

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/20/2026
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)		
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 observation, interview, and record review for one of three residents reviewed for quality of care (Resident 1), the facility failed to ensure:1. An appropriate assessment and evaluation were conducted prior to obtaining an order for Lorazepam (generic name for Ativan, a medication used to treat anxiety) as needed (PRN) for 14 days on June 21, 2026; and2. An appropriate assessment, monitoring, and evaluation were conducted prior to obtaining an order for Lorazepam 0.5 milligram (mg- unit of measurement) give one tablet by mouth every 12 hours for anxiety manifested by striking out, on July 6, 2021. This failure placed Resident 1 at high risk for unnecessary medication use without proper assessment. Findings:1. On July 16, 2026, at 9:10 a.m., an observation with concurrent interview was conducted with Resident 1. Resident 1 was in bed, alert, interviewable, and appeared to be confused. Resident 1 was observed with multiple fading purplish yellow skin discolorations, variable in size, on the left side of the forehead, left and right inner periorbital area (area surrounding the eyes), bridge of nose, both arms and anterior hands. Resident 1 stated she did not know how she got her skin discolorations. On July 16, 2026, at 9:45 am, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated Resident 1 was confused, exhibits combative behavior during care, and sometimes physically strikes staff. On July 20, 2026, at 2:18 p.m., a record review with a concurrent interview was conducted with Registered Nurse (RN) 1. Resident 1 was admitted to the facility on [DATE], with diagnoses including anxiety. The document titled, HISTORY AND PHYSICAL, dated January 26, 2026, indicated Resident 1 did not have the capacity to understand and make decisions. The physician's order indicated to give Lorazepam 0.5 mg to give one tablet by mouth every 12 hours as needed for anxiety for 14 days (ordered June 21, 2026, and discontinued July 5, 2026). The PRN Lorazepam order did not specify a target behavior for its use. In addition, there was no documented assessment or evaluation conducted by the Licensed Nurse (LN) and/or physician, to justify the use of PRN Lorazepam for Resident 1, and there was no documentation explaining why the LN obtained the PRN lorazepam order on June 21, 2026. In a concurrent interview, RN 1 stated the LN who carried out the order for the PRN Lorazepam 0.5 mg for anxiety for 14 days, on June 21, 2026, did not document the reason why the order was obtained and there was no documentation of an assessment or evaluation conducted prior to obtaining the order. RN 1 stated the PRN Lorazepam did not indicate a specific target behavior for use. RN 1 stated there should have been documentation by the licensed nurse why the Lorazepam PRN order was obtained and carried out. 2. On July 16, 2026, at 9:32 a.m., Certified Nursing Assistant (CNA) 1 was interviewed. CNA 1 stated Resident 1 was confused, exhibits combative behavior during care, and sometimes physically strikes staff. On July 20, 2026, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses including anxiety. The document titled, HISTORY AND PHYSICAL, dated January 26, 2026, (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 1 did not have the capacity to understand and make decisions.The CNA ADL (Assisted Daily Living) notes indicated: (Name of Resident).7/5/2026 19:59.increasingly agitated and extremely combative, hitting, scratching, biting, kicking, when performing care, 4 eyes/2 people are strongly recommended for Pt (abbreviation to indicate 'patient') and staff safety.06/24/2026 21:47.Resident was being combative, which made it really hard to take blood pressure tried more than 6x throughout the day.06/24/2026 11:44.Pt was showing signs of agitation, was punching, biting (sic.) and kicking CNAs nurse informed.There was no documented evidence Resident 1's combative behavior identified on June 24, 2026, and July 5, 2026, were reported, monitored, and/or addressed by the Licensed Nurse (LN).Resident 1 had the following physician's orders:- Lorazepam 0.5 milligrams (mg- unit of measurement) give one tablet by mouth every 12 hours as needed for anxiety for 14 days, ordered June 21, 2026, and discontinued July 5, 2026;- Lorazepam 0.5 mg give one tablet by mouth every 12 hours for anxiety manifested by striking out, ordered July 6, 2026;- Monitor episodes of anxiety manifested by striking