STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555247	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rancho Mirage Health and Rehabilitation Center	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46145 Based on observation & interviews, the facility failed to ensure resident's call light was within reach for one out of three residents (Resident 1). This failure had the potential to result in Resident 1 unable to call nursing staff for assistance. Findings: On December 24, 2024, at 8:30 a.m., an unannounced visit was made to the facility, for a quality of care issue. On December 26, 2024, at 1:10 p.m., a concurrent observation of Resident 1 lying in bed, and interview with resident, was conducted. Resident observed with a contracted right hand, and left hand under the covers. Observed resident's call light out of reach, as it was tied around the bed rail, hanging down the right side of the bed, towards the floor. Resident 1 asked by this writer, How do you call the nurses for help? Resident stated, I usually can't reach my call light, I'll ask my roommate to call the nurses. Resident 1 observed unsuccessfully trying to reach her call light with her right contracted hand. A review of Resident 1's medical records, titled, Resident Information, dated, January 2, 2025, 2:02 p.m., indicated, resident was admitted to the facility on , November 4, 2022, with a diagnosis of, cerebral infarction (Stroke), and multiple sclerosis (a disease which causes nerve damage, and impaired coordination). A review of Resident 1's, Brief Interview for Mental Status ({BIMS}-a cognitive assessment), indicated a score of 12, (moderately cognitively impaired). A review of Resident 1's, care plan, titled, Resident at risk for unavoidable falls with injury (related to) limited mobility, initiated, January 13, 2023, indicated an intervention of, . Be sure the resident's call light is within reach . On December 26, 2024, at 1:20 p.m., a concurrent observation, and interview was conducted with Resident 1's roommate. Roommate was observed sitting on the left side of her bed, reading, call light within her reach. Resident 1's roommate stated, she calls the nurses for Resident 1, because resident can't find her call light. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 26, 2024, at 1:25 p.m., a concurrent interview with Certified Nursing Assistant (CNA) 1, and observation of Resident 1's call light, was conducted. CNA 1 stated, she was assigned to care for Resident 1. CNA stated, residents use their call lights to notify nursing staff help is needed. CNA 1 stated, the call light should be within the resident's, reach at all times. CNA stated, Resident 1's call light stays within reach by Clipping, the call light, via a small metal clip, to resident's clothing on their right side. Resident 1 was observed lying in bed, with her call light hanging off the right side of her bed, not clipped to resident's clothes. CNA 1 verified, resident call light was out of Resident 1's reach, as the call light was not clipped to resident's clothing and hanging down the right side of resident's bed. On December 26, 2024, at 1:35 p.m., a concurrent interview with Licensed Vocational Nursing (LVN) 1, and observation, of Resident 1 lying in bed and placement of call light was conducted. LVN stated, residents are to use their call lights to call the nurse (for assistance), and the call lights, should always be within the resident's reach. LVN 1 further stated, Resident 1's call light is to be clipped to her (clothes) at chest level. LVN observed resident 1 lying in bed, with resident's call light hanging off the right side of resident's bed, toward the floor. LVN 1 stated, Oh (Resident 1's) call light is not clipped to her. LVN verified, Resident 1's call light was out of reach of resident. On December 26, 2024, at 2:17 p.m., an interview was conducted with the Director of Nursing (DON), who stated, her expectations, are for call lights to always be within the resident's reach, to call for assistance. A facility policy, titled, Answering the Call Light, revised, September 2022, indicated, .Purpose: The purpose of this procedure is to ensure timely responses to the resident's requests and needs . General Guidelines . 5. Ensure that the call light is accessible to the resident when in bed .

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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 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** 46145 Based on observation, interview, and record review, the facility failed to initiate a care plan (an individualized, plan of care, specific to resident's healthcare needs) for hard of hearing for one of three residents (Resident 3). This failure had the potential to negatively impact the resident's quality of life, as well as the quality of care and services received for Resident 3. Findings: On December 24, 2024, at 9:10 a.m., during a concurrent observation and interview with Resident 3, Resident 3 stated she was hard of hearing and had to get close to her ear or speak louder. Resident 3 was observed wearing hearing aids. Resident 3 stated she still could