated, Aripiprazole 2 mg (milligram, unit of measurement), give one tablet by mouth in the morning for Schizophrenia (mental illness) m/b (manifested by) visual hallucination AEB (as evidenced by) seeing people not there.A review of Resident 10's Care Plan Report, indicated a focus area initiated on June 15, 2025 for At risk for adverse side effects of psychotropic medications Aripiprazole r/t (related to dx (diagnosis) of Schizophrenia with interventions that included, Administer Psychotropic medication as ordered by physician. Monitor for side effects and effectiveness Q (every)- shift.Monitor/document/report PRN (as needed) any adverse reactions of Psychotropic medications.A review of Resident 10's medical record on September 17, 2025, indicated there was no physician's order to monitor side effects related to use of aripiprazole.A review of Resident 10's Medication Administration Record (MAR), dated June 16, 2025, through September 16, 2025, indicated Resident 10 was administered aripiprazole as ordered. There was no documented evidence in Resident 10's medical record that the side effects were monitored and documented by nursing staff during the use of aripiprazole between June 16, 2025, to September 16, 2025.On September 17, 2025, at 12:05 p.m., during an interview and record review, the Director of Nursing (DON) confirmed that nursing staff did not monitor or document side effects during the administration of aripiprazole. The DON acknowledged this should have been done according to the facility's psychotropic and antipsychotic monitoring process. The DON stated monitoring is crucial to ensure residents do not experience negative effects on daily living or discomfort. The DON emphasized the importance of evaluating residents for movement disorders or other side effects to determine if medication adjustments are needed. A review of the CP's monthly MRRs for Resident 10, dated June 24, 2025, July 19, 2025, and August 8, 2025, indicated there were no recommendations from the CP related to side effect monitoring during aripiprazole use. On September 17, 2025, at 3:35 p.m., during an interview and record review with the DON, it was confirmed that there were no recommendations from the CP for monitoring side effects of aripiprazole on June 24, July 19, and August 8, 2025. The DON stated that such recommendations should have been provided for Resident 10.A review of the Prescribing Information (PI, manufacturer's instructions) for aripiprazole tablet, dated May 2023, retrieved from DailyMed (a public website maintained by the U.S. Food and Drug Administration), indicated, Adverse Reactions.Stroke.Neuroleptic Malignant Syndrome (NMS, rare life-threatening reaction that causes high fever, severe muscle stiffness, confusion).Tardive Dyskinesia (TD, uncontrolled movements of the face and body).Falls.Seizures.Cognitive and Motor Impairment.nausea, vomiting, constipation, headache, dizziness, akathisia (restlessness), anxiety, (continued on next page)

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	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Springs Healthcare & Wellness Centre	82262 Valencia Avenue Indio, CA 92201

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	insomnia (difficulty sleeping). 2. On September 17, 2025, a review of Resident 5's admission Record, indicated Resident 5 was initially admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including bipolar disorder (a mental health condition that causes extreme mood swings), psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality), dementia (memory loss), Parkinsonism (a brain condition that cause slowed movements, rigidity, and tremors), and depression. A review of Resident 5's medical record indicated the resident had been receiving quetiapine in various doses since June 2023. Resident 5's current Order Summary Report, indicated the following physician's orders:- Quetiapine 200 mg, give one tablet by mouth at bedtime for Schizoaffective d/o (disorder) AEB (as evidenced by) angry outbursts, date ordered July 14, 2025; and- Monitor for side effects of antipsychotic medication due to use of Seroquel (brand name for quetiapine) every shift, dated May 13, 2025.A review of Resident 5's MARs, dated May 13, 2025, through September 16, 2025, indicated Resident 5 was administered quetiapine as ordered. On September 17, 2025, at 12:59 p.m., during a concurrent interview and record review, the DON confirmed Resident 5 had been on quetiapine since June 2023. The DON could not find documentation for lipid monitoring as per manufacturer's instructions and emphasized its importance to avoid complications.A review of the CP's monthly MRRs for Resident 5 dated May 21, 2025, June 24, 2025, July 19, 2025, and August 8, 2025, indicated there were no recommendations from the CP related to manufacturer's specified monitoring of lipids during quetiapine use. On September 17, 2025 at 3:05 p.m., during a concurrent interview and record review of Resident 5's MRR with the DON, the DON confirmed there were no recommendations from the CP related to manufacturer's specified monitoring of lipids during quetiapine use and stated there should have been recommendations from the CP, from May to August 2025.A review of the PI for quetiapine tablet, dated January 2025, retrieved from DailyMed, indicated, Warnings and Precautions.Dyslipidemia: Undesirable alterations have been observed.Appropriate clinical monitoring .including fasting blood lipid testing at the beginning of, and periodically, during treatment.A review of the facility's policy and procedure titled, Medication Regimen Review, dated October 2012, indicated, The consultant pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the following.Laboratory results.Resident is monitored for adverse consequences.Side effects, adverse reactions.are evaluated.Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's [active record] and reported to the Director of Nursing, and/or prescriber as appropriate.A review of the facility's policy and procedure titled, Behavior/Psychoactive Medication Management, revised date April 24, 2025, indicated, Monitoring and Reporting for Side Effects.The resident will be observed and/or monitored for side effects, and adverse consequences.All complications and side effects should be reported to the Healthcare practitioner.