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	07/01/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), was free from sexual abuse when there were no interventions developed to protect Resident 1 after Resident 2 subjected the resident to sexual abuse on May 19, 2026. Resident 1 was witnessed by facility staff being kissed and inappropriately touched on the breast by Resident 2. In addition, the facility staff did not immediately intervene when Resident 1 was witnessed being kissed and sexually inappropriately touched by Resident 2. Resident 1 has dementia (a decline in mental abilities which affects memory, thinking, and social abilities), has severe cognitive impairment, and has history of wandering (act of walking, moving and traveling without a specific destination or fixed route, often in an aimless manner). This failure resulted in Resident 1 being sexually abused the second time at the facility by another male resident (Resident 3) on June 6, 2026. This failure had the substantial probability of resulting in Resident 1 experiencing anxiety, distress, and trauma which negatively affects the resident's psychosocial well-being.Findings: A review of Resident 1's (alleged victim) admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included dementia. A review of Resident 1's Brief Interview of Mental Status (BIMS-a cognitive assessment), dated April 9, 2026, indicated a score of 99, severe cognitive impairment resulting in the inability to complete the assessment. A review of Resident 1's History and Physical, dated, July 4, 2025, indicated, . Has fluctuating capacity to understand and make decisions . A review of Resident 1's IDT (Interdisciplinary Team Notes), dated May 19, 2026, at 6:06 p.m., indicated, . At approximately 10:15 a.m., staff members witnessed (Resident 1) being touched, inappropriately by (Resident 2) . (Resident 1) is unable to recall events . (Law enforcement notified) . A review of Resident 1's care plan initiated on May 19, 2026, indicated, . (Resident 1) has a psychosocial wellbeing problem r/t (related to) other resident(s) kissing and touching this resident inappropriately .Interventions: Allow to verbalize feelings and fears. Increase communication between residents/family/caregivers about care and environment. Monitor and document feelings relative to isolation, unhappiness, anger, loss . Further review of Resident 1's care plan related to the sexual abuse incident on May 19, 2026, did not indicate how the facility will keep the resident safe from further sexual abuse. A review of Resident 2's (alleged perpetrator) admission Record indicated that the resident was admitted to the facility on [DATE], with diagnoses which included urinary tract infection (bacterial infection in the urinary system). A review of Resident 2's BIMS dated April 11, 2026, indicated a score of 11, which meant moderate cognitive impairment. A review of Resident 2's Progress Notes, dated May 19, 2026, at 12 p.m., documented by Licensed Vocational Nurse (LVN) 1, indicated, .was told by the activities staff (AA) that pt. (patient) (name of Resident 2) who is A & O X 4 (Alert and Oriented to Person, Place, Time and Situation) was seen having inappropriate sexual behavior with a resident (Resident 1) who is alert and oriented x 1 (self) since pt. (referring to Resident 2) was conscious of what he was doing police department was contacted . On May 20, 2026, at 10:15 a.m., during an interview, Director of Nursing (DON) 1 stated that on May 19, 2026, a facility staff (Activity Assistant) witnessed Resident 2 inappropriately touching Resident 1 on her breasts and placing his (Resident 2) hands down (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident 1's pants. DON 1 further stated Resident 1 has a history of confusion. On May 20, 2026, at 11:45 a.m., during an interview, the AA stated if resident abuse is occurring, staff were expected to intervene and stop the abuse right away. The AA stated that on May 19, 2026, at approximately 10:15 a.m., she was walking by the resident's lounge in hallway 500 and witnessed Resident 2 kissing Resident 1 on the mouth, touching her breasts and Private area. The AA stated Certified Nursing Assistant (CNA) 1 was in the hallway, close to the lounge, and she (AA) informed CNA 1 that Resident 2 was inappropriately touching Resident 1. The AA stated she should have intervened when she witnessed Resident 2 kissing and touching Resident 1 before reporting to CNA 1. On May 20, 2026, at 12:14 p.m., during an interview, CNA 1 stated the following: -To ensure resident safety during a conflict, immediately separate those involved, assign staff to each resident until the issue is resolved, and notify supervisors; and - On May 19, 2026, after being alerted by the AA, (CNA 1) saw Resident 2 kissing Resident 1 and had his hands down Resident 1's pants in the resident's lounge. On May 20, 2026, at 12:47 p.m., during interview, the CNA Team Leader (TL) stated that staff should immediately separate residents during unsafe interactions, keep them apart, and report incidents to supervisors for safety. She (CNA TL) recalled that on May 19, 2026, CNA 1 informed her that Resident 2 was inappropriately touching Resident 1. CNA TL stated she saw Resident 2 leaving Resident 1's room, noting that staff should have stayed with Resident 2 to ensure safety while reporting the incident. She stated Resident 1 has confusion and is oriented only to person, while Resident 2 is fully aware. On May 20, 2026, at 2:06 p.m., during an interview with the Assistant Director of Nursing (ADON), she stated that in unsafe resident-to-resident situations, residents should be separated immediately, monitored by staff, and proper authorities should be notified. Resident 1 is easily confused and only oriented to person. On