out, ordered July 6, 2026;- .Intervention(s) that best works to alleviate behavior. Key: 0-No intervention attempted.2-Redirect 3- Remove from situation/Ensure resident Safety 4- Calm Environment.12-Resident refused. Every shift for intervention Document the corresponding number of interventions attempted. Document effectiveness of interventions. ordered December 1, 2025; and,- Monitor anxiety manifested by inability to relax, ordered December 2, 2025, and discontinued July 6, 2026.The document titled, Care Plan Report, dated November 9, 2022, indicated, .Behavioral symptoms.physically abusive hitting, striking out, grabs, scratches.resists care: hits out, yells and kicks.R/T (related to) Dementia.Interventions.Assess for pain. Provide interventions as deemed necessary.attempt to determine the cause of upset and resolve if possible.monitor behavior q shift and record. Notify MD (Medical Doctor) if behavior interferes with functioning.Nursing staff to leave resident when combative and return when she is calm to provide care.The document titled, Care Plan Report, dated September 9, 2022, indicated, .Focus.The resident uses anti-anxiety medications Lorazepam 0.5mg by mouth two times a day for anxiety M/B (manifest by) striking out r/t anxiety disorder.Intervention.Monitor/record occurrence of for target behavior symptoms.Specify.violence/aggression towards staff/others. and document per facility protocol.The electronic medication Administration Record (eMAR) dated July 1 to 31, 2026, indicated the following:- The PRN Lorazepam order to give 0.5 mg by mouth every 12 hours as needed for anxiety was administered to Resident 1 on the following dates:- July 1, 2026, at 12:49 pm;- July 2, 2026, at 5:28 p.m.:- July 3, 2026, at 3:07 p.m.; and- July 4, 2026, at 8:19 a.m., and 8:57 p.m.The eMAR did not indicate the target behavior intended for the PRN Lorazepam use prior to administering the medication on those dates;- Resident 1 had two episodes of anxiety manifested by inability to relax (July 3 and 4, 2026) during the period from July 1 to 6, 2026;- There were no non-pharmacological interventions attempted or offered to Resident 1 to address the anxiety behaviors from July 1 to 6, 2026; and-The monitoring of Resident 1 for aggressive or combative behavior did not begin until July 6, 2026.The document titled, MONTHLY PSYCHOTROPIC SUMMARY, indicated Resident 1 had 25 episodes of inability to relax behavior for the month of June 2026. The document did not indicate Resident 1 was being monitored for combative or striking out behavior for the month of June 2026.The document titled, .Change in Condition Evaluation. completed by LVN 1 and dated July 6, 2026, indicated, .Signs and Symptoms Identified.Multiple discolorations to face and to bilateral upper extremities. Increased combativeness.This condition, symptom or sign has occurred before.Unknown.Mental Status Evaluation.No changes observed.Date and time of clinician notification.07/06/26 12:50.Recommendation of Primary Clinician.new order for Ativan (brand name for Lorazepam).Is the behavioral assessment relevant to the change in condition been reported .Not clinically applicable to (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the change in condition being reported.Describe behavioral changes: (no entered response by LVN 1).Is the resident/patient displaying any of the following signs and symptoms? (No entered response by LVN 1) . The Change of Condition Evaluation notes did not indicate an assessment, monitoring, or evaluation conducted to address Resident 1's combative and striking out behavior from July 1 to 6, 2026, prior to obtaining the order for Lorazepam 0.5 mg by mouth every 12 hours for anxiety manifested by striking out on July 6, 2026.On July 16, 2026, at 1:25 p.m., an interview with a concurrent record review was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated:- Resident 1's previous Lorazepam order was .Lorazepam.Give 0.5 mg by mouth every 12 hours as needed for anxiety . ordered June 21, 2026, and discontinued July 5, 2026;- On July 5, 2026, Resident 1 had an incident of increased combative behavior with staff. LVN 1 notified the physician on July 6, 2026 and received an order for routine Lorazepam 0.5 mg orally every 12 hours for anxiety with striking out.