STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555226	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Healthcare Center at the Carlotta	41505 Carlotta Drive Palm Desert, CA 92211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility failed to ensure a care plan was developed and implemented for two of three residents reviewed (Residents 142 and 143) when: 1. For Resident 142, a pacemaker (a small device used to control irregular heart beats) was identified on admission and there was no care plan that included the pacemaker information - the manufacturer, type of pacemaker, model and serial number, and the date the pacemaker was implanted. This failure had the potential to place Resident 142 at risk for not receiving immediate care and services in the event of pacemaker malfunction; and 2. For Resident 143, multiple bruising of the upper extremities, left hand bruising, and abrasion of the left knee were identified upon admission, and multiple skin tears identified after admission. There was no person-centered care plan developed and implemented for Resident 143's bruising and multiple skin tears. This failure had the potential to result in Resident 143 not receiving the proper care and treatment for the skin tears. Findings: On April 30, 2024, Resident 142's record was reviewed. Resident 142 was admitted to the facility on [DATE], with diagnoses which included COPD (Chronic Obstructive Pulmonary Disease - lung disease), CHF (Congestive Heart Failure) and presence of cardiac pacemaker. The history and physical dated March 8, 2024, indicated Resident 142 had the capacity to understand and make decisions. The facility's document titled Admission/Readmission Screen and Baseline Care Plan . dated April 8, 2024, was reviewed. The admission details under cardiovascular indicated Resident 142 had a pacemaker on the chest area. The date of the last pacemaker check was blank. The physician's orders dated April 8, 2024, was reviewed. The orders indicated Resident 142 had an order for the pacemaker appointment. On hold from 4/17/24 - 4/20/24. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence a care plan was developed for the pacemaker to include the pacemaker manufacturer, model number, serial number and the date the pacemaker was implanted. The nursing progress notes dated March 17, 2024, indicated Resident 142 complained of shortness of breath, elevated blood pressure of 220/120, and oxygen saturation (blood oxygen level) was 72% (low value). Resident 142 was sent out to the acute hospital for evaluation. Resident 142 was readmitted to the facility on [DATE]. There was no documented evidence in the nurse's notes indicating the pacemaker information on March 19, 2024. There was no documented evidence a care plan was initiated and developed for Resident 142's pacemaker on March 19, 2024. During a concurrent observation and interview on May 1, 2024, at 8:47 a.m., with Resident 142, in her room, Resident 142 was observed sitting in her wheelchair with oxygen on at three liters per minute through her nose. Resident 142 was alert and able to verbalize her needs. She stated she had a pacemaker for years, and was being followed by a cardiologist (heart specialist). She stated she had not gone out for an appointment for her pacemaker. She stated she could not remember the type of pacemaker she had. During a concurrent observation and interview on May 1, 2024, at 9:05 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 142 was observed with an implanted pacemaker on her left chest. LVN 1 stated Resident 142 had a pacemaker on her left chest. LVN 1 stated when a resident has a pacemaker, licensed staff should obtain the pacemaker information from the resident or family member, and document the pacemaker information in resident's care plan. LVN 1 stated there was no care plan for Resident 142's pacemaker. LVN 1 was not able to find Resident 142's pacemaker information in the record. During a concurrent interview and record review on May 1, 2024, at 9:39 a.m., with the Director of Nursing (DON), the Admission/Readmission Screen and Baseline Care Plan, document was reviewed. The document did not indicate the date of the last pacemaker check. The DON acknowledged Resident 142's pacemaker was identified on admission. The DON was not able to locate a care plan for Resident 142's pacemaker. The DON was not able to find documented evidence of pacemaker information for Resident 142. The DON stated she would usually develop the resident's care plan on admission. She stated there was no care plan for Resident 142's pacemaker. The DON stated Resident 142's cardiology appointment was canceled when Resident 142 was transferred to the hospital on April 17, 2024. She stated the pacemaker information like the type, manufacturer, date of implant, model number and serial number, should have been included in Resident 142's care plan. The facility's policy and procedure titled, Pacemaker, Care of a Resident with a, dated December 2015, was reviewed. The policy indicated, .For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission; .The name, address and telephone number of the cardiologist; type of pacemaker; type of leads; Type of leads; Manufacturer and model; Serial number; date of implant; and Paced rate . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure titled, Care Planning - Interdisciplinary Team, dated September 2013, was reviewed. The policy indicated, .Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident . 2. During a concurrent observation and interview on April 29, 2024, at 1:05 p,m., with Resident 143, at the Physical Therapy department, Resident 143 was observed performing leg exercises on the stationary bike. Resident 143 stated I don't know what's going on. Resident 143's responsible party (RP) stated Resident 143 had a stroke and was on a blood thinner. She stated Resident 143 had a stroke on the right side of the brain affecting his left side. She stated Resident 143 gets confused. Resident 143 was observed with multiple dry scabs on his left arm with discoloration of the skin. Resident 143 was observed with a dressing (a piece of material placed on a wound to protect it) on the shin of the left leg. On April 30, 2024, Resident 143's record was reviewed. The record indicated Resident 143 was admitted to the facility on [DATE], with diagnoses which included left sided weakness, following cerebral infarction (stroke - disrupted blood flow to the brain), post traumatic stress disorder (PTSD) and falls. The Brief Interview for Mental Status (BIMS - a cognitive screening tool) dated March 12, 2024, indicated a Score of 8 (moderately impaired). The physician's orders for the month of April 2024, included the following: .Monitoring for anticoagulant side effects, signs of bleeding . Monitor skin tear to left arm with steri strips in place for s/sx infection every shift for 14 days . Braden Scale (used for early identification of patients at risk for forming pressure sores) Charting weekly x 4 weeks one time a day every 7 day(s) for wound prevention for 30 days . On April 30, 2024, at 3:50 p.m., Resident 143 was observed asleep, in a low bed with a private sitter at his bedside. On May 1, 2024, at 9:29 a.m., Resident 143 was observed being wheeled in his wheelchair by the RP to the Physical Therapy department. The physician's orders summary for the month of May 2024, included the following: .Check for signs of bleeding secondary to anticoagulant intake and call MD if signs of bleeding is present . Braden Scale Charting weekly x 4 weeks one time a day every 7 day(s) for wound prevention for 30 Days . Monitor skin tear to left arm with steri strips in place for s/sx (signs and symptoms) infection every shift for 14 days . The facility's document titled, Admission/Readmission Screen and Baseline Care Plan, dated April 10, 2024, was reviewed. The document indicated, under Skin and Wound Assessment Resident 143 had left hand bruising, left knee abrasion and multiple bruising on his upper extremities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's notes were reviewed. The notes indicated the following: .On 4/22/2024, at 2:46 p.m., Pt (patient) being pushed in wheelchair by wife, pt extended arm and caught in doorway of activity room causing skin tear to left lateral arm. Site cleansed, patted dry, skin approximated, skin prep applied. No c/o (complaint of) pain or discomfort verbalized. MD aware of incident . On 4/24/2024, at 4 p.m. Pt (patient) was up in wheelchair and during that time he had somehow torn open the skin to his 4th toe on his left foot . On 4/29/2024, entered at 2:46 p.m., Pt had a witnessed fall at 0930 (9:30 a.m.). Wife stated he wanted to get off the toilet, under estimated own limits and fell over. No injuries noted to the head, VSS (vital signs stable), AO (alert oriented) x 3 pleasantly confused at times. small skin tear to left shin. Cleaned with saline and covered with dressing. MD made aware . There was no documented evidence a care plan was developed for the skin tears, bruising on the left hand, abrasion to the left knee, and multiple bruising identified on admission and completed by the DON. There was no documented evidence a care plan was developed and implemented for skin tears sustained on April 22, 2024, April 24, 2024, and April 29, 2024. During a concurrent interview and record review on May 2, 2024, at 9:50 a.m.,with the DON, the admission assessment was reviewed. The assessment indicated skin tears on the left hand, abrasion left knee, and multiple bruising on upper extremities. The DON stated she completed the admission assessment for Resident 143 on May 10, 2024. The DON stated she should have initiated a care plan for the skin assessment. The DON stated the skin tears Resident 143 had on April 22, April 24 and April 29, 2024, should have been care planned. The facility's policy and procedure titled, Care Planning- Interdisciplinary Team, dated September 2013, was reviewed. The policy indicated, .Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment . The facility's policy and procedure titled, Care Plans, Comprehensive Person- Centered, dated December 2016, was reviewed. The policy indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility failed to ensure the care plan was updated and revised when the resident's indwelling urinary catheter (a devise inserted into the bladder held in place by a water-filled balloon which prevents it from falling) was pulled out for one of four residents reviewed (Resident 143). This failure had the potential to place Resident 143 at risk for further trauma when measurable goals and interventions were not formulated to prevent Resident 143 from pulling his indwelling urinary catheter. Findings: During a concurrent observation and interview on April 29, 2024, at 1:05 p.m., with Resident 143, at the Physical