

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 01/16/2026
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 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** Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to one of three residents reviewed for accidents (Resident 1), who was wheelchair bound and cognitively impaired. Resident 1 was left unsupervised while outside the facility. In addition, there was no interventions developed by the facility to address the resident who was at risk for injury and accidents due to impaired cognition. This failure resulted in Resident 1 being hit by a moving vehicle while out in the parking lot of the facility, which has the potential to cause pain or injury to Resident 1. Findings: On January 12, 2026, at 10:51 a.m., an unannounced visit was conducted at the facility to investigate a complaint and facility reported incident involving an accident. On January 12, 2026, at 10:51 a.m., during an observation of the facility parking lot, front patio, and front entrance, the following were observed: a. The facility had a large parking lot with a smooth surface that connected directly to a u-shaped driveway and the facility entrance. b. There was no observed caution signage, patio seating, or safety barrier for pedestrians due to expected vehicle traffic on the u-shaped driveway near the facility entrance. c. The facility entrance had an automatic sliding door. d. Upon entering, the lobby was clean with seating available. The receptionist sat behind a desk with a tall countertop that had a box of facial masks and signage, obstructing the view of the entrance. On January 12, 2026, Resident 1's medical record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (one-sided body weakness resulting in brain damage after a stroke). A review of the care plans for Resident 1 did not indicate interventions addressing the resident's risk for injury related to impaired cognition. A review of Resident 1's Minimum Data Set (MDS- an assessment tool), dated November 10, 2025, indicated Resident 1 had a BIMS (Brief Interview of Mental Status- a cognitive assessment tool) score of 9 (moderate cognitive impairment). A review of Resident 1's eINTERACT Change in Condition Evaluation, dated January 2, 2026, indicated, .resident was hit by a SUV [sport utility vehicle - a larger car that sits higher off the ground than most regular cars] outside facility in the parking lot while she was propelling her wheelchair .But resident keeps on stating to feel left elbow discomfort .A review of Resident 1's COC (Change of Condition)/INTERACT ASSESSMENT FORM, dated January 2, 2026, at 1:49 p.m., indicated, .resident was propelling herself .outside left side parking lot .white little suv was backing out .resident was behind the vehicle .driver did not see resident .sitting in her wheelchair .hit resident on the left side of the wheelchair .resident was yelling .to stop the car .one eyewitness was honking .to stop the car .other witness ran .alerted the driver .MD (medical doctor) advice to send resident to ER (emergency room) .eval (evaluation) and treatment .A review of the hospital document titled Summary of Care Document, dated January 2, 2026, indicated .Encounter Diagnoses .pain in left elbow .On January 12, 2026, at 2:38 p.m., an interview was conducted with LVN (Licensed Vocational Nurse) 1. LVN 1 stated Resident 1</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555247
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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>was oriented to self and place but not oriented to the situation. LVN 1 stated Resident 1 required increased supervision due to impaired judgement. LVN 1 stated residents were allowed in the activities room and dining room; and could go to the front or back patios only with supervision. LVN 1 stated all residents that sit outside on front patio should be supervised. LVN 1 stated Resident 1 should not have been on front patio unsupervised or alone due to impaired judgement and wandering risk. On January 12, 2026, at 4:14 p.m., an interview with concurrent record review of Resident 1's MDS dated [DATE], was conducted with the Director of Nursing (DON). The DON stated Resident 1's BIMS score indicated cognitive impairment. The DON stated the resident (Resident 1) should have been supervised while outside. On January 15, 2026, at 2:38 p.m., an interview was conducted with the DON. The DON stated the facility did not have staff or patrol assigned to monitor the facility exits or parking lot. The DON stated the facility exit doors did not have alarms. The DON stated there were no facility policy for resident designated areas. On January 15, 2026, at 3:35 p.m., LVN 2 stated in an interview that residents could access the back patio without restrictions unless the weather was unsafe. LVN 2 stated the facility door was unlocked and accessible 24/7. LVN 2 stated residents with cognitive impairment required supervision on the back patio and were only allowed on the front patio if accompanied by a CNA, licensed nurse, caregiver, or family member, to ensure safety. On January 16, 2026, at 12:22 p.m., an interview was conducted with Certified Nurse Assistant (CNA) 1. The CNA stated a resident with cognitive impairment cannot be in front of facility or parking lot without supervision. On January 16, 2026, at 1:45 p.m., an interview was conducted with the receptionist. She reported that on January 2, 2026, Resident 1 requested candy at her desk, then exited to the front patio unsupervised. The facility exit doors open automatically by sensor motion. She stated that monitoring and supervising residents was not part of her responsibilities. On January 16, 2026, at 3:41 p.m., an interview was conducted with Certified Occupational Therapist Assistant (COTA). The COTA stated Resident 1 was not ambulatory and required 1 person assist for transfers. The COTA stated a resident with cognitive impairment should not be outside of the facility without supervision. The COTA stated the incident could have been prevented by the facility.</p>		