May 19, 2026, the AA informed her that Resident 2 was touching Resident 1. She observed Resident 2 being guided away from Resident 1's bedroom after the incident in the resident's lounge and that staff should have been monitoring both residents for safety. A review of Resident 1's Progress Notes, dated, June 8, 2026, at 9:33 p.m. indicated, . ON 06/06/2026 at approximately 12:15 a.m., CNA (CNA 2) witnessed this resident (Resident 1) a male resident (Resident 3, alleged perpetrator different from the perpetrator on May 19, 2026) bent over, kissing her (Resident 1), while she (Resident 1) was sitting in a chair . CNA (CNA 2) reported to the nurse (LVN 2) . who immediately separated both residents . Resident (Resident 1) wasseen (sic) for psychosocial well-being, she (Resident 1) is unable to recall the event . A review of Resident 3's (alleged perpetrator on June 6, 2026, incident) admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills). A review of Resident 3's BIMS score, dated May 9, 2025, indicated a score of 3, which meant the resident is severely cognitively impaired. A review of Resident 3's eInteract SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers, dated June 6, 2026, at 12:20 a.m., indicated, . This nurse (LVN 2) was called into the activity T.V. room as I walk (sic) in I observed patient (name of Resident 3) was in front of (name of Resident 1). Patient (name of Resident 3) had his short (sic) down on the floor, the disposable brief was still on, and he (Resident 3) was asking (name of Resident 1) to touch his private area . CNA (CNA 2) reported observing resident (name of Resident 3) kissing (Name of Resident 1) . On June 9, 2026, at 8:40 a.m., during an interview with the ADON, she stated that Resident 1 has a history of wandering onto other units throughout the facility. The ADON stated that on the night of June 6, 2026, Resident 1 wandered off her unit onto another unit's television room where Residents 1 (alleged victim) and 3 (alleged perpetrator different from the first incident on May 19, 2026) were observed kissing by CNA 2. On June 9, 2026, at 10:02 a.m., during an interview, Resident 1 stated she did not remember going to another unit on June 6, 2026, and kissing Resident 3. On June 10, 2026, at 7:38 a.m., during an interview, CNA 2 stated that on the night of June 6, 2026, he was unsure of the exact time, sometime in the middle of the night, he observed Residents 1 and 3 on the (name of facility unit different from the unit where Resident 1 resides), alone in the T.V. room. CNA 2 stated (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident 1 was sitting in a chair, and Resident 3 was standing, bent over, and kissing Resident 1. The CNA stated he immediately notified LVN 2, so that the LVN could intervene, while he went back to provide resident care. CNA 2 stated he should have immediately intervened by asking Residents 1 and 3 to stop kissing and separating them. CNA 2 further stated Resident 1 has a history of confusion and wandering the facility and requires redirection. CNA 2 stated on the night of June 6, 2026, he was not aware Resident 1 was on the (name of the facility unit different from where Resident 1 resides), in the T.V. room with Resident 3, as Resident 1's assigned nurses did not notify CNA 2 that Resident 1 had wandered. On June 10, 2026, at 3:32 p.m., during an interview, LVN 2 stated on the night of June 6, 2026, she was a charge nurse on the (name of the unit different from the unit where Resident 1 resides), and at approximately 12:30 a.m., CNA (CNA 2) notified her (LVN 2) that Residents 1 and 3 were in the T.V. room kissing. LVN 2 stated she immediately went to the T.V. room and observed Resident 3 standing in front of Resident 1 who was sitting in a chair. LVN 2 stated Resident 3 had his shirt off and his pants off, his adult brief was still on, and he (Resident 3) was asking Resident 1 to touch his private parts. LVN 2 stated she immediately intervened by asking Residents 1 and 3 to stop. LVN 2 stated she redirected Resident 1 back to her unit. LVN 2 reported the incident to Resident 1's charge nurse (LVN 3). LVN 2 stated LVN 3 was not aware Resident 1 had wandered off her unit. On June 10, 2026, at 2:06 p.m., during an interview, LVN 3 stated she was Resident 1's assigned LVN on June 6, 2026, and she and CNA 4 were responsible for monitoring Resident 1 during her shift (11 pm to 7 am shift). LVN 3 stated she did visual checks but did not document monitoring residents. LVN 3 stated she did not know the exact time, but she was at the (name of unit where Resident 1 resides) nurses station when a nurse from the (name of unit different from where Resident 1 resides) came over and informed her that Resident 1 was found in the other facility unit's T.V. room kissing Resident 3, and Resident 1 had been returned to her unit. LVN 3 stated she did not know Resident 1 was off her unit and on the other unit at the time. On June 30, 2026, at 3:18 p.m., during an interview, CNA 4 stated she was Resident 1's assigned CNA for the night shift (11 p.m. to 7 a.m.) on June 6, 2026. CNA 4 stated Resident 1 has a history of being confused and would wander into other residents' bedrooms. CNA 4 stated she tried to visually monitor Resident 1's whereabouts every 30 minutes to an hour, between resident care. CNA 4 stated she was not aware Resident 1 was observed kissing Resident 3 in the T.V. room located at the other unit on the night of June 6, 2026. On June 30, 2026, at 4:15 p.m., a concurrent interview and record review were conducted with Director of Nursing (DON) 2, DON 2 verified Resident 1's care plan initiated on May 19, 2026, had no interventions that could safeguard Resident 1 from further sexual abuse incidents by other residents. DON 2 further stated interventions initiated