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	12/10/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an allegation of abuse was thoroughly investigated and results of the investigation were reported to the state survey agency (CDPH - California department of Public Health) within five (5) calendar days of the incident, in accordance with the facility's policy and procedure, for two of three residents reviewed (Resident A and B).This failure had the potential for further abuse or mistreatment to other residents in the facility.Findings:On November 24, 2025, at 10:15 a.m., an unannounced visit was conducted at the facility to investigate a resident-to-resident abuse. On November 24, 2025, at 10:40 a.m., an interview was conducted with the Social Service Director (SSD). The SSD stated Residents A and B had an altercation on November 9, 2025. The SSD stated Residents A and B were married but were roomed separately. The SSD stated Residents A and B got into an argument because another resident had feelings for Resident A, and Resident B became jealous. The SSD stated Resident B was angry and went to take back a television that belonged to her from Resident A, which turned into a physical altercation.On November 24, 2025, at 11:30 a.m., a review of Resident B's medical record was conducted. Resident B was admitted to the facility on [DATE], with diagnosis which included schizoaffective (a serious mental illness with symptoms of hallucinations and delusions) disorder, psychosis (mental state where you lose touch with reality), and bipolar (brain condition causing extreme mood swings) disorder. A review of Resident B's Progress Notes, dated November 9, 2025, indicated the following:- at 2 p.m., indicated, .physical altercation between Resident B and Resident A.they started arguing verbally. She stated [room B] pushed and slapped her to the right side of the face, redness noted, she slapped him after in defense. [Room B] claims Resident B initiated the argument.she went into the room and slapped him and struck him in the ribs.he pushed her in self defense. The residents were separated.sheriff was notified.the resident was detained and escorted out by the sheriffs.-at 2:06 p.m., indicated, .two residents (male & female) altercation.stated she had argued with Resident A about the TV. Situation escalated to a verbal & physical altercation.she is very upset.Notified DON (director of nursing) of the incident & reported to law enforcement.per officers, resident was picked up after an investigation related the nature of both parties [sic] statements.resident handcuffed left the building with the sheriffs.On November 24, 2025, at 1 p.m., an interview was conducted with Resident A. Resident A stated had a misunderstanding with Resident B and smacked him in the head. Resident A stated Resident B came to get the television which she owns, and she hit him on the head. Resident A stated he then slapped Resident B in the mouth with the TV remote.On November 24, 2025, at 2:35 p.m., a review of Resident A's medical record was conducted. Resident A was admitted to the facility on [DATE], with diagnosis which included cerebral infarction (stroke-when blood flow to part of the brain is blocked) and COPD (chronic obstructive pulmonary disease-a progressive lung condition that blocks airflow, causing shortness of breath, cough, wheezing, and chest tightness).A review of Resident A's Progress Notes, dated November 11, 2025, indicated the following: -at 1:22 p.m., indicated, . change of condition: monitoring x (times) 72 hours for psychosocial well being problem r/t (related to) patient to patient altercation. Every shift for 3 (three) days document changes in behavior.-at 2:31 p.m., indicated, . notified for two residents altercation in the room.staff reported that he wheeled himself as quickly as he can to the patio. Found resident outside at the patio, in his wheelchair with other residents.was bit anxious, stated that he was hit hard in the head by Resident B who was visiting but situation escalated to physical altercation. DON notified and reported to the law enforcement.they proceeded to patio and spoke to Resident A privately. -at 4:26 p.m., indicated, .staff called the LN (licensed nurse) to room [number], a female resident was outside the room, yelling that she wants to take the TV.female resident stated that Resident A hit her in the forehead. On November 24, 2025, at 4:45 p.m., an interview was conducted with the RN Supervisor (RNS). The RNS stated she was notified by the staff that Resident B was sitting at the nurse's station, looking anxious and upset. The RNS stated Resident B told her that Resident A had hit her in the face, her face was notably red. The RNS stated she went and spoke with Resident A about the incident, and Resident A stated he was the one who got hit. The RNS stated she called the DON and the police department, and interviewed both residents and Resident C (Resident A's roommate). The officers came to the facility and spoke with Resident A, B, and C, the officers told the RNS that Resident B is being arrested on charges of battery (the crime of unconsented physical contact with another person, even when the contact is not violent, merely menacing or offensive), and that Resident B was yelling Resident A started it, when the police escorted her out of the