Therapy department, Resident 143 was observed performing leg exercises on the stationary bike. Resident 143 stated I don't know what's going on. Resident 143's responsible party (RP) stated Resident 143 had a stroke and currently on blood thinner. She stated Resident 143 had a stroke on the right side of the brain affecting his left side. She stated Resident 143 gets confused. On March 30, 2024, at 12:19 p.m., Resident 143 was observed sitting up at the bedside chair, eating lunch being assisted by the facility staff. Resident 143 was observed with an indwelling urinary catheter attached to a drainage bag, draining yellow urine. On April 30, 2024, Resident 143's record was reviewed. The record indicated Resident 143 was admitted to the facility on [DATE], with diagnoses which included left sided weakness, following cerebral infarction (stroke - disrupted blood flow to the brain), post traumatic stress disorder (PTSD) and falls. The Brief Interview for Mental Status (BIMS - a cognitive screening tool) dated March 12, 2024, indicated a Score of 8 (moderate cognitive impairment). The nurse's notes dated March 10, 2024, indicated Resident 143 was admitted with a Foley catheter (also called an indwelling urinary catheter). The facility's document titled, SBAR (Situation, Background, Assessment, and Recommendation - a structured communication used to share information about patient's condition) Communication Form, dated March 14, 2024, at 6 p.m., indicated, .CNA (Certified Nursing Assistant) had reported to nurse to find his catheter bag filled with red urine . The nursing progress note dated March 14, 2024, indicated licensed staff had received a physician's order for a urine test with culture and sensitivity. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 15, 2024, at 7 a.m., Resident 143 was sent out to the acute facility for evaluation. Licensed staff documented Resident 143 had pulled out his Foley catheter with the balloon inflated. The care plan for indwelling urinary catheter related to obstructive uropathy (a condition in which the flow of urine is blocked) dated March 11, 2024, was reviewed. The care plan indicated, on March 15, 2024, Resident pulled Foley catheter and was sent to the ER (emergency room) for eval (evaluation) . The care plan goals and interventions were not revised after Resident 143 had pulled his Foley catheter and was sent out to the emergency room for evaluation. During a concurrent interview and record review on May 2, 2024, at 10:09 a.m., with the Director of Nursing (DON), Resident 143's care plan dated March 11, 2024, was reviewed. The care plan indicated Resident 143 had pulled out his catheter and was sent out to the ER for evaluation on March 15, 2024. The DON acknowledged the care plan was not revised after Resident 143 had a change in condition. The DON stated the care plan for Resident 143's Foley catheter should have been revised with new goals and interventions. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated December 2016, indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Assessments of residents are on going and care plans are revised as information about the resident's condition .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44173 Based on observation, interview, and record review, the facility failed to ensure a skin assessment was completed and documented for one resident reviewed (Resident 11). This failure had a potential for a delay of treatment for Resident 11's left shoulder wound. Findings: During a concurrent observation and interview on April 29, 2024, at 12:42 p.m., with Resident 11, Resident 11 was seen sitting in bed, having lunch. Resident 11 had a foam dressing (dressing - a piece of material such as a pad applied to a wound to promote healing and protect the wound from further harm) on her left shoulder. Resident 11 stated she fell from her bed about two to three weeks ago and hit her left shoulder on the metal foot of the bed. Resident 11 stated she had a deep cut on her left shoulder. Resident 11's record was reviewed. Resident 11 was admitted to the facility on [DATE], with diagnoses which included diabetes (high blood sugar) and hypertension (high blood pressure). During a review of Resident 11's Minimum Data Set (MDS - an assessment tool), dated March 28, 2024, the MDS indicated Resident 11 did not have any skin problems on admission. During a review of Resident 11's Change in Condition (CIC), dated April 7, 2024, the CIC indicated Resident 11 had a fall and a skin assessment was done. The skin assessment indicated Resident 11 did not have any observable injury. During a review of Resident 11's Progress Notes, dated April 30, 2024, the progress notes indicated, . resident initially seen by wound specialist for a boil (a painful pus-filled [pus - a thick yellowish or greenish fluid produced in infected tissue] bump under the skin) left shoulder . There was no documented evidence Resident 11's left shoulder was assessed and the left shoulder wound was identified before April 25, 2024. During a concurrent interview and record review on May 1, 2024, at 3:09 p.m., with the Treatment Nurse (TN), the TN stated Resident 11's left shoulder wound was a scratch when she saw it two weeks ago. The TN stated there was no documentation of Resident 11's left shoulder scratch. During a concurrent interview and record review on May 1, 2024, at 3:28 p.m., with the Director of Nursing (DON), the DON stated Resident 11 had an order for daily foam dressing change of the left shoulder. She stated the TN should have assessed Resident 11's left shoulder wound during the dressing change and should have documented. The DON stated there was no documentation of any skin changes on Resident 11's left shoulder. She stated the Registered Nurse (RN) worked on April 21, 2024, and asked the wound care specialist to evaluate Resident 11's left shoulder wound. She stated the wound care specialist identified Resident 11's left shoulder wound as a boil on April 25, 2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on May 1, 2024, at 11:25 a.m., with the RN, the RN stated she did not document the redness identified on Resident 11's left shoulder two weeks ago. She stated she asked for the wound care physician to evaluate Resident 11's left shoulder wound on April 21, 2024, but did not document. During a review of the facility's policy and procedure (P&P) titled, Resident Examination and Assessment, dated February 2014, the P&P indicated, .Physical Exam .Skin .presence of bruises, pressure sores, redness .Documentation .The date and time the procedure was performed .The name and the title of the individual(s) who performed the procedure .All assessment data .The signature and title of the person recording the data .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39920 Based on observation, interview and record review the facility failed to ensure medications and biologicals were properly stored and disposed when an expired COVID-19 test (a test used to detect COVID-19 - an infectious disease), was found inside a medication cart, readily available for use. This failure had the potential for the residents to be administered an expired COVID-19 test and could result in an inaccurate test result. Findings: On [DATE], at 2:23 p.m., during a medication cart inspection with Licensed Vocational Nurse (LVN) 1, a box containing a COVID-19 test was observed stored in the medication cart, readily available for use. The test had an expiration date of [DATE]. In a concurrent interview, LVN 1 stated the expired test should not have been stored in the medication cart readily available for use and should have been discarded. On [DATE], at 2:38 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the expired COVID test should not have been stored in the medication cart and should have been discarded. On [DATE], at 2:45 p.m., an interview and concurrent record review was conducted with the Infection Preventionist (IP) and the DON. The IP stated the test expiration date was extended by the manufacturer. The IP verified the test manufacturer's website, which indicated the lot number with the expiration date of [DATE], had the expiration date extended to [DATE]. The DON stated the test was expired. A review of the Food and Drug Administration (the governmental agency responsible for the safety, efficacy, and security of drugs, biological products, and medical devices) website indicated, (name of manufacturer and name of COVID test) Lot Number (number lot of the COVID test) with printed expiration date as of [DATE], had extended expiration date as of [DATE]. The facility's policy and procedure, titled, Medication Labeling and Storage, revised February 2023, was reviewed. The policy indicated, .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44173 Based on observation, interview, and record review, the facility failed to ensure the cook followed the directions for preparing egg salad pureed diet for lunch on April 30, 2024. This failure had the potential to compromise the nutritional status for one resident (Resident 20) reviewed for pureed diet. Findings: During a review of the undated facility document titled, Recipe Name: Pureed Salads-Meat/Poultry/Egg/Seafood, the document indicated, .Directions .Remove portions required from regular prepared recipe and place in food processor. Slowly add broth and process until smooth. Use as little broth as necessary to get a smooth product .If needed, add Thickener and process until smooth in consistency .Ensure mixture achieves moist mashed potato or pudding-like consistency . During an observation on April 30, 2024, at 12:12 p.m., with the cook, and the Registered Dietician (RD) present, the cook prepared one portion of pureed egg salad for Resident 20. The cook looked at the recipe for pureed food. The cook started to create a new serving of the pureed egg salad instead of pureeing the regular portion of egg salad as indicated in the recipe directions. The cook put two hard, boiled eggs, added some mayonnaise, using a metal serving spoon, in a blender. He added a mixture of liquid chicken broth he made from hot water and powdered chicken bouillon and blended the mixture. During a concurrent interview, the cook was asked if he followed the procedure in the recipe for a pureed diet. The cook stated he did not follow the procedure as indicated in the recipe for a pureed diet. During an interview on April 30, 2024, at 12:23 p.m., with the Registered Dietician (RD), the RD stated the cook did not follow the procedure as indicated in the recipe for a pureed diet. She stated the cook should have followed the procedure in the recipe for a pureed diet. During a review of the facility document titled, Diet Type Report, dated April 30, 2024, the document indicated, .Resident 20 .Diet Type .Regular .Diet Texture .Pureed .