- He did not see a recorded or documented increased combative or striking out behavior documentation in Resident 1's record prior to obtaining the routine Lorazepam order on July 6, 2026;- The licensed nurses should have documented, monitored, assessed, evaluated, and determined the cause of the increased combative and striking out behavior prior to obtaining the routine Lorazepam order on July 6, 2026; and- There was no adequate monitoring and evaluation conducted on Resident 1's increased combative and striking out behavior prior to obtaining the routine Lorazepam order on July 6, 2026.The facility's policy and procedure titled, Psychotropic Medication Use, dated July 2022, indicated, .Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying cause.Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications.Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.For psychotropics that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.Resident Evaluations.Situations which may prompt an evaluation or re-evaluation of the resident include.a new, persistent, or recurrent clinically significant symptom or problem.a worsening of an existing problem or condition.The evaluation may include.an evaluation of resident status (co-morbid conditions, symptoms, psychiatric diagnosis, etc.).resident goals and preferences.history or medication use.When determining whether to initiate, modify, or discontinue medication therapy, the IDT (Inter Disciplinary Team) conducts an evaluation of the resident. The evaluation will attempt to clarify whether.other causes for symptoms (including symptoms that mimic psychiatric disorder have been ruled out.signs and symptoms are clinically significant to warrant medication therapy.		

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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** Based on observation, interview, and record review, the facility failed to ensure the licensed nurse appropriately assessed and monitored the combative behavior incident resulting in multiple areas of skin discoloration for one of three residents evaluated for quality of care (Resident 1). In addition, the licensed nurse did not promptly inform the physician or responsible party after Resident 1's combative incident identified on July 5, 2026. This failure placed Resident 1 at risk for delayed medical intervention and increased the likelihood of complications related to the combative incident. On July 16, 2026, an unannounced visit was conducted at the facility to investigate a complaint about lack of notification regarding an incident involving Resident 1. On July 16, 2026, at 9:10 a.m., an observation with a concurrent interview was conducted with Resident 1. Resident 1 was in bed, alert, interviewable, and appeared confused. Resident 1 was observed with fading purplish yellow skin discolorations, variable in size, on the left side of the forehead, left and right inner periorbital area (area surrounding the eyes), bridge of nose, both arms and anterior hands. Resident 1 stated she did not know how she got her skin discolorations. On July 16, 2026, at 9:45 am, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated he was assigned to Resident 1 on the morning shift of July 6, 2026. CNA 1 stated he noticed the multiple skin discolorations on Resident 1's face and arms and informed both the night and morning Licensed Nurses (LN) between 7:00 am and 8:00 am that day. CNA 1 stated he did not know what happened to Resident 1 since he did not receive a report from the night shift of any incident involving Resident 1. On July 16, 2026, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses including dementia (memory loss). The Nursing Progress Notes, completed by a LN, dated July 6, 2026, 9:22 a.m., indicated, .This writer was called by the charge nurse to assess discoloration to arms for resident. During assessment notes skin discoloration to nose bridge that extend to bilateral inner canthus (the area around the eye next to the nose) of the eye and left temporal site. There is multiple skin discoloration to upper extremities with different marks to skin. Advise calling the nurses from previous shift to ask if resident had a behavior of aggressiveness due to previous history. The Nursing Progress, completed by Licensed Vocational Nurse (LVN) 1, dated July 6, 2026, at 11:31 a.m., indicated, .Situation: The Change in Condition/s reported on this CIC Evaluation are/were: Other change in condition. Outcomes of Physical assessment .Mental Status Evaluation: No changes observed. Functional Status Evaluation: No changes observed: Behavioral Status Evaluation (No response entered by LVN 1). Neurological Status Evaluation (No response entered by LVN 1). Primary Care Provider Feedback. Recommendations: New order for Ativan (medication used to treat anxiety). The ADL (Assisted Daily