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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 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. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care and treatment were provided, for one resident of six residents reviewed (Resident E), when the resident had a critical low hemoglobin (an iron containing protein in red blood cells-transports oxygen from the lungs to the body). In addition, there was no care plan developed to address Resident E's low hemoglobin levels. This failure resulted in Resident E not receiving appropriate monitoring, care and services to address critically low blood levels.Findings:On November 24, 2025, at 10:15 a.m., an unannounced visit to the facility was conducted, for an investigation of a complaint regarding quality of care. On November 24, 2025, at 2:20 p.m., an observation and attempted interview was conducted with Resident E. Resident E was in physical therapy performing upper and lower body exercises with small weights, no verbal response when spoke with resident.On November 24, 2025, a review of Resident E's medical record was conducted. Resident E was admitted to the facility on [DATE], with diagnosis which included dementia (severe memory and thinking loss) and cognitive communication deficit (difficulty talking, listening, writing, due to brain problems).A review of Resident E's Telephone/Verbal Order, included a physician order, dated September 15, 2025, which indicated, Lab: CBC (complete blood count - a routine blood test measuring red cells, white cells, and platelets to check for anemia, infection, and other conditions) .every 2 (two) weeks on Mon (Monday) for 4 (four) weeks.A review of Resident E's Lab (laboratory) Results Report, indicated the following hemoglobin levels:-September 22, 2025; 9.7 g/dl (gram/deciliter - unit of measurement); -October 6, 2025; 6.8 g/dl. CL (critical low).The laboratory report of Resident E, dated October 6, 2025, indicated the report was sent to facility at 11:17 p.m., and the laboratory reached out to the facility to notify about the CL hemoglobin level but was not able to talk to someone on the following dates and times;-October 7, 2025, at 12:36 a.m.;-October 7, 2025, at 1:12 a.m.; and-October 1:47 a.m. A review of Resident E's Progress Note, dated October 7, 2025, at 3:02 p.m., indicated, .MD notified of critical lab results hgb (hemoglobin) 6.8, awaiting response. Further review of Resident E's record indicated there was no documentation the CL hemoglobin level on October 6, 2025, was addressed by the physician for appropriate action.On November 24, 2025, at 4:25 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the facility protocol for residents with low hemoglobin levels is to send the resident to the emergency room (ER) if the hemoglobin level is less than 7 g/dl, and to closely monitor the resident while at the facility if the resident's hemoglobin is above 7 g/dl. On December 9, 2025, at 4:17 p.m., a concurrent interview and record review was conducted with the DON. The DON stated the following regarding Resident E:-admitted to the facility with low hemoglobin level and was ordered to have hemoglobin levels to be checked every two (2) weeks;-Had a CL hemoglobin level on October 6, 2025, and the laboratory reached out to the facility three (3) times on October 7, 2025, to inform about the CL hemoglobin, but was unable to talk to someone from the facility;-The licensed nurse (LN) referred the CL hemoglobin level of 6.8 to the physician on October 7, 2025, at 3:02 p.m., and was awaiting physician response;-The DON was notified of the CL hemoglobin level on October 7, 2025 (unable to recall the time at night) and instructed the LN to send out the resident to the ER; -There was no documentation the resident was sent out to the ER on [DATE]. However, there was documentation the resident was readmitted on [DATE], at 9:49 a.m., after blood transfusion at the general acute care hospital (GACH);-The LN should have referred to the physician the resident's CL hemoglobin level of 6.8 immediately to address the change of condition to prevent further complications;-There was no monitoring for 72 hours after Resident E was readmitted to the facility on [DATE]. The DON stated Resident E should have been monitored at least for 72 hours when the resident was readmitted after blood transfusion from the GACH;-There was no care plan developed to address Resident E's low hemoglobin level since admission. The DON stated the facility should have developed a care plan to address the low hemoglobin level; and-There was no review conducted by the facility to find out the cause of the low hemoglobin level of Resident E, for the physician to give orders to address the low hemoglobin level. A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, dated February 2021 , indicated, .The nurse will notify the resident's attending physician or physician on call when there has been .significant change in the resident's physical, emotional/mental condition . 'significant change' of condition.requires interdisciplinary review and/or revision to the care plan.the nurse will make detailed observations and gather relevant and pertinent information from the provider information prompted by the Interact SBAR Communication Form the nurse will record in the

