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	04/15/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's rights to privacy was provided, for two of four residents reviewed (Residents 2 and 3), when Resident 1, who was identified with wandering behavior, entered other residents' bedrooms without permission. The failure resulted in Resident 2 and 3's right to privacy being violated and had the potential to affect psychosocial well being.Findings:On March 25, 2026, at 8:55 a.m., an unannounced visit was made to the facility to investigate resident to resident altercation.On March 25, 2026, at 9:15 a.m., Resident 1 was observed lying in bed and fidgeting around a magazine on her hand.On March 25, 2026, at 9:22 a.m., Resident 3's room was observed to be the first room off the hall from Resident 1. There were no staff observed present in the hallway to monitor the residents' whereabouts.On March 25, 2026, Resident 1's record was reviewed. Resident 1's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included subarachnoid hemorrhage (a life-threatening type of stroke caused by bleeding into the space surrounding the brain).A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated March 17, 2026, indicated Resident 1 had a Brief Interview of Mental Status (BIMS - a cognitive assessment), indicated a score of 6, indicating severe cognitive impairment.A review of Resident 1's care plan, dated June 10, 2025, indicated, .The resident is an elopement risk/wanderer r/t (related to) currently attempts to leave facility unattended. The care plan did not include interventions to address elopement or wandering behavior.A review of Resident 1's Progress Notes, dated March 9, 2026, at 8:51 p.m., indicated, .Patient/Resident seen for psychosocial wellbeing r/t allegation on abuse: patient rolled into room (room number), male resident began to yell at her to get the hell out and then ran into her with electric scooter, hitting her lower extremities.On March 25, 2026, a review of Resident 3's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke) and left sided body weakness.A review of Resident 3's, MDS, dated March 13, 2026, indicated a BIMS score of 14 (cognitively intact).On March 25, 2026, at 9:30 a.m., Certified Nursing Assistant (CNA) 1 was interviewed. CNA 1 stated Resident 1 wanders throughout the facility and would go into other resident's rooms. CNA 1 stated Resident 1 needed to be re-oriented to her surroundings and redirected to leave the other resident's rooms. CNA 1 stated the staff needed to keep an eye on Resident 1 as the resident often wanders.On March 25, 2026, at 9:55 a.m., an interview was conducted with Resident 2. Resident 2 stated Resident 1 had entered his bedroom and used his bathroom without permission approximately one to two weeks ago. Resident 2 stated he called out for a nurse to help, and Licensed Vocational Nurse (LVN) 1 entered his room and opened the bathroom door, revealing Resident 1 sitting on the toilet. Resident 2 stated LVN 1 removed Resident 1 from his bathroom. Resident 2 stated the situation made him upset and angry because he doesn't like Resident 1 entering his bedroom and using his bathroom without permission. Resident 2 further stated, Resident 1 did not listen to him when he asked her to stay out of his bedroom, and staff do not monitor and keep her out of his bedroom.On March 25, 2026, Resident 2's record was reviewed. Resident 2's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fractured right femur (long bone of upper leg).A review of Resident 2's MDS, dated November 20, 2025, which indicated a BIMS score of 12, indicating moderate cognitive impairment.On March 25, 2026, at 12 p.m., an interview was conducted with LVN 1 who stated it is the facilities policy to allow residents to visit other residents' bedrooms, if the residents consent to accept visitors. LVN 1 stated if a resident is confused and enters another resident's bedroom, staff are to monitor and redirect the resident to their own bedroom. LVN 1 stated she heard yelling coming from Resident 2's bedroom on March 15, 2026. LVN 1 stated she entered Resident 2's bedroom, and Resident 2 was upset yelling that a resident was in his bathroom and he wanted her out of from there. LVN 1 stated she opened the bathroom door and Resident 1 was sitting on the toilet. LVN 1 stated she redirected Resident 1 by telling her that it was not her bathroom and escorted her out of Resident 2's bedroom. LVN 1 stated Resident 2 was upset and yelling, I don't want (Resident 1) in my room, she needs to get out of here. LVN 1 stated she was not sure if she documented the incident, but she should have.On March 25, 2026, at 2:09 p.m., an interview was conducted with the Central Supply Staff (CSS) who stated he was walking down the hall towards Resident 3's bedroom on March 9, 2026, when he heard Resident 3 yelling loudly, Get the hell out of here. The CSS stated when he got to Resident 3's bedroom, he observed Resident 1 inside of Resident 3's bedroom. The CSS stated he removed Resident 1 from Resident 3's bedroom and escorted Resident 1 back to her unit and reported the incident to the Social Services Director (SSD). The CSS further stated, Resident 1 wanders into other residents' bedrooms, because she gets confused.On March 25, 2026, at 2:35 p.m., an interview was conducted with the SSD, who stated, (on March 9, 2026, time not given), she was waived over to Resident 3's bedroom by the CSS, when she presented to Resident 3's bedroom, CSS reported to SSD Resident 3 was upset because Resident 1 had entered his bedroom. The SSD stated she interviewed Resident 3 who was upset and started yelling that Resident 1 comes into his bedroom to use his bathroom, and Resident 1 had done it a couple other times, and How come you guys (staff) don't do anything about it! The SSD stated she reported the incident to the DON and documented it.On March 26. 2026, at 2:45 p.m., an interview was conducted with the Director of Nursing (DON), who stated residents have the right to leave their unit and enter other facility units. The DON stated the following:-Residents also have the right to not want other residents to enter their bedrooms and use their bathrooms without permission;-She expects staff to monitor residents throughout the facility to ensure they are not entering the bedrooms of other residents without the other residents' permission;-Resident 1 liked to wander the facility and usually ends up in the front lobby being monitored by staff or the receptionist;-Resident 1 was not permitted to enter the bedrooms of other residents or use their bathrooms;-Staff were instructed to monitor Resident 1 when she would wander around the facility and were instructed to redirect her by taking her back to the unit or asking her to sit in the lobby;-Resident 1 entered Resident 3's bedroom without permission upsetting Resident 3 on March 9, 2026. The DON stated Resident 1 gets confused at times thinking Resident 3's bedroom is hers. The DON stated Resident 3 had the right to not want Resident 1 in his bedroom and Resident 1 violated Resident 3's right to privacy, when she entered Resident 3's bedroom without his permission;-She expected staff to monitor Resident 1 and redirect her from going into other residents' bedrooms without permission; and-She was unaware Resident 1 entered Resident 2's bedroom on March 15, 2026, and used his bathroom without permission. The DON stated Resident 2 had the right not to want Resident 1 in his bedroom using his bathroom. The DON verified Resident 1 violated Resident 2's right to privacy by entering his bedroom and using his bathroom without his permission. The DON stated she expects staff to monitor Resident 1 and redirect her from going into other residents' bedrooms without permission.A facility Policy and Procedure, titled Visitation, revised August 2022, indicated, . Our facility permits residents to receive visitors subject to the resident's wishes and the protection of the rights of other residents in the facility.Restriction of Individual Visitors: .The resident has the right to deny visitation at any time.