Living) CNA notes, completed by CNA 2, dated July 5, 2026, at 7:59 p.m., indicated, After Dinner, brief change, pt (patient) became increasingly agitated and extremely combative, hitting, scratching, biting, kicking, when performing care, 4 eyes/2 people are strongly recommended for pt and staff safety. The Nursing Progress notes for the evening shift on July 5, 2026, did not indicate that an incident was reported by CNA 2 and/or that a LN conducted an assessment following Resident 1's combative and striking behavior toward CNA 2 during care. Furthermore, there is no indication in the record that the physician or Resident 1's responsible party were notified of Resident 1's combative incident prior to July 6, 2026. On July 16, 2026, at 2:02 pm, an interview was conducted with LVN 1. LVN 1 stated:- She was the licensed nurse assigned to Resident 1 on July 6, 2026, during the morning shift;- CNA 1 reported to her during change of shift that Resident 1 had multiple discolorations on her face and bilateral arms around between 7:00 a.m. to 8 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m.; - She asked the night shift LN what happened to Resident 1 during their shift and the night shift LN told her she did not know; - She and the night shift LN checked Resident 1, but neither knew what happened or received an incident report for the previous day's event (July 5, 2026);- Resident 1 had a behavior of striking out and combative during care; - Resident 1's physician was not notified of the combative incident that occurred on July 5, 2026, until she reported to the physician on July 6, 2026.On July 20, 2026, at 2:18 p.m., an interview with a concurrent record review on Resident 1's CNA ADL notes was conducted with Registered Nurse (RN) 1 and LVN 2. Bothe RN 1 and LVN 2 stated:- CNA 2 documented on Resident 1's ADL notes on July 5, 2026, at 7:59 p.m., that Resident 1 was, .increasingly agitated and extremely combative, hitting, scratching, biting, kicking, when performing care.;- CNA 2 did not indicate if the LN was notified of Resident 1's combative behavior and there was no documentation CNA 2 notified the LN about Resident 1's combative behavior on July 5, 2026, at 7:59 p.m; and- There was no documentation from the LN on July 5, 2026, during the p.m. shift, that Resident 1 was reported combative during the care with CNA 2, and/or the LN assessed, evaluated the resident, and notified the physician and family. On July 20, 2026, at 2:40 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated:- Resident 1 had a history of combative behavior and striking out. Resident 1 had an incident of combative behavior with CNA 2 on July 5, 2026, during the p.m. shift;- Resident 1's hands can be everywhere when she gets combative. She hits, spits, and kicks and her skin discolorations may have been caused by that;- The LN, LVN 3, assigned to Resident 1 during that shift should have reported to the physician and notified Resident 1's family of her combative and striking out behavior on July 5, 2026, during the p.m., shift;- LVN 3 should have documented what had happened and started a Change in Condition (COC) monitoring on Resident 1 during her shift on July 5, 2026. The facility's policy and procedure titled, Resident Examination and Assessment, dated December 2011, indicated, .The purpose of this procedure is to examine and assess the resident for any abnormalities in health status.Review the resident's admission assessment and/or preliminary care plan to assess for any special situations regarding resident care.Examine and note the following.Vital Signs.Cardiovascular.Respiratory.Neurological.Musculoskeletal.Skin.Activity Level.Psychiatric/Behavioral.oriented to time, place, person.affect.attention span.appropriate response to questions.combativeness.Pain.The following information should be recorded in the resident's medical record.The date and time the procedure was performed.The name and title of individual (s) who performed the procedure.All assessment data obtained during the procedure.Reporting.Notify the physician of any abnormalities such as, but not limited to.change in cognitive, behavioral or neurological status from baseline.Report other information in accordance with the facility policy and professional standards of practice.The facility's policy and procedure titled, Change in a Resident's Condition or Status, dated April 2011, indicated, .Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) or changes in the resident's medical/mental condition.The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.		