should have included monitoring Resident 1 with set time frames, providing activities, and/or including Resident 1 in outings, which could have helped keep Resident 1 busy and occupied. On July 1, 2026, at 1:55 p.m. during an interview, the ADON stated she would expect staff to effectively monitor their assigned residents, and to know where they are at all times. On July 2, 2026, at 11 a.m., during an interview, Resident 1's (alleged victim) responsible party stated Resident 1's memory is compromised and at times Resident 1 is unable to recall whether she has eaten her meals or if her adult brief requires changing. The responsible party stated Resident 1 has a history of wandering around the facility, and she expressed concern that the facility was not monitoring Resident 1 closely enough to keep her safe, because the second incident (referring to the sexual abuse incident on June 6, 2026) occurred in the middle of the night, when the resident (Resident 1) wandered off her unit without staff's knowledge, at which time she was exposed to sexually inappropriate behavior by Resident 3. A review of the facility Policy and Procedure (P & P) titled, Identifying Sexual Abuse and Capacity to Consent, revised September 2022, indicated, . Policy Statement: A resident's consent to sexual activity is not valid if obtained from a resident who lacks the capacity to consent . Policy Interpretation and implementation: 5. The facility will . protect a resident from non-consensual sexual relations anytime there is reason to suspect that the resident . may not have the capacity to consent . Investigating an Allegation or Suspicion of Sexual Abuse: 1. For any alleged violation or suspicion of (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	sexual abuse, protective measures . include: a. immediately implementing safeguards to prevent further potential abuse .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a referral was sent in a timely manner, to Resident 4's insurance company, for authorization to schedule an oncology appointment for thrombocytopenia (Low platelet count - fragments in the blood that form clots to prevent bleeding). This failure resulted in the delay of Resident 4 from seeing an Oncologist sooner to evaluate his diagnosis of thrombocytopenia. Findings: A review of Resident 4's Resident Information, indicated, resident was admitted to the facility on [DATE], with diagnoses which included end stage kidney disease (ESRD-occurs when the kidneys are no longer able to carry out their daily functions, requiring either dialysis or transplantation to sustain life). A review of Resident 4's Brief Interview for Mental Status (BIMS- a screening test used to evaluate a patient's basic cognitive function, memory, and orientation) indicated a score of 15 out of 15, cognitively intact. On April 18, 2026, at 3:44 p.m., during an interview, the Social Services (SS) staff stated the following: - When a doctor's appointment requires insurance authorization, the process is for SS or the Case Manager (CM) to submit a request for authorization to the insurance company (via a referral form); - The process to receive an authorization should take approximately three to four days; and -The follow-up with an oncologist was ordered on February 23, 2026, and she notified CM 1 that an authorization from the resident's insurance company was needed, so the appointment could be scheduled. However, she was unsure of the approximate date she notified CM 1. A review of Resident 4's physician orders dated February 23, 2026, at 12:56 a.m., indicated, . Follow up with (Oncologist) . for evaluation and management of thrombocytopenia . On April 18, 2026, at 3:55 p.m., during a concurrent interview and record review, CM 1 stated the following: -Receiving authorization to set an appointment should take a couple of weeks; -For appointments needing insurance authorization, she would request an authorization for the appointment from the resident's insurance company, and once obtained, the appointment would be scheduled; -Resident 4 has a physician order dated February 23, 2026, to follow up with an Oncologist for evaluation of thrombocytopenia; -The SS notified CM 1 an authorization was needed for Resident 4's Drs appointment; -She (CM 1) was unsure of the exact date she sent the referral for authorization, but she received authorization on April 23, 2026, and today (May 18, 2026) she followed up with the resident's insurance company and found out Resident 4's Oncology appointment has been set for May 21, 2026; -She (CM 1) and SS do not have a process to follow up with each other to discuss and/or review resident authorizations; and -There was a delay in requesting the authorization for Resident 4's oncology appointment, which may have been due to the transition into her new position, and a lack of communication with SS. A review of Resident 4's, Referral for Authorization form, dated April 23, 2026, indicated, . Specialty Hematology/Oncology . approved . decision date April 23, 2026, . Diagnosis . Thrombocytopenia . On May 22, 2026, at 9:08 a.m., during an interview, the SS staff stated she is responsible for receiving insurance authorizations for Custodial (On-going support of chronic conditions not covered by Medicare) residents. A review of Resident 4's physician order dated, December 30, 2025, indicated . Custodial level of Care effective (January 2, 2026) . A review of the facility policy and procedure, titled, Referrals, Social Services, revised December 2008, indicated, . 1. Social services personnel shall coordinate most resident referrals . 2. Referrals for medical services must be based on . physician(s) order 3. Social Services will collaborate with . other pertinent disciplines to arrange for services that have been ordered by the physician .