not hear well even she had the hearing aids. A review of Resident 3's medical record, titled, Resident Information, dated, December 31, 2024, at 10:25 (a. m.), indicated, resident was admitted to the facility on [DATE], with a diagnosis of, Hemorrhage of Cerebrum (Brain bleed). A review of Resident 3's Brief Interview of Mental Status ({BIMS}-a cognitive assessment), dated, December 09, 2024, indicated a score of 12 (mildly cognitively impaired). A review of Resident 3's Admission Data Tool, dated, December 7, 2024, at 5:06 p.m., indicated, . B. Hearing 1. Ability to hear (with hearing aid or hearing appliances if normally used) 2. Resident (3) wears hearing aids in both ears . A review of Resident 3's Baseline Care Plans (Developed within 48 hours of admission), dated, December 08, 2024, untimed, indicated, section, 2. Hearing, assessment was not completed. Further review indicated, . (Baseline Care Plan) summary . (Resident 3) wears hearing aids . A review of Resident 3's Minimum Data Set ({MDS}-Comprehensive Assessment of resident's functional capabilities, and healthcare issues), dated, December 19, 2024, was conducted. Section B, indicated, resident had adequate hearing, and did not wear hearing aids. A review of Resident 3's Comprehensive Care Plans (developed from the comprehensive assessment), indicated, there was no care plan initiated for Resident 3's hard of hearing. On December 26, 2024, at 12:02, Licensed Vocational Nurse (LVN) 4 was interviewed. LVN 4 stated, she put in her hearing aids this morning and had replaced the batteries on couple of other occasions. LVN 3 stated she did not inform Social Services, the DON, the doctor, and the family member about the resident's issue about her hearing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 30, 2024, at 3:21 p.m., the Minimum Data Set Nurse (MDSN) was interviewed. The MDSN stated Resident 3's admission data indicated that the resident was hard of hearing and wore hearing aids, but the resident's comprehensive assessment did not reflect the information.The MDSN further stated that the information about the resident being hard of hearing and wearing hearing aids would have triggered the initiation of a care plan, but no care plan was initiated because the information was not included in the resident's comprehensive assessment. On December 31, 2024, at 11:47 a.m., a concurrent record review of Resident 3's Care Plans, Admission Data Tool (dated, December 7, 2024), Comprehensive Assessment (dated, December 19, 2024), and Drs orders (dated, December 7, 2024), and an interview with the Director of Nursing (DON) was conducted. The DON stated, the night-shift nurses review resident information, and initiate the baseline care plans, while the MDS nurses initiate comprehensive care plans after completing the resident's comprehensive assessment. The DON verified Resident 3 was hard of hearing and wore hearing aids. The DON stated Resident 3 did not have a care plan addressing hard of hearing. The DON stated, a care plan for hard of hearing should have been initiated for Resident 3. The DON stated, it was her expectation that staff initiate care plans at the time a healthcare issue is identified. The DON stated, the care plan should have included interventions for the resident's hard of hearing and the use of hearing aids, as well as instructions on what should be done if the hearing aids were not functioning properly. A review of the facilities P&P, titled, Care Plans, Comprehensive Person-Centered, revised, 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 . 1. The interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . 8. The comprehensive, person-centered care plan will: g. Incorporate identified problem areas; . k. Reflect treatment goals, timetables, and objectives in measurable outcomes; L. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program . 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37536 Based on interview and record review, the facility failed to: 1. Provide fall prevention interventions for a resident assessed as a fall risk, for one out of three residents (Resident 3). This failure resulted for Resident 3 falling and sustaining a scalp hematoma (localized collection of blood that forms beneath the skin of the scalp due to trauma). 2. Ensure that the bed alarm (a device used as a fall precaution intervention to alert staff when a resident attempts to get out of bed) was properly attached to the resident, for one out of two residents (Resident 2). This failure had the potential to result in injury to Resident 2 if the resident attempted to get out of bed without staff knowledge. Findings: A review of Resident 3 ' s, medical record, titled, Resident Information, dated, December 31, 2024, at 10:25 (a.m.), indicated, resident was admitted to the facility on [DATE], with diagnosis ' which include, fracture of the second cervical vertebra (neck fracture) and muscle weakness. A review of Resident 3 ' s, Brief Interview of Mental Status ({BIMS}-a cognitive assessment), dated, December 09, 2024, indicated a score of 12 (mildly cognitively impaired). A review of Resident 3 ' s, Admission