

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Desert Springs Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000</p> <p>Based on observation, interview, and record review, the facility failed to ensure preferences were honored, for one of four residents (Resident 1), when the facility staff used bleach to clean her room despite Resident 1's request not to use bleach when disinfecting her room while she was inside the room.</p> <p>This failure resulted to Resident 1's preference not honored and could affect the resident's overall psychosocial well being.</p> <p>Findings:</p> <p>On March 14, 2025, at 10:40 a.m., an unannounced visit was made to the facility to investigate a complaint on physical environment.</p> <p>On March 14, 2025, at 12:39 p.m., during an interview conducted with Housekeeper (HK) 1, she stated she would clean the residents' rooms daily with several cleaning products, including bleach. HK 1 stated approximately 1 month prior, Resident 1 requested her not to clean her bedroom with any chemicals that smell like bleach, because the resident did not like the smell, and it made her cough. HK 1 stated she informed her supervisor of Resident 1 ' s request and did not use bleach in Resident 1's room since then.</p> <p>On March 14, 2025, at 1:19 p.m., during an interview conducted with the Environmental Supervisor (EVS), he stated two types of bleach products were being used to clean the resident rooms. The EVS stated the facility used Clorox Urine (a brand of disinfectant solution) remover spray which was being used on mattresses and/or floors, and the Clorox Fusion spray, which was used to disinfect high touch surface areas. The EVS stated Resident 1 complained the bleach products used to clean her room, made her cough, and she did not like the smell, stating It's too strong, approximately one month prior. The EVS stated he instructed all HK's not to use bleach products in Resident 1's bedroom.</p> <p>On March 14, 2025, at 4:51 p.m., during an interview conducted with Resident 1, she stated she did not want anyone to clean her room using bleach products, because the smell would make her cough. Resident 1 stated she had asked staff for months, not to use bleach products to clean her room, but they still do.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On March 17, 2025, at 8:20 a.m., during an interview was conducted with the Director of Nursing (DON), she stated Resident 1 had mentioned, a while back (exact time unknown), chemical smells of bleach were strong in her room and hallway, and she did not like the smell. The DON stated, I know (Resident 1) had spoke to (a staff member) about that, not sure who, and the HK's, and she thought they had resolved the issue.</p> <p>On March 18, 2025, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included depression (mood disorder). A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated March 12, 2025, indicated Resident 1 had modified indepedence in making decisions.</p> <p>A review of Resident 1's Progress Notes, dated March 18, 2025, at 2:27 p.m., indicated, .On 03/17/2025 (March 17, 2025) @ (at) approximatelt 2300 (11 p.m.), Resident requested that her overhead (sic) table be cleansed, upon doing so by CNA (Certified Nursing Assistant), she became upset, due to the smell of the wipes. The wipes were disregarded into trashcan, but when Nurse on duty tried to remove the wipes from her room, as she complained about the smell, resident became verbally aggressive .</p> <p>On March 19, 2025, at 12:16 p.m., during an interview was conducted with CNA 1, CNA 1 stated on March 17, 2025, at approximately 10:30 p.m., she was asked by her charge nurse, Licensed Vocational Nurse (LVN) 5, to Wipe down, the resident ' s bedside tables, and throw away extra trash. CNA 1 stated when she got to Resident 1 ' s bedroom, she used a bleach wipe to wipe off the resident ' s bedside table. CNA 1 stated Resident 1 became very upset that she used bleach in her room, stating The (bleach) smell was too strong. CNA 1 stated she wiped the remaining bleach off the resident ' s bedside table with a wet towel. CNA 1 stated Resident 1 was upset about the use of bleach wipes in her room. CNA 1 further stated she was not aware Resident 1 did not like the smell of bleach in her room.</p> <p>On March 19, 2025, at 12:57 p.m., during an interview conducted with LVN 6, she stated she asked CNA 1 to wipe down, the residents' tables on March 17, 2025, at approximately 11 p.m. LVN 6 stated she was not aware Resident 1 did not like the smell of bleach. LVN 6 stated Resident 1 became upset because she did not like the bleach smell after CNA 1 cleaned Resident 1's area with the bleach wipe.</p> <p>On March 19, 2025, at 2:47 p.m., during an interview conducted with Resident 1, she stated CNA 1 came into her bedroom, and used a bleach wipe to clean her bedside table on March 17, 2025, (time unknown). Resident 1 stated the smell of bleach went Right up my nose, and made me upset. Resident 1 stated she asked CNA 1, Didn ' t anyone tell you not to use bleach in my room?