

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2024
NAME OF PROVIDER OR SUPPLIER Rancho Mirage Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 39950 Vista Del Sol Rancho Mirage, CA 92270	

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 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** 47202</p> <p>Based on interview and record review, the facility failed to ensure that one of three residents (Resident 1) was monitored following an allegation of physical abuse.</p> <p>This failure had the potential to affect Resident 1 ' s emotional and psychosocial wellbeing.</p> <p>Findings:</p> <p>On September 10, 2024 at 9:00 a.m., an unannounced visit to the facility was conducted to investigate an allegation of physical abuse.</p> <p>On September 10, 2024, Resident 1 ' s medical record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included left shoulder osteoarthritis (a disease where the tissues [a group of cells] of the joints break down overtime.)</p> <p>A review of Resident 1 ' s History and Physical, dated August 22, 2024, indicated, Resident 1 had mental capacity.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS - an assessment tool), dated August 26, 2024, indicated Resident 1 had a Brief Interview for Mental Status (tool used to assess a resident's cognitive function) score of 15 (cognitively intact).</p> <p>A review of Resident 1 ' s eINTERACT Change of Condition Evaluation, dated August 26, 2024, indicated, . Caregiver .alleged CNA handled resident roughly during transfer causing moderate to severe pain in the left shoulder .</p> <p>Further review of Resident 1's progress notes from August 26 to August 29, 2024, indicated there was no documented evidence Resident 1 was monitored after the physical abuse allegation.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On September 10, 2024, at 10:10 a.m., during a concurrent interview and review of Resident 1 ' s progress notes with License Vocational Nurse (LVN) 1, he stated, Resident 1 ' s caregiver alleged CNA 1 was rough and caused pain to resident during a transfer on August 26, 2024. LVN 1 further stated the process for abuse monitoring requires that the resident involved be monitored for 72 hours after the abuse incident or allegation to observe for any psychosocial effect, emotional distress, behavioral changes , or delayed physical injuries. LVN 1 stated, Resident 1 was not monitored for 72 hours after the alleged physical abuse. LVN 1 further stated, Resident 1 should have been monitored for any emotional distress or any behavior changes.</p> <p>On September 10, 2024, at 10:45 a.m., during a concurrent interview and review of Resident 1 ' s progress notes with the Director of Nursing (DON), she stated, Resident 1 was not monitored after the alleged physical abuse incident on August 26, 2024. The DON stated a resident involved in an abuse allegation needs to be monitored for 72 hours to detect any negative effects on the resident. The DON further stated, it is important to monitor the resident after an abuse allegation to assess for any emotional or psychosocial effects and latent physical injuries. The DON stated her expectation is for nursing to conduct 72-hour monitoring and documentation of the resident involved after an abuse incident or allegation. The DON further stated, Resident 1 should have been monitored for any emotional distress, and or latent bodily injuries.</p> <p>On September 10, 2024, at 1:20 p.m., during an interview with the DON, she stated the facility does not have a specific policy related to 72-hour monitoring. The DON further stated it is the facility ' s standard practice to monitor residents every shift for 72 hours after any abuse allegations, and the monitoring is documented in the resident ' s medical records.</p>		