Fall Risk Assessment, dated, December 7, 2025, at 5:06 p.m., indicated, resident was assessed as a fall risk. A review of Resident 3 ' s, Care Plans, indicated, a falls risk care plan (An individualized plan of care for specific healthcare needs) with safety interventions was not initiated. On December 26, 2024, at 4:40 p.m., a concurrent record review of Resident 3 ' s Admission Fall Risk Assessment, dated, December 7, 2024, care plans and an interview with the Director of Nursing (DON) were conducted. The DON stated when a resident is assessed as a fall risk, fall precaution interventions are initiated to help prevent falls. The DON stated that fall precaution interventions are individualized and may include keeping the resident's door open, performing frequent checks, ensuring the call lgiht is always within reach, keeping the bed in the lowest position, placing floor mats on both sides of the bed , and/or using bed alarms. The DON further stated, Resident 3 was assessed as a fall risk during admission to the facility, but a fall risk care plan or additional interventions to prevent falls were not initiated. A review of Resident 3 ' s, Doctor ' s (Drs) orders, indicated, - December 7, 2024, at 9:45 p.m., Wear C-collar (Neck Brace) at all times . for (neck fracture) ., - December 7, 2024, at 11:31 a.m., . PT (Physical Therapy) eval (Evaluation) . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3 ' s PT Evaluation, dated December 9, 2024, untimed, indicated, . Current Referral . (Resident 3 referred to PT in order to address unsteadiness on feet, weakness, difficulty walking, decline in functional mobility . impaired balance and safety . Risk Factors: Due to documented physical impairments and associated functional deficits (Resident 3) is at risk for: . falls . A review of Resident 3 ' s, Change of Condition ({COC}-deviation from resident ' s baseline health conditions), by Registered Nurse (RN) 1, dated, December 17, 2024, at 11:55 p.m., indicated, . (Resident 3) was found sitting down on the floor in her room, she states she got up to (turn) off the light and saw something on the floor she reached down to pick (up item) and when she stood up lost her balance fell (to the) floor on her buttock then she fell backwards and hit her head . back of (Resident 3) head has a lump and some scant bleeding . A review of Resident 3 ' s, Progress Notes, dated, December 18, 2025, indicated, .Pt (Resident 3) was transferred out via 911 .pt found sitting on the flood .When she (Resident 3) stood up she lost her balance and fell back on the floor, she states she hit her head .911 was called she was transferred out at 2340 (11:40 p.m. December 17, 2024)) .(Resident Representative) states she asked 2 (two) nurses, to put an alarm on the patient (Resident 3) because she (Resident Representative) noticed pt (Resident 3) had started to become more active within the room . A review of GACH, CT ({Computed Tomography}-detailed images) (of) Head, dated December 18, 2024, at 1:37 a.m., indicated, . Impressions: 1. Small right posterior parietal-occipital scalp hematoma (collection of blood located in the middle of the back of the brain) . On December 30, 2024, at 7:32 a.m., an interview was conducted with RN 1. RN 1 stated, when a resident is identified a fall risk, individualized fall precaution interventions are initiated, such as, keeping the resident ' s door open, positioning the bed close to the floor, placing landing pads (floor mats) on both side of the bed, and/or using bed alarms. RN 1 stated, she was the assigned nurse to Resident 3, on the night the resident fell , December 17, 2024. RN 1 stated, during shift report, nurses communicate which residents are considered fall risks. RN 1 stated, she was not informed by the off going nurse that Resident 3 was a fall risk. RN 1 stated, Resident 3 did not have fall risk interventions in place to help prevent resident from falling. RN 1 stated, she found Resident 3 ' s bed not in the low position, no landing pads, and no bed alarm. RN 1 further stated, after the fall, she contacted Resident 3 ' s representative, who informed her they (resident ' s representative) had previously requested the Licensed Vocational Nurse (LVN) 3, to place a bed alarm on Resident 3 ' s bed because the resident had been moving around more. On December 30, 2024, at 2:14 p.m., an interview was conducted with LVN 3, who stated, bed alarms are used for resident ' s who are fall risks. LVN 3 stated, bed alarm sounds an alert if the resident is trying to get out of bed without assistance. LVN 3 stated, if a resident representative requested a bed alarm for the resident ' s safety, she would contact the resident ' s doctor to get an order, notify the resident and/or representative. LVN 3 stated, Resident 3 ' s representative had requested a bed alarm for the resident ' s bed prior to the fall on December 17, 2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 3 stated, she did not inform the physician to request a bed alarm, nor did she place a bed alarm on Resident 3 ' s bed for safety. LVN 3 further stated, she should have asked the doctor, and it could have avoided