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an orthotic (an external brace or support used to align, support, prevent, or correct the function of the musculoskeletal system, like custom shoe inserts, ankle braces, or spinal supports, while orthotics refers to the science or practice of creating and applying these devices) consultation as recommended by the physical therapy (PT) was ordered timely, for one of five residents (Resident C).This failure had the potential to result in a delay in the rehabilitation progress of Resident C.Findings:On November 24, 2025, at 10:15 a.m., an unannounced visit to the facility was conducted to investigate a quality of care issue. On November 24, 2025, at 1:20 p.m., an interview was conducted with Resident C. Resident C stated he had been working with physical therapy and a leg brace was supposed to be ordered for him. On November 24, 2025, a review of Resident C's medical record was conducted. Resident C was admitted to the facility on [DATE], with diagnosis which included paraplegia (paralysis from waist down), hemiplegia (paralysis on one side of the body), and hemiparesis (weakness on one side of the body).A review of Resident C's care plan, dated June 9, 2024, indicated, .resident.is at risk for ADL (activities of daily living)/Mobility decline r/t (related to) cerebral infarction (when a blood clot blocks an artery in the brain, cutting off oxygen-causing brain cells to die) hemiplegia and hemiparesis.affecting non-dominant side. A review of Resident C's Minimum Data Set (MDS - a resident assessment tool), date August 28, 2025, indicated the resident had a BIMS (Brief Interview of Mental Status) score of 14 (cognitively intact).A review of Resident C's Physical Therapy Treatment Encounter Notes, date November 21, 2025, indicated, .Orthotist consult for (L - left) AFO (Ankle-Foot Orthosis, a brace supporting the foot and ankle for stability and function) pending at this time .A review of Resident C's Physical Therapy Treatment Encounter Notes, dated November 24, 2025, indicated, .(L) (left) hemiplegia, (L) knee buckling fall/risks.gait (walk) was a lot better with DF ([NAME] flex-ankle and foot movement, point toes and foot upward towards shin) assist but patient refuses to use it. Several times, pt (patient) had to be cued to straighten ankle.before putting wt (weight) on it due to high risk of injury.A review of Resident C's order summary indicated there was no order for an assistive device/brace or referral for orthotic consult. On November 24, 2025, at 4:05 p.m., an interview was conducted with the Social Services Director (SSD). The SSD stated she will review Resident C's physical therapy notes for a knee brace and check with central supply about ordering it.On December 5, 2025, at 11:30 a.m., an interview and record review was conducted with the Physical Therapist (PT). The PT stated an orthotist (person who works with prosthetics and braces) consult for an AFO was pending at this time. The PT stated the request for the brace and consultation was put in on November 10, 2025, from rehabilitation services to the interdisciplinary team. The PT stated the social worker would contact the outside vendor (orthotist) for the brace. The PT stated the AFO brace is needed as soon as possible for Resident C, because a delay in ordering could delay in Resident C's progress for his treatment.On December 9, 2025, at 4:17 p.m., an interview was conducted with the SSD. The SSD stated that the facility's process with orthotic referrals was for the rehab department to make an assessment and communicate to social services the need for an orthotic/prosthesis referral and to be submitted to the vendor for processing. The SSD stated she did not receive any communication or recommendations from the rehabilitation department for a left leg brace for Resident C. On December 10, 2025, at 2:36 p.m., an interview was conducted with the Director of Rehabilitation (DOR). The DOR stated the following:-The process to get a brace for a resident is for the rehab department to assess the resident and make the appropriate recommendations, which is then communicated to the social services and nursing department to get an order for an orthotic consultation;-Once there is an order for orthotic consult, an appointment is to be scheduled for a fitting with the vendor and then proceed with the orthotist treatment;-The rehab department tried a prefabricated AFO for Resident C, but did not work, and a recommendation was made to get an order for an AFO consultation;-The DOR stated she emailed social services assistant (SSA) on November 10, 2025, that an order for an AFO consult for Resident C was needed, and did not receive a response from SSA;-The DOR followed up with the Director of Nursing (DON) on December 3, 2025, and December 4, 2025 through email, and had not received a response. The DOR stated response time varies, however, a month was a long time for Resident C to wait for a brace. On December 10, 2025, at 3:57 p.m., an interview was conducted with the DON. The DON stated a month was too long for Resident C to wait for an order to be placed for the AFO brace he needs, it should have been coordinated in a timely manner. The DON stated