</p> <p>On March 19, 2025, at 4:39 p.m., during an interview conducted with the DON, she stated, when a resident complains they do not like a chemical (bleach) smell, she will ask all staff not to use bleach in the resident's room, get a Doctor's order not to use bleach products, and post a sign in the resident's bedroom Do not use bleach. The DON stated she was informed during a stand-up meeting (Department heads gather in the morning for a report) before Christmas time last year (date unknown), that Resident 1 did not want bleach to be used in her room because she did not like the smell of it. The DON stated she asked the CNAs not to use bleach in Resident 1's bedroom and notified the EVS to inform the HK's not to use bleach inside Resident 1's bedroom. The DON further stated she did not get a doctor's order for No bleach products, or put a No bleach sign in resident ' s room or document in Resident 1's medical record Resident 1's preference. The DON further stated she should have put a No bleach, sign in the resident ' s room, and documented Resident 1 did not like the smell of bleach in the resident's medical record.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure titled, Cleaning and Disinfection of Environmental Surfaces, dated August 2019, indicated, .Environmental surfaces will be cleaned and disinfected according to current CDC (Center for Disease Control and Prevention) recommendations for disinfection of healthcare facilities . Non-critical items are those that come in contact with intact skin but not mucous membranes .Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors .Non-critical surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant . Intermediate or low-level disinfectants for non-critical items include .ethyl or isopropyl alcohol .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility's policy and procedure on accounting for narcotic controlled substances was followed when:</p> <ol style="list-style-type: none"> 1. The liquid Ativan (anti-anxiety medication) for one of one resident (Resident 1) was not appropriately verified against the Narcotics and Controlled Substances Count Sheet (a sheet used to monitor the administration of a medication); and 2. The off-going (end of shift) and on-coming (beginning of shift) nurses did not sign the Narcotic and Controlled Substance (Shift-to-Shift) Count Sheet, after completion of the end of shift resident narcotic medications count. <p>These failures could have led to an inaccurate medication count, and a discrepancy in medication count records, and has the potential for drug diversion.</p> <p>Findings:</p> <p>On March 14, 2025, at 10:35 a.m., an unannounced visit was made to the facility to investigate a complaint regarding pharmacy services.</p> <p>1. A review of Resident 2 ' s Admission Record, indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses, which included anxiety disorder (a disorder that can lead to unrelieved feelings of anxiety).</p> <p>A review of Resident 2 ' s, Order Summary Report, included a physician's order, dated November 14, 2024, which indicated, Lorazepam (Ativan - a narcotic medication to help with anxiety) Oral Concentrate 2 MG/ML (milligram/milliliter - unit of measurement) Give 0.25 ml by mouth every 6 (six) hours as needed for Anxiety .</p> <p>On March 14, 2025, at 2:44 p.m., during an interview conducted with Licensed Vocational Nurse (LVN) 1, she stated the licensed nurses (LN) would count the quantity left in each of the narcotic medications in the narcotic box and verify it against the narcotic count sheet. LVN 1 stated there were some narcotic medications stored inside the medication room refrigerator which they should also count. LVN 1 stated at the end of the narcotic count, the LNs should sign the shift to shift report sheet verifying the narcotic counts was correct and the incoming nurse is taking over the medication cart without discrepancies.</p> <p>On March 14, 2025, at 2:55 p.m., during an interview conducted with LVN 2, she stated a narcotic medication count was to be completed by the off-going and on-coming nurses at the end of the shift. LVN 2 stated during the count, the off-going nurse would check against the narcotics binder (which contains the resident ' s narcotic sheets) with the resident ' s narcotic medications and the amount remaining. The on-coming nurse would verify against the narcotic medications in the cart, the resident ' s name, medication and the medication count left. LVN 2 stated the liquid Ativan was kept locked in the medication room refrigerator, and counted separately from the cart narcotic medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On March 14, 2025, at 3:12 p.m., LVN 2 (off-going) and LVN 3 (on-coming) nurses were observed performing end of shift narcotic medication count at the 500 hall. LVN 2 was observed with the narcotics binder, stating the names of the resident 's and medication to be counted. LVN 3 was observed counting cart medications, verifying the resident 's names, medications, and the remaining doses. At the end, LVN 2 was observed to state, there was one liquid Ativan to count in the medication refrigerator. LVNs 2 and 3 were observed looking at Resident 1 's narcotic sheet in the binder. LVN 2 then stated, we have 23.50 milliliters (ml - a unit of measurement) left (remaining dosage). LVNs 2 and 3 were then observed walking back to the medication room with keys to open the medication refrigerator located at 600 hall, the narcotics sheet was left on top of the medication cart. Inside the medication room, LVN 2 opened the refrigerator with a set of keys, and removed a black box containing a box of liquid Ativan. The liquid Ativan was removed by LVN 2, and LVN 3 was observed assessing the measurement of the remaining liquid Ativan in the bottle. LVN 3 then stated, Yep, 23.50 (ml) left.</p> <p>In a concurrent interview with both LVNs 2 and 3, they stated the narcotic count sheet for the liquid Ativan was on top of the medication cart (outside of the medication room). LVNS 2 stated, I looked at what the count was supposed to be, before I came in (to the medication room), when she was asked how she would verify the medication on the count sheet was the same as the medication inside the medication room refrigerator. LVN 3 stated, I was here yesterday, so I pretty much know what the count should be. LVNs 2 and 3 stated the narcotics book should be with them when they verify the narcotic medication from the medication refrigerator to accurately verify the right resident, medication, and the amount remaining.</p> <p>On March 17, 2025, at 8:50 a.m., during an interview conducted with the Director of Nursing (DON), the DON stated, the on-coming/off-going licensed nurses should count the narcotic medications with each other at change of shift. The DON stated the off-going nurses were expected to count with the narcotics book/sheet present verifies the medication count from the book, and the on-coming nurse should verify the count in the cart. The DON stated oral solutions, such as liquid Ativan, was to be kept in the medication room refrigerator. The DON stated she expected the medication nurses to verify the narcotic oral solutions count with the narcotics book/sheets present. The DON further stated, the medication nurses, need the (narcotics) sheets with them, so they do not go by memory. The DON stated it was her expectation for the medication nurses to do the full end of shift medication count with the narcotics sheets present.</p> <p>2. A review of the facility document titled, Narcotic and Controlled Substance Shift-to-Shift Count Sheet (a form where the licensed nurse would document narcotic medications were verified every shift), for the month of February 2025, indicated there was no licensed nurse signature for either in-coming or out-going licensed nurses on the following dates and shift:</p> <ul style="list-style-type: none"> - February 5, 2025, 1st shift (7 a.m. to 3 p.m.), Off-Going nurse; - February 8, 2025, 1st shift, On-coming nurse; - February 8, 2025, 2nd shift (3 p.m. to 11 p.m.), Off-going nurse; - February 11, 2025, 1st shift, Off-going nurse; - February 11, 2025, 2nd shift, Off-going nurse; <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - February 15, 2025, 3rd shift (11 p.m. to 7 a.m.), Off-going nurse; - February 16, 2025, 2nd shift, Off-going nurse; - February 16, 2025, 2nd shift, On-coming nurse; - February 16, 2025, 3rd shift, Off-going nurse; - February 20, 2025, 2nd shift, Off-going nurse; and - February 28, 2025, 3rd shift, On-coming nurse. <p>On March 19, 2025, at 4:15 p.m., during an interview conducted with LVN 4, she stated she worked February 16, 2025, at 10 a.m., and did a shift-to-shift narcotic medication count with the Off-going nurse. LVN 4 stated, I don ' t remember signing a book, just doing a shift-to-shift count. LVN 4 stated she was a Registry Nurse (contracted by an outside agency), and it was the first time she worked at the facility, and she did not know she had to sign the shift-to-shift count sheet. LVN 4 further stated, at the end of her shift, she did a shift-to-shift medication count with the On-coming 2nd shift nurse (LVN 5). LVN 4 stated that at the end of the narcotic count, LVN 5 asked if there was a (shift-to-shift) sheet to sign, LVN 4 stated, I told (LVN 5), I had not seen one (shift-to-shift count sheet). LVN 4 verified the medication count was correct, but both off-going and on-coming nurses did not sign the shift-to-shift count sheet.</p> <p>On March 19, 2025, at 4:55 p.m., during an interview conducted with LVN 5, who stated she was a registry nurse, and she worked on February 16, 2025, (On-coming) 2nd shift. LVN 5 stated when she presented for her shift, she did medications count with the off-going nurse (LVN 4). LVN 5 verified the count was correct without discrepancies. LVN 5 stated, When we were done counting (medications), there was no (Shift-to-shift count sheet) to sign. LVN 5 stated she asked the off-going nurse where the shift-to-shift count sheet was, and the off-going nurse stated, there was not a sheet to sign.</p> <p>On March 19, 2025, at 5:15 p.m., during an interview conducted with the Director of Nursing (DON), the DON stated the shift-to-shift count sheet should always be available in the front of the narcotics book for the off-going/on-coming nurses to sign after shift-to-shift count. The DON stated the medication nurses do a count together at the beginning/end of shift then each nurse signs the shift-to-shift count sheet, which would indicate the medication count was correct and without discrepancies. The DON stated she expected the off-going & on-coming nurses to sign the shift-to-shift sheet, unless there was a discrepancy in the medication count, at which time the nurses should notify the DON of the discrepancy so an investigation into the discrepancy could be initiated.</p> <p>A review of the facility's policy and procedure titled, Controlled Substances, revised, December 2012, indicated, .The facility shall comply with all laws, regulations and other requirements related to handling, storage, disposal, and documentation of schedule II and other controlled substances .Controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record .Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services .</p>		