Resident 3 ' s fall. A review of Resident 3 ' s, Post-Fall Review, by the Interdisciplinary Team ({IDT}-Department heads), dated, December 20, 2024, untimed, indicated, . Immediate Action taken (Fall risk intervention implemented): Bed Alarm/pressure alarm in place (placed on Resident 3 ' s bed) . On December 30, 2024, at 4:15 p.m., an interview was conducted with the DON, who stated, bed alarms are used for the safety of resident ' s who are fall risks, unsteady on their feet, have difficulties using call lights, or may require additional nursing assistance. The DON stated, she had learned about the conversation between LVN 3 and Resident 3 ' s representative, who had requested a bed alarm for the resident as the resident was not using the call light. DON stated, LVN 3 did not handle the situation correctly, as LVN 3 should have notified Resident 3 ' s doctor of the resident representative ' s request for a bed alarm as a fall precaution intervention. A facility Policy & Procedure (P&P), titled, Fall Risk Assessment, undated, indicated, . 6. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls . 7. The staff with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, activities of daily living (ADL) capabilities, activity tolerance, continence, and cognition . 9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable . 2. A review of Resident 2 ' s medical records titled, Resident information, dated, January 2, 2025, indicated, resident was admitted to the facility on [DATE], with a diagnosis of hemiplegia and hemiparesis (weakness or paralysis on one side of the body), and a BIMS score of 00 (Severe cognitive impairment). A review of Resident 2 ' s, care plan dated April 4, 2019, indicated, .Resident is High risk for falls (related to) . incontinence . poor safety .Interventions . resident uses chair/bed electric alarm. Ensure the (alarm) is in place as needed . On December 30, 2024, at 4:15 p.m., an interview was conducted with the DON, who stated, bed alarms were used as a fall risk intervention to ensure safety of residents who had difficulty using the call light. The DON stated, the bed alarm alerted staff when a resident was attempting to get out of bed. On December 30, 2024, at 4:40 p.m., a concurrent observation of Resident 2, and interviews with LVN 2 and the Director of Nursing (DON) were conducted. LVN 2 stated, his process when checking on assigned residents was to ensure the bed alarm was in place, turned on, and properly attached to the resident. LVN 2 stated that bed alarms were attached to a resident's clothing via a small metal clip on a string. LVN 2 stated, when a bed alarm was in use, if the resident attempted to get out of bed, the string would detach from the alarm, causing it to sound. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the observation, Resident 2 was lying in bed on her back, with her eyes closed, and did not respond to verbal cues or conversation. A bed alarm was observed attached to the upper right bed rail via a Velcro strap. A string extended from the alarm under the right side of Resident 2 ' s pillow. LVN 2 followed the alarm string, and pulled it out from under the resident ' s pillow, revealing the alarm was not attached to the resident. LVN 2 verified, the bed alarm was not attached to the resident. LVN 2 stated, the bed alarm should be attached to Resident 2. LVN 2 further stated, Sometimes the CNA forgets to re-attach (the alarm to the resident). During a concurrent interview with the DON, the DON verified, Resident 2 ' s bed alarm string was under the right side of resident ' s pillow, and not attached to the resident. DON stated, the alarm should be attached to Resident 2. On December 30, 2024, at 4:55 p.m., an interview was conducted with CNA 2, who stated, her process to ensure the alarm was on and attached to the resident was to check the alarm and its placement before leaving the resident ' s room. CNA 2 stated, she was in Resident 2 ' s room, not too long ago and had changed the resident ' s shirt. CNA 2 further stated, she saw the bed alarm to the right of the resident ' s head and thought it was connected but did not confirm. CNA verified, she did not check Resident 2 ' s bed alarm to ensure it was on and properly attached before leaving the room. On December 30, 2024, at 5:05 p.m., an interview was conducted with the DON, who stated, she was disappointed Resident 2 ' s bed alarm was not attached to the resident. The DON stated, her expectation was for staff to check and ensure resident's bed alarms were attached and turned on when entering and exiting resident rooms. On January 3, 2025, at 1:33 p.m., an interview was conducted with the Administrator, who stated, the facility does not have a policy & procedure in place for the use of bed alarms. A facility Policy & Procedure (P&P), titled, Fall Risk Assessment, undated, indicated, . 6. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls . 7. The staff with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, activities of daily living (ADL) capabilities, activity tolerance, continence, and cognition . 9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable .