STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555339	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Springs Post Acute	74-350 Country Club Drive Palm Desert, CA 92260

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 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** 46145 Based on observation, interview, and record review, the facility failed to ensure effectiveness of interventions to address multiple falls were evaluated and provide new interventions to prevent further falls, for one of three residents (Resident 1). This failure had the potential for Resident 1 to experience further falls and sustain serious injury from repeated unwitnessed falls. Findings: On January 28, 2025, at 10 a.m., an unannounced visit to the facility was made for a quality of care issue. On January 28, 2025, at 2:12 p.m., a concurrent observation and interview of Resident 1 was conducted. Resident 1 was observed resting in a low bed with blue padded mats at both sides of the bed. Bed alarm (alerts staff when resident ' s getting out of bed-{OOB}) was observed attached to the bed and a motion pad (alarms when body pressure is lifted from pad) located underneath Resident 1. Resident 1 stated she had three recent falls but could not remember the dates. Resident 1 stated she fell because, I try to do things myself, then I end up falling. On January 28, 2025, a review of Resident 1 ' s Admission Record, indicated Resident 1 was admitted to the facility, on April 29, 2024, under hospice care (end-of-life care) with a diagnosis of chronic obstructive pulmonary disease (COPD -a group of lung diseases that cause breathing problems), and a history of falls. A review of Resident 1 ' s, Minimum Data Set (MDS - a resident assessment tool), dated December 25, 2024, indicated Resident 1 had a Brief Interview for Mental Status (BIMS -a mental acuity assessment) score of 11 (moderate cognitive impairment). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 29, 2025, at 12 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the nursing staff would document a Nurses Note, and/or complete a Change of Condition (COC - deviation from baseline mental, physical, psychosocial health) after a resident falls. The DON stated the Interdisciplinary Team (IDT - a group of healthcare professional) would meet the next day to determine the root cause of the fall, re-evaluate fall interventions, initiate new fall interventions (to help prevent future falls), update the resident ' s care plan with new interventions, and complete an IDT Fall note; would notify the physician of the fall and obtain fall interventions from the physician. The DON further stated fall interventions used to help prevent falls could include: keeping the call light within resident ' s reach, re-orient to the use of the call light, keep bed in low position with wheels locked, move the resident to a room closer to the nursing station for increased observation, ensure resident wears non-skid socks to help prevent slipping, padded floor mats on one or both sides of the bed; the use of bed alarms (alert staff when resident is getting OOB); and sitters. The DON stated interventions should be elevated and initiated, after each fall, to help prevent future falls. A concurrent interview and record was conducted with the DON regarding Resident 1's fall incidents. The DON stated the following interventions were initiated in the care plan for Resident 1 due to multiple falls in January 2025 (January 1, 10, 14, 15, 21, and 24, 2025): - Keep call light within reach; Educate/remind resident to call for assistance with all transfers; (date initiated: April 19, 2024); - Keep bed in low position with brakes locked; use bed alarm to alert staff that patient is getting OOB; Keep within supervised view as much as possible; (date initiated: October 20, 2024); - Provide proper, well-maintained footwear as indicated; Safety devices as ordered (date initiated January 16, 2025); The DON stated the following Progress Notes, indicated seven fall incidents for Resident 1, for January 2025 (January 1, 11, 14, 15, 21, 24, and 27, 2025), on the following dates and times: - January 1, 2025, at 2:25 p.m., indicated, . (Resident 1) has an unwitnessed fall at 11:25 a.m . bed is in lowest position .; - January 1, 2025, at 2:29 p.m., indicated, .Pt's (Resident 1) bed found broken after recent fall resulting to being tilted to the left side which may have contrinuted to the pt's fall, who fell on the left side of the bed towards the bathroom .Maintenance fixed bed .; - January 1, 2025, at 5:16 p.m., indicated, .Pt had a fall as she was trying to sit up on the [NAME] of the bed .; - January 2, 2025, at 11:36 a.m., indicated, .IDT .Patient had an unwitnessed fall 1/1/25 (January 1, 2025) around 1118 (11:18 a.m.), per report patient found by staff on the floor on the left side of the bed upon assessment the bed frame was missing screws .fall intervention; January 6, 2025, note indicated, Prior Interventions: Anticipate and meet needs; Keep bed in low position with brakes locked; use bed alarm to alert staff that patient is getting OOB; keep call light within reach. Current Intervention(s): use bed alarm to alert staff that patient is getting OOB; Medication regimen review as indicated; Educate/remind resident to call for assistance with all transfers .; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- January 11, 2025, at, 11:41 p.m., indicated, COC Fall .Lethargic .Recommendations: Hourly Rounding (Checking on resident); Landing (floor) Mat Provided; Bed Alarm Applied, Low Bed Locked .no new orders .; - January 14, 2025, untimed, Post Fall Rehabilitation (Rehab) Screen, indicated, . Comments .monitor positioning in the middle of the bed; consider wide bed . Information reported to IDT on (January 13, 2025) . - January 14, 2025, at 10:04 p.m., indicated, .Alerted by CNA (Certified Nursing Assistant) that patient was found on floor at 21:15 (9:15 p.m.) on the left side of the bed. Pt noted to be sitting on floor with legs folded .; - January 15, 2025, at 11:06 p.m., indicated, .around 2225 (10:25 p.m.), LLVN (sic Licensed Vocational Nurse) was doing rounds and seen pt sittin on her floor mat, when asked what happened, resident stated that she was trying to get up to get water because her throat was so dry .; - January 16, 2025, at 8:15 a.m., indicated, .IDT .Patient was found on her side, lying on a landing mat, her legs were bent and hands on her head, patient was not able to recall the incident .current intervention(s) . Keep within supervisde view as much as possible . - January 21, 2025, at 1:23 p.m., indicated, .The nurse was called into patients room by assigned CNA, Pt was on the left side of her bed laying on her right side on the floor matt . - January 22, 2025, at 3:19 p.m., indicated, .IDT .patient was found laying on the floor mat . There was no new interventions recommended by the IDT to address multiple repeated falls; - January 24, 2025, at 11:37 p.m., indicated, .Bed alarm heard, staff arrived to patient's room to find patient on the floor laying on left side. Small skin tear to left arm noticed .; and - January 27, 2025, at 10:05 a.m., indicated, .patient was found laying on the floor on left side, patient sustained a small skin tear to left arm . There was no new interventions recommended by the IDT to address the repeat fall. The DON stated resident fall interventions are individualized to each resident ' s care needs. The DON verified Resident 1 had an unwitnessed fall on January 1, 2025, and the IDT met on January 2, 2025, to review the fall, and re-evaluate fall interventions. The DON verified Resident 1 had a history of confusion, and not compliant with using her call light to ask for staff ' s assistance, prior to getting OOB. The DON stated Resident 1 ' s re-evaluated fall interventions were, the use of a bed alarm, and a padded floor mat on left side of bed. The DON stated a right sided floor mat was added as an additional fall intervention. The DON verified, a bed alarm and left floor mat did not prevent Resident 1 from having an unwitnessed fall on January 1, 2025, and adding a floor mat on the right side of Resident 1 ' s bed may not prevent a fall in the future. The DON further stated a sitter, is an elevated fall intervention that could have helped prevent Resident 1 from future falls. The DON verified the use of a sitter was not evaluated or initiated, by the IDT, as a fall intervention for Resident 1. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated Resident 1 had multiple repeat falls and recommendations for Hourly rounding, could help anticipate resident ' s needs, but may not help resident from falling out of bed, as resident had confusion while awake and was not compliant with use of the call light for assistance from staff. The DON verified the recommended interventions of a bed alarm, low bed with locked position, were prior initiated fall interventions, were not effective and Resident 1 continued to fall despite interventions initiated. The DON stated she was aware and agreed with rehab ' s recommendation for Resident 1 to have a wider bed, to help prevent resident from rolling OOB. The DON stated she requested a bigger bed from hospice agency on January 27, 2025 (13 days after rehab recommended on January 14, 2025) and still waiting for approval. The DON further stated a sitter, is an elevated fall intervention that could help prevent Resident 1 from future falls, as resident was confused, and non-compliant with the use of the call light. The DON verified a sitter was not added to Resident 1 ' s plan of care. The DON further stated Resident 1 ' s, representative had expressed concerns about resident falling OOB, and provided a private sitter, to stay over nights with resident, on the dates of January 17, and 18, 2025. The DON stated Resident 1 ' s representative could not afford to provide a private sitter, past the date of January 18, 2025, and the sitter was canceled. The DON verified hiring a private sitter was not the resident ' s representative ' s responsibility. The DON stated it is the facility's responsibility to ensure Resident 1 was safe, and the facility's responsibility to provide a sitter. The DON verified the sitter was an effective fall intervention, as Resident 1 did not have any falls, while being monitored by the sitter. The DON verified the IDT did not re-evaluate the fall intervention of adding a sitter, after the dates of January 17 and 18, 2025. The DON further stated the facility probably should have offered to get Resident 1 a sitter to monitor for safety from falls. On January 30, 2025, at 3:57 p.m., an interview was conducted with the Hospice Nurse (HN). The HN stated she assessed Resident 1 on January 17, 2025, due to the resident ' s history of repeated unwitnessed falls. The HN stated she had discussed with the DON the possibility of facility providing a sitter, for Resident 1 ' s safety, and the DON told her the facility could not provide a sitter. The HN stated she convinced Resident 1's representatives to provide a private (representative provided and paid for) sitter, to supervise resident at bedside. (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 the facility's policy and procedure titled, Falls and Fall Risk, Managing, revised on March 2018, indicated, . Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .Fall Risk Factors . Resident conditions that may contribute to the risk of falls include .delirium and other cognitive impairment .Medical factors that contribute to the risk of falls include .neurological disorders; and e. balance and gait disorders; etc .Resident-Centered Approaches to Managing Falls and Fall Risks .The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls .If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant .In conjunction with the attending physician, staff will identify and implement relevant interventions .to try to minimize serious consequences of falling .Monitoring Subsequent Falls and Fall Risk .The staff will monitor and document each resident ' s response to interventions intended to reduce falling or the risk of falling .If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified .