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	04/24/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a homelike environment was provided, for three of three residents reviewed (Residents 52, 53, and 20) when:1.Resident 52 consistently heard yelling or screaming from a confused resident in another room throughout the shift.This failure resulted in Resident 52 experiencing sleep disruption and increased noise levels affecting his immediate environment.2. Resident 53 was not assisted by staff to put away her personal belongings such as clothes and blanket found on the floor of the resident's room.This failure resulted in Resident 53's clothes and blanket left on the floor, creating clutter and making her room less comfortable and homelike; and3.Resident 20's personal credit card was not kept safe and accounted for.This failure resulted in Resident 20 losing his credit card and placed him at risk for financial abuse.Findings: 1.On April 20, 2026, at 11:15 a.m., an observation was conducted outside Resident 177's room. Resident 177 was observed ringing his call bell for assistance by banging the bell against the overhead table and screaming for help in Spanish. A Licensed Nurse was observed in Resident 177's hallway by her medication cart, and did not respond to Resident 177's call for assistance. On April 21, 2026, the following were observed: - At 9:31 a.m., a second observation was conducted outside Resident 177's room. Resident 177 was screaming for help while ringing his call bell at the same time. Staff were observed down Resident 177's hallway and did not respond to his call for assistance; and - At 9:40 a.m., Resident 177 continued to scream loudly for help while banging his call bell against the table. A Licensed Nurse was observed down Resident 177's hallway and did not attend to his call for assistance. On April 21, 2026, at 10:30 a.m., an interview was conducted with Resident 52. Resident 52 stated he was unable to sleep at night due to residents screaming in the hallway across from his room. Resident 52 stated he had notified staff several times over the last month regarding noise level; however, nothing had changed. Resident 52 stated the staff told him to keep his door closed, but he preferred to keep his door open. Resident 52 stated the screaming occurred during the day, evening, and at night. Resident 52 stated he was woken up at 3 a.m. on April 21, 2026, because of Resident 177 screaming. Resident 52 stated he was unable to rest and sleep at night due to the noise. On April 23, 2026, at 10:35 a.m., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated there were approximately five residents in Resident 52's hallway who had behavior of screaming and/or yelling due to confusion. CNA 1 stated the screaming and/or yelling occurred (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	throughout the entire shift. CNA 1 stated when this happened, the staff attempt to redirect them, such as having them watch television, but the redirection was unsuccessful most of time. CNA 1 stated there were residents who requested their doors to be closed due to the noise level being too much. CNA 1 further stated that there have been no room changes conducted in the last several months due to residents' complaints about noise level. On April 24, 2026, at 9:03 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated the residents have the right to a homelike environment that included comfortable noise levels. The DON further stated she was currently aware of three residents who have the behavior of screaming in Resident 52's hallway. The DON stated that room changes may have been implemented to address these noise concerns, however, this was not done in the last couple of months. The DON stated Resident 52, who notified the staff of the unreasonable noise levels, did not experience a homelike environment. On April 23, 2026, Resident 177's record was reviewed. Resident 177 was admitted to the facility on [DATE], with diagnoses which included left hemiplegia (left side weakness) due to cerebral infarction (stroke caused by sudden lack of oxygen to the brain due to blood clot). On April 24, 2026, Resident 52's record was reviewed, Resident 52 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease (lung disease). A review of the facility's policy and procedure titled, Quality of Life – Homelike Environment, dated May 2017, indicated, .residents are provided with a safe, clean, comfortable and homelike environment.characteristics of the facility that reflect a personalized, homelike setting.including comfortable noise levels. minimize.characteristics of the facility that reflect a depersonalized, institutional setting.including environmental disruptions. 2. On April 21, 2026, at 12:27 p.m., during a concurrent observation and interview with Resident 53 in her room, Resident 53's clothes and blanket were observed on the floor. Resident 53 stated she asked the staff to help her put away her clothes multiple times and no one had assisted her. Resident 53's record was reviewed. Resident 53 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (muscle weakness) and hemiparesis (muscle paralysis) following other nontraumatic intracranial hemorrhage (bleeding inside the skull) affecting right dominant side. On April 22, 2026, at 9 a.m., during an interview with CNA 2, CNA 2 stated CNAs were responsible for assisting residents in maintaining a clean room, helping residents put away clothes, making sure rooms were tidy and home-like, and placing soiled clothing in laundry. CNA 2 stated the housekeeping staff cleaned resident's room twice a day. On April 22, 2026, at 2:45 p.m., during an interview with CNA 3, CNA 3 stated Resident 53 had asked her to put away her clothes and blankets that were on the floor today. CNA 3 stated that she had noticed her belongings on the floor prior days and should have offered to put it away. On April 24, 2026, at 9:42 a.m., during an interview with the Director of Staff Development (DSD), the DSD stated it was the responsibility of the CNAs to assist residents in maintaining clean and safe surroundings. The DSD stated CNAs should offer to put away personal items to ensure resident safety, comfort, and infection control daily as part of their routine care. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On April 22, 2026, at 8:21 a.m., during an interview with Resident 20 stated his wallet, which contained his credit card, was missing in late January to February 2026 and was later found in the bathroom by an unknown staff member. Resident 20 stated his credit card company contacted him regarding unusual transactions. Resident 20 stated he reported the incident to a facility staff, who stated she would investigate. Resident 20's record was reviewed. Resident 20 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease (irreversible kidney damage). A review of Resident 20's Inventory of Personal Effects dated November 5, 2025, indicated Resident 20 had three credit cards, which was signed by Resident 20 and staff. On April 23, 2026, at 9:35 a.m., during a concurrent interview and review of Resident 20's inventory list with Social Service Manager (SSM), the SSM stated residents' credit cards were secured in the facility safe. The SSM stated if a resident chose to keep credit cards at the bedside, a lock box would be provided, and the resident would be given a key. The SSM stated Resident 20's credit cards were to be stored in the facility safe. The SSM further stated CNAs should have offered Resident 20 a lock box. On April 23, 2026, at 9:40 a.m., during a concurrent observation and interview with SSM and Resident 20 in the resident's room, no lock box was observed. Resident 20 stated he had not been informed about the options for safekeeping of his credit cards. The SSM stated Resident 20 should have been informed of the choices of safekeeping of his credit cards to secure personal belongings such as credit cards and prevent psychosocial distress. On April 23, 2026, at 10:38 a.m., during an interview with CNA4, CNA 4 stated she did not recall whether Resident 20 had credit cards at the time of admission. CNA 4 stated when a resident had credit cards upon admission, she would notify the licensed nurse and offer options for safekeeping of his credit cards. CNA 4 stated Resident 20 should have been offered options for safekeeping for safety. On April 24, 2026, at 9:14 a.m., during an interview with Licensed Vocational Nurse (LVN) 7, LVN 7 stated Resident 20 should have been offered options for safekeeping to prevent missing items and psychosocial distress. LVN 4 stated residents' belongings were important and should be secured to ensure residents felt safe. On April 24, 2026, at 10:30 a.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated Resident 20's wallet went missing during transfer to another unit. The ADON stated unauthorized charges were identified on one of Resident 20's credit cards. The ADON stated options for safekeeping should have been offered to Resident 20 to secure personal belongings while in the facility. A review of the facility's policy and procedure titled, Personal Property, dated August 2022, indicated, .Resident belongings are treated with respect .facility promptly investigates any complaints of misappropriation or mistreatment of resident property .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure professional standards of practice were followed for 21 out of 21 sampled residents (Resident 176, 164, 12, and 18 residents in 800 hallway), when: 1. For Resident 176, medications scheduled at 9 a.m. were administered outside the facility's medication administration timeframe. This failure had the potential for the medications to be ineffective;2. For Resident 176, Empagliflozin (generic for Jardiance, a medication used to treat heart failure [a chronic condition where the heart cannot pump blood efficiently enough to meet the body's oxygen needs] with or without type 2 diabetes mellitus [DM, a condition where the body has trouble regulating blood sugar levels]) was prescribed with an indication for diabetes mellitus despite no documented diagnosis of diabetes, resulting in an incorrect medication indication. This failure had the potential for Resident 176 to receive unnecessary medication;3. For Resident 164, required documentation following administration of Norco (narcotic pain medication) was not completed, including pre-medication pain assessment, confirmation of administration, and post-medication effectiveness. This failure had the potential for ineffective pain management;4. For Resident 164, medication documentation was inaccurate when Senna-S (a medication used to treat constipation) was refused by the resident but documented as administered in the Medication Administration Record (MAR). This failure had the potential for Resident 164 ?s refusal of medications not to be assessed appropriately ;5. For Resident 12, the correct lunch meal tray was not served according to the diet order. This failure had the potential for Resident 12 to have complications related to wrong diet and texture such as choking and could affect the overall health condition; and 6. The licensed nurse did not check the meal trays for 18 out of 18 residents before serving the meal trays to the residents. This failure placed residents at potential risk for being served wrong physician diet orders, wrong modified texture and/or modified liquid, which could compromise the residents' overall health condition.Findings: 1. On April 20, 2026, at 11:06 a.m., during a record review, a review of Resident 176's Medication Administration Record (MAR), dated April 2026, indicated all 9 a.m. medications were documented as administered, including: - Empagliflozin (used to treat diabetes and heart failure) 10 mg (milligram – unit of measurement); - Metoprolol Succinate ER (extended-release, a medication used to treat high blood pressure) 100 mg; - Potassium Chloride ER (potassium supplement) 10 mEq (milliequivalent – unit of measurement); - Apixaban (anticoagulant, blood thinner) 2.5 mg; - Zonisamide (anti-seizure medication) 100mg; and - Cholecalciferol (Vitamin D supplement) 2000 IU (international unit - unit of measurement) A review of Resident 176's physician orders indicated the above medications were ordered for 9 a.m. administration. On April 20, 2026, between 11:54 a.m. and 12:11 p.m., during a medication administration observation (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed administering the above medications scheduled for 9 a.m. On April 20, 2026, at 12:15 p.m., during an interview with L VN 4, LVN 4 stated that he documented medications scheduled at 9 a.m. as administered but were administered between 11:54 a.m., to 12:11 p.m., which was outside the timeframe of administration of 9 a.m. LVN 4 stated scheduled medications should be administered one hour before or one hour after (between 8 a.m. to 9 a.m.) On April 21, 2026, at 4 p.m., during an interview with LVN 4, LVN 4 confirmed the medications were not administered at the scheduled time and acknowledged documenting the medications as administered prior to actual administration. LVN 4 stated that when medications are not administered within the required time frame, nursing staff should notify the physician, obtain instructions on whether the medications should be administered, and document the physician's guidance in the medical record. LVN 4 acknowledged this process was not followed. On April 23, 2026, at 6:04 p.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated the facility's medication administration timeframe for medications scheduled for 9 a.m. is between 8 a.m. and 10 a.m. The ADON stated nursing staff are expected to consult with the physician when medications are administered outside the required time frame and to document administration after medications are given. A review of the facility's policy and procedures (P&P) titled, Administering Medications, dated April 2019, indicated, .Medications are administered in accordance with prescriber orders, including any required time frame .Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.The individual administering the medication checks.right time .of administration before giving the medication .The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones . 2. A review of Resident 176's medical record titled, admission Record, indicated, the resident was admitted to the facility on [DATE], with diagnoses including epilepsy (seizure disorder), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels), atherosclerotic heart disease (narrowing of arteries supplying blood to the heart), pulmonary hypertension (high blood pressure in the lungs), atrial fibrillation (irregular heart rhythm), chronic systolic (congestive) heart failure (condition where the heart cannot pump effectively), and presence of cardiac pacemaker (a small, battery-powered device implanted under the skin to keep the heart beating at a healthy, consistent pace). A review of Resident 176's physician orders indicated: - Empagliflozin 10 mg, give 1 tablet by mouth one time a day for DM. Take with food, dated April 13, 2026. A review of Resident 176's medical record, titled Physician diagnosis verification (PDV) V2.0, dated April 14, 2026, indicated: .Diagnosis List.Type 2 Diabetes Mellitus without complication.Physician Attestation Statement. As of the date of admission to the facility: I verify that the above medical diagnosis are ACTIVE and have a DIRECT RELATIONSHIP to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death. signed and dated on April 14, 2026. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 21, 2026, at 11:11 a.m., during an interview with Resident 176 in the resident's room, the resident stated he had not been diagnosed with diabetes. On April 21, 2026, at 11:42 a.m., during a concurrent interview and record review with the MDS Coordinator (MDSC), the MDSC confirmed diabetes mellitus was listed as a diagnosis in the electronic medical record system. However, a review of hospital records, referral documentation, and history and physical reports did not indicate a diagnosis of diabetes mellitus. On April 23, 2026, at 3:25 p.m., during an interview with the Medical Director (MD), the MD confirmed the diagnosis of diabetes mellitus was inaccurate for this resident and stated empagliflozin should have been prescribed for heart failure indication, not diabetes. On April 24, 2026, at 11:35 a.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON confirmed the diagnosis of diabetes mellitus was incorrectly entered for Resident 176 and acknowledged it caused additional interventions, including blood glucose monitoring and a diabetic diet. The DON stated the facility's process includes review of newly admitted residents' orders and diagnoses on a daily basis, however, this discrepancy was not identified and corrected through the facility's review process. A review of the facility's policy and procedure titled, Attending Physician Responsibilities, dated August 2014, indicated, .Providing appropriate care .The Attending Physician will perform accurate, timely, and relevant medical assessments with active and inactive diagnosis relevant to the care of the resident .The physician will verify and clarify symptoms, problems, and diagnoses .In consultation with facility staff, the physician will identify appropriate treatments and services, consistent with each individual's diagnoses, condition .The Attending Physician will provide .appropriate medical orders . A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for Empagliflozin tablets, dated January 2026, retrieved from DailyMed, indicated, . JARDIANCE (brand name for Empagliflozin) is.indicated: To reduce the risk of cardiovascular (heart and blood vessel) death and hospitalization for heart failure in adults with heart failure. To reduce the risk of cardiovascular death in adults with type 2 diabetes mellitus and established cardiovascular disease. As an adjunct to diet and exercise to improve glycemic (blood sugar) control in adults.with type 2 diabetes mellitus. 3. On April 20, 2026, at 10:14 a.m., during a medication administration observation for Resident 164, LVN 4 was observed preparing and administering medications scheduled 9 a.m. including hydrocodone-acetaminophen (brand name Norco, scheduled II controlled substance used for pain) 10-325 mg after the resident reported a pain level of 8. On April 20, 2026 at 1:22 p.m., during a review of Resident 164's medical record titled, admission Record, indicated the resident was admitted to the facility on [DATE] with diagnoses including: spinal stenosis of lumbar region (narrowing of the spinal canal in the lower back), lumbar radiculopathy (nerve pain originating from the lower spine), and low back pain. A review of Resident 164's physician order for Norco 10/325 mg, indicated give 1 tablet by mouth every 4 hours as needed for moderate to severe pain (4-10) [pain scale], dated February 1, 2026. A review of Resident 164's MAR, dated April 2026, indicated missing documentation for Norco (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration, including no documented pre-medication pain assessment, no confirmation of administration, and no post-medication effectiveness. On April 20, 2026, at 3:52 p.m., during an interview with LVN 4, LVN 4 confirmed the pain level was assessed but not documented and acknowledged that post-medication effectiveness was not documented. A review of the facility's policy and procedure titled, Administering Medications, dated April 2019, indicated, .As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered; .e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug . 4. On April 20, 2026, at 10:14 a.m., during a medication administration observation, Resident 164 stated she did not want to take the stool softener (Senna-S). On April 20, 2026, at 1:22 p.m., during a review of Resident 164's physician order for Senna S indicated: Senna S tablet 8.6-50 mg, give 1 tablet by mouth one time a day for constipation. Hold for loose stool, dated February 2, 2026. A review of Resident 164's MAR indicated Senna-S was documented as administered in the MAR. On April 20, 2026, at 3:52 p.m., during an interview with LVN 4, LVN 4 confirmed Senna-S was not administered because the resident refused the medication. LVN 4 also confirmed the medication was documented as administered for April 20, 2026, at 9 a.m. dose. On April 23, 2026, at 6:30 pm., during an interview with the ADON, the ADON stated medications should be documented after administration and appropriate coding should be used for refused medications, including documentation of pain assessment and post-medication effectiveness for pain medications. On April 24, 2026, at 10:27 a.m., during an interview with the DON, the DON stated nursing staff are expected to document medication administration after giving medications and to accurately document refusals. A review of the facility's policy and procedure titled, Administering Medications, dated April 2019, indicated, .If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document accordingly. 5. On April 20, 2026, at 1:11 p.m., a concurrent observation and interview was conducted in Resident 12's room. Resident 12 was observed eating her lunch when Certified Nurse Assistant (CNA) 7 was observed attempting to deliver another lunch tray to Resident 12. Resident 12 was observed to be eating the lunch tray that belonged to the resident in bed B (Resident 19). Resident 12 was observed feeding herself and had consumed 30% of the meal from the wrong meal tray. In a concurrent interview with CNA 8, CNA 8 stated she served the wrong tray to Resident 12. CNA 8 stated she should have verified the full name and room number before serving the lunch tray. CNA 8 stated Resident 12 and the resident in bed B have the same first name and she only checked Resident 12's first name. CNA 8 further stated Resident 12 can be at risk for choking or complications if not served the correct diet as ordered by the physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 12's meal tray ticket indicated, .CCHO (Controlled Carbohydrate), Texture.IDDSI (a standardized framework that classifies food and drinks to improve safety for people with swallowing difficulties) 5 (Minced and Moist).NAS (No Added Salt). Resident 19's meal tray ticket indicated, .Texture: IDDSI 6: Soft and Bite Sized. A review of Resident 12's admission Record, indicated an admission date of August 22, 2017, with diagnoses which included dementia (memory loss). A review of Resident 12's History and Physical, dated January 28, 2026, indicated Resident 12 does not have the capacity to make health care decisions. A review of Resident 12's Physician Orders dated April 22, 2026, indicated, .IDDSI 5: Minced and Moist texture (texture-modified diet that requires minimal chewing). On April 20, 2026, at 1:27 p.m., an interview was conducted with Licensed Vocational Nurse MM (LVN [NAME]). LVN MM stated CNA ES should have checked Resident 12's first and last name to ensure the correct lunch tray was delivered. LVN MM stated it was important to correctly identify the resident to ensure the correct tray was delivered to prevent complications such as choking and allergic reactions. On April 22, 2026, at 3:20 p.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated CNAs are primarily responsible for delivering meal trays to residents and must ensure the resident's full name matches the resident's identification bracelet. The DSD stated CNA 8 should have verified Resident 12's full name prior to delivering the lunch tray. The DSD stated that failing to correctly identify a resident by their full name could result in choking, allergic reactions, or failure to follow the physician's prescribed diet orders. A review of the facility policy and procedure titled, Assisting the Resident with Meals, dated December 2013, indicated, .Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow. 6. A review of the facility Resident council minutes on January 13, 2026, indicated, Nursing: Concerns: Nursing not checking trays . A review of the facility Resident council minutes on February 24, 2026, indicated, Nursing: Concerns: Residents looking for staff to check the food trays for lunch and dinner. On April 22, 2026, at 8:47 a.m., the Dietary Director (DD) was observed to bring meal cart 800 which included the test tray and parked outside room [ROOM NUMBER] hallway at 8:49 a.m. and stayed there in the hallway waiting for nursing staff to grab the meal trays and to deliver to the residents. At 8:58 a.m., Certified Nursing Assistant (CNA) 9 started removing first meal tray from Meal cart 800. At 9:09 a.m., CNAs completed delivery of all meal trays in the Meal cart 800 to residents. In a concurrent interview with the DD, the DD stated that during the whole process of observation delivery of meal trays to residents, no license nurse checked the meal trays before CNAs deliver the meal trays. The DD stated Meal cart 800 was holding 18 residents' meal trays from room [ROOM NUMBER] until 906. On April 22, 2026, at 1:15 p.m., an interview was conducted with the Director of Nursing (DON). The (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated Licensed Nurses should check the residents' meal trays before CNAs deliver them to the residents. The DON stated that without checking meal trays, residents could get wrong therapeutic diets (is a nutritionally planned diet that is ordered by a physician or recommended by a dietitian to meet a specific medical need. It modifies the type, texture, nutrient content, or amount of food to support a patient's treatment plan.), wrong modified texture, wrong modified liquid which could cause harm to residents. A review of the facility's policy and procedure titled, Assisting the Resident with Meals, dated 2013, indicated, .Purpose The purpose of this procedure is to provide appropriate assistance for residents during meals. Preparation .Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the food consistency is appropriate to the resident's ability to chew and swallow. A review of the facility's policy and procedure titled, Meal Service, revised January 2023, indicated, .Nursing personnel will serve the trays immediately upon checking the tray to be sure.the diets are correct.

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	04/24/2026

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

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dialysis (the process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood) services where consistent with professional standards of practice and facility's policy and procedure, for two of five residents reviewed for dialysis (Residents 16 and 137), when:1a. For Resident 16, the dialysis access site was not assessed and maintained. This failure had the potential to result in infection, including bloodstream infection, increased pain, and further decline in the president's health condition.1b. For Resident 16, received more than his physician prescribed 1500 milliliters (ml- a unit of measurement) of fluids per day. This failure placed Resident 16's care needs to go unmet and had the potential to result in fluid overload. 2. For Resident 137, there was no coordination between the facility and the dialysis clinic to address the resident's refusal to go to dialysis treatments, from March 3, 2026, to April 21, 2026. In addition, there was no care and treatment provided for the resident's dialysis access site when it was not being used due to refusal to go to dialysis treatments, including coordination with the dialysis clinic to address care and maintenance of the dialysis access site. These failures had the potential to result in serious complications including fluid overload, electrolyte imbalance, cardiac arrhythmias (irregular heart rate), infection to the dialysis access site, hospitalizations, and could affect overall health condition of Resident 137.Findings:1a. On April 21, 2026, at 8:44 a.m., Resident 16 was observed with a dressing covering a CVC access site (Central Venous Catheter - a catheter inserted into a large vein used for dialysis) on the right upper chest, with a date of April 20, 2026. The dressing was observed with greenish brown drainage.On April 22, 2026, at 8:30 a.m., during a concurrent observation and interview with Resident 16, Resident 16 stated he had pain at the CVC access site since yesterday afternoon. Resident 16 stated the licensed nurses had not checked on it. The dressing was observed to have greenish brown drainage.Resident 16's record was reviewed. Resident 16 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease (ESRD - the process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). A review of Resident 16's physician order, dated March 9, 2026, indicated, .Resident has IJ catheter (a type of central venous catheter (CVC) or central line inserted into the large internal jugular vein [a paired, deep blood vessel in the neck that drains oxygen-depleted blood from the brain, face, and neck, carrying it toward the heart] in the neck) with (enter number) lumens, which is located on the RUC (right upper chest). Monitor Q (every) shift for signs or symptoms of infection (i.e., redness, swelling, pain, warmth, discharge, induration) or bleeding. Notify physician of abnormal findings every shift.On April 22, 2026, at 11:45 a.m., during an interview with Licensed Vocational Nurse (LVN) 13, LVN 13 stated there had been no report of concerns regarding Resident 16's access site reported to her from the previous shift. LVN 13 stated she had not assessed the resident's access site for today and was not aware of any complaint of pain or drainage. LVN 13 further stated that the CVC dressing was usually changed at the dialysis clinic, but the licensed nurse at the facility monitors and assesses it Q shift and notifies the physician of any abnormal findings.On April 22, 2026, at 2:10 p.m., during an interview with the Director of Nursing (DON), the DON stated she was not aware that Resident 16's dialysis access site had any drainage. The DON stated the licensed nurse were expected to assess the site, report abnormalities and notify the physician. The DON further stated it was important to monitor the access site because it could become infected and lead to serious illness.A review of the facility's policy and procedure titled, Hemodialysis Catheters - Access and Care of, dated June 2025, indicated, .Hemodialysis catheters are only accessed by medical personnel who have received training and demonstrated clinical competency regarding use of this catheter.Central catheters.this is not the preferred site for long-term placement. There is more risk of clotting and infection.the dressing change is done in the dialysis center post treatment.if dressing (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	becomes wet, dirty, or not intact, the dressing will be changed by a licensed nurse trained in this procedure.the central catheter site must be kept clean and dry at all times.the nurse should document in the residents medical record every shift as follows: location of catheter; condition of dressing (interventions if needed); if dialysis was done during shift; any part of report from dialysis nurse post-dialysis being given; and observations post-dialysis.1b. On April 22, 2026, at 8:30 a.m., during an interview with Resident 16, Resident 16 stated every time he goes for his dialysis treatment, they remove at least 3.5 kilograms, he further stated, the facility usually brings him lots of fluids to drink but does not drink it all. On April 22, 2026, at 8:30 a.m., during a concurrent observation and interview with CNA 13, CNA 13 observed bringing Resident 16's breakfast tray with 8 fl. oz. (fluid ounce - unit of measurement) Nonfat milk (240 ml - milliliter [unit of measurement]), cranberry juice (120 ml), Nephro supplement drink (237 ml), a cup of water (180ml), and a cup of coffee (180 ml), total of 957 ml for breakfast. CNA 13 further stated, she was not sure how much fluid intake the resident who was diagnosed with ESRD should have, she thinks it is 1500 ml per meal but will double check. Resident 16's meal tray ticket indicated, thin, Renal.4 fl oz Cranberry juice. 8 fl oz. Non-fat milk.8 fl oz Nepro.On April 22, 2026, at 9 a.m., during an interview with CNA 13, CNA 13 stated that Resident 16 should be only 1500 ml fluid intake for the whole day. CNA 13 further stated she informed she removed the cup of water and juice.A review of Resident 16's physician order, dated April 14, 2026, indicated, . HD fluid restriction of 1500 ml/24 hrs. Nursing: Give 275 for AM shift, 275 ml for PM shift, and 50 ml for Night shift (total= 600ml). Dietary: give 420 m for AM shift, 240 ml for PM shift, and 240 ml for night shift (total= 900 ml) .A review of Resident 16's Fluid Intake Record, for the month of April 2026, indicated the resident consumed more than 1500 ml/day on the following dates:-April 7, 2026; 1615 ml;-April 14, 2026; 2120 ml;-April 20, 2026; 1590 ml; and-April 21, 2026; 1690 ml.On April 22, 2026, at 2:10 pm, during an interview via telephone with Dialysis Clinic Clinical Coordinator (DCCC). The DCCC stated Resident had a weight gain of 6.6 kg (kilogram - unit if measurement) today when he arrived for his treatment. The DCCC further stated resident 16 had problems with too much weight gain in between treatment, and that the facility has been made aware.A review of Resident 16's Hemodialysis Communication Record, dated April 15, 2026, indicated, .to be completed by Dialysis Center following dialysis treatment and to accompany resident on return to facility post dialysis.Recommendations: monitor fluid intake.On April 24, 2026, at 12:04 p.m., during an interview with the DON. The DON stated Resident 16 was on a fluid restriction of 1500 ml per day, and there could be possible outcome for residents who consumed greater than their prescribed amount would be fluid overload, respiratory distress, and edema. The DON further stated her expectation was for staff to follow the order and notify the physician if residents consumed more than their prescribed fluid amount.A review of the facility's policy and procedure titled, Fluid Restricted Diet, revised April 13, 2026, indicated, .Fluid restrictions are usually ordered to treat CHF (congestive heart failure - chronic, progressive condition where the heart muscle cannot pump blood efficiently enough to meet the body's needs for oxygen), hyponatremia (a medical condition where the sodium concentration in the blood is abnormally low), or renal failure. The restriction is an estimate of the amount of fluids which will assist in management of the condition.The following guidelines may be used in distributing fluids between Nursing and Dietary.1500 ml/24 hours.Nursing.600.Dietary.900.2.On April 22, 2026, at 11:08 a.m., during an observation and interview with Resident 137, Resident 137 stated he had dialysis scheduled every Tuesday and reported he had not attended dialysis treatments for approximately two months. Resident 137 stated he was refusing to go to dialysis treatment because he did not like the scheduled time given to him. Resident 137 stated he had CVC access on his right upper chest, and that no one has looked at it. Resident 137's CVC was observed on the resident's right upper chest, exit site exposed, with no dressing covering it.Resident 137's record was reviewed. Resident 137 was admitted to the facility on [DATE], with diagnoses which included End Stage Renal Disease (ESRD).A review of Resident 137's physician order, dated January 27, 2026, indicated, .Resident to receive dialysis at [name of dialysis clinic].The dialysis schedule is 1 (one) time per week on Tuesdays, (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dialysis pick up time is 8 a.m., transportation to dialysis provided by [name of transportation company].A review of Resident 137's physician order, dated October 16, 2025, indicated, .Resident has catheter with (enter number) lumens, which is located on the RUC. Monitor Q shift for signs and symptoms of infection (i.e., redness, swelling, pain, warmth, discharge, induration) or bleeding. notify physician of abnormal findings every shift.check dialysis catheter site dressing Q shift. May reinforce dressing as needed. Do not get wet.Dialysis center to provide dialysis catheter access site care including changing caps.A review of Resident 137's care plan, dated November 20, 2025, indicated, .Explain risks vs benefits to resident/ responsible party.interventions: notify MD and responsible party each time they refused.A review of Resident 137's Hemodialysis Communication Records, indicated that Resident 137's last dialysis treatment was on February 26, 2026. Further review of records indicated that Resident 137 has missed his dialysis treatment from March 3, 2026, until April 21, 2026.A review of Resident 137's Progress Notes, documented by Registered Dietitian (RD) 2, indicated Resident 137 refused to go to dialysis once a week because he was upset with the dialysis day and time being changed as documented on the following dates and times:-March 9, 2026, at 7:27 a.m.;-March 15, 2026, at 5:27 a.m.;-March 22, 2026, at 8:26 a.m.;-March 29, 2026, at 6:39 a.m.;-April 6, 2026, at 5:15 a.m.; and-April 12, 2026, at 10:45 a.m.Further review of Resident 137's record indicated there was no coordination between the facility and the dialysis clinic to address the resident's refusal to go to dialysis treatment and make accommodations to the preferred day and time for the resident's dialysis treatments.On April 22, 2026, at 11:28 a.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated Resident 137 had been refusing dialysis treatments, with the last completed dialysis treatment on February 26, 2026. The ADON stated the dialysis clinic is responsible for doing dressing changes for the CVC.On April 23, 2206, at 8:29 a.m., during an interview with the Dialysis Facility Administrator (DFA), the DFA stated Resident 137 was discharged from the dialysis facility on March 31, 2026, due to missed treatments. The DFA stated Resident 137's last dialysis treatment was on February 10, 2026. The DFA stated the dialysis social worker contacted someone from the facility (unable to state the name of the facility staff member) to inform them that Resident 137 was discharged from the dialysis clinic on March 31, 2026, due to missed dialysis treatments. The DFA stated when a resident refuses dialysis, the facility should coordinate with the dialysis provider to ensure appropriate care of the access site, including cleaning and flushing of the catheter ports. The DFA stated the access site should have been evaluated for removal if not longer in use.Further review of Resident 137's record from March 3, 2026, through April 21, 2026, indicated there was no documented evidence that the facility coordinated with the dialysis provider regarding Resident 137's missed treatments or discharge and the care of the CVC access site. In addition, there was no documented evidence that the facility maintained the resident's dialysis access site following missed treatments.On April 23, 2026, at 5:03 p.m., during an interview conducted with the DON, the DON stated the following:-There was no documentation from nursing that Resident 137 was refusing dialysis treatments on the scheduled date of dialysis from March 3, 2026, to April 21, 2026;-There was no documentation the facility coordinated with the dialysis clinic regarding the reason of Resident 137's refusal to go to dialysis treatments;-The facility should have coordinated with the dialysis clinic to see if Resident 137's preferred schedule for dialysis could be accommodated;-They were not aware Resident 137 was discharged from the dialysis clinic on March 31, 2026;-There was no documentation care and treatment for the CVC access site was provided by the facility; -There was no coordination between the facility and the dialysis clinic regarding care for the CVC dialysis access site since the resident was refusing to go to the dialysis clinic. The DON stated the facility should have coordinated with the dialysis clinic regarding the care for the CVC access site.A review of the facility policy and procedure titled, Hemodialysis Catheters- Access and Care of, dated June 2025, indicated, .Hemodialysis catheters are only accessed by medical personnel who have received training and demonstrated clinical competency regarding use of this catheter.Central catheters.this is not the preferred site for long-term placement. There is more risk of clotting and infection.the dressing (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	change is done in the dialysis center post treatment.if dressing becomes wet, dirty, or not intact, the dressing will be changed by a licensed nurse trained in this procedure.the central catheter site must be kept clean and dry at all times.the nurse should document in the residents medical record every shift as follows: location of catheter; condition of dressing (interventions if needed); if dialysis was done during shift; any part of report from dialysis nurse post-dialysis being given; and observations post-dialysis.A review of the facility policy and procedure titled Requesting, Refusing and/or Discontinuing Care or Treatment, dated February 2021, indicated, .detailed information relating to the request, refusal, or discontinuation of treatment are documented in the resident's medical record.documentation pertaining to a resident's request, discontinuation or refusal of treatment include at least the following: a. the date and time the care or treatment was attempted.b. the type of care or treatment.c. the resident's response and stated reasons for request, discontinuation or refusal.d. the name of person who attempted to administer the care or treatment.e. That the resident was informed of the purpose of the treatment and potential outcome of not receiving of the medication/ or treatment.f. The resident's condition and any adverse effects due to the request.g. The date and time the practitioner was notified as well as the practitioner's response.h. All other pertinent observation.i. the signature and title of the person recording the data.the healthcare practitioner must be notified of treatment in a time frame determines by the resident's condition and potential serious consequences of the request.

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	555339	A. Building B. Wing	04/24/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure sufficient staff were provided to meet the needs of the residents when the facility did not meet the required minimum of actual total Certified Nurse Assistant (CNA) Direct Care Hours Per Patient Day (DHPPD - measure the numbers of hours of direct care given to residents in skilled nursing facility) of 2.4 hours for the months of November 2025, December 2025, January 2026, February 2026, March 2026, and April 2026.The failure to maintain the required minimum CNA DHPPD hours had the potential to place residents at risk for unmet needs, compromised safety, and decreased quality of care. Findings:On April 24, 2026, at 2:30 p.m., during an interview with Certified Nursing Assistant (CNA) 14, CNA 14 stated there were days when there were not enough staff to take care of the residents on the weekends and residents may be calling for assistance for extended period of time which may lead to residents' needs not being met. CNA 14 stated she was responsible to provide care to 13 residents during the morning shift, specially during the weekends, which would make it difficult for them to complete the care to be provided to the residents. On April 24, 2026, at 2:45 p.m., the facility staffing records were reviewed with the Director of Staff Development (DSD). The review indicated the facility's CNA staffing levels were below the minimum required DHPPD of 2.4 hours on the following weekend dates: -November 1, 2025; 2.35-November 8, 2025; 2.19-November 9, 2025; 2.30-November 16, 2025; 2.31-November 29, 2025; 2.34-December 7, 2025; 2.21-December 13, 2025; 2.13-December 14, 2025; 2.31-December 21, 2025; 2.26-December 27, 2025; 2.12-December 28, 2025; 2.32-January 3, 2026; 2.24-January 4, 2026; 2.35-January 11, 2026; 2.33-January 17, 2026; 2.37-January 18, 2026; 2.30-January 24, 2026; 2.38-January 31, 2026; 2.38-February 8, 2026; 2.28-February 14, 2026; 2.28-February 15, 2026; 2.22-February 21, 2026; 1.96-February 22, 2026; 2.10-February 28, 2026; 1.98-March 1, 2026; 2.00-March 7, 2026; 2.23-March 8, 2026; 2.23-March 15, 2026; 2.37-March 21, 2026; 2.32- March 22, 2026; 2.32- March 28, 2026; 2.27- March 29, 2026; 2.12-April 5, 2026; 2.25-April 12, 2026; 2.38In a concurrent interview with the DSD, the DSD stated the facility's CNA DHPPD hours were below 2.4 hours on the above dates that fell on weekends. The DSD further stated CNA DHPPD hours should be maintained at 2.4 hours or above to ensure residents' needs were met and quality care was provided.On April 24, 2026, at 3:12 p.m., during an interview with CNA 8, CNA 8 stated she works full time during the morning shift, and she would be providing care to 10 to 13 residents at a time. CNA 8 stated there were not enough staff to meet the residents' needs.A review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing, dated April 2025, indicated, .facility provides sufficient numbers of nursing staff.to provide nursing and related care and services for all residents.Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered determination of sufficient and competent staffing.

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	555339	A. Building B. Wing	04/24/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services were provided to meet the needs of the residents, for four of 13 residents reviewed (Residents 16, 17, 88, and 146), when:1. For Resident 16, the staff did not follow the physician's order when calcium acetate (medication to treat hyperphosphatemia [high phosphate levels] in patients with end-stage kidney disease) was not given with meals.This failure had the potential to reduce its effectiveness as a phosphate binder, placing the resident at risk for elevated phosphorus levels and related complications.2. For Resident 17, a blood pressure medication with holding parameters was not administered in accordance with the physician's order.This failure had the potential to significantly lower blood pressure and could cause dizziness, confusion, fainting, and a fall.3. For two out of 11 randomly selected residents (Resident 88 and 146), documentation on the Controlled Drug Records (CDR - a medication count sheet, an inventory record used to document the receipt, use, and count of controlled substances [CS, those with high potential for abuse and addiction]) did not reconcile with the Medication Administration Record (MAR - a record used by a licensed nursing staff to document medications administered to a resident).These failures resulted in inaccurate accountability of controlled substances, which had the potential for misuse or diversion (medication taken by someone other than for whom it is prescribed) of controlled substances.
Findings: 1. On April 22, 2026, at 8:30 a.m., during an interview conducted while Resident 16 was eating breakfast, the resident stated he is supposed to take his phosphorus binder (calcium acetate) with meals, but the nurses do not give it with meals. A review of Resident 16's admission Record, indicated he was admitted to the facility on [DATE], with diagnoses including End^Stage Renal Disease (ESRD- the process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). A review of Resident 16's Medication Administration Record (MAR), indicated he had an active order for calcium acetate to be administered with meals. On April 22, 2026, at 10:30 a.m., during an interview with Licensed Vocational Nurse (LVN) 15, LVN 15 stated she administered Resident 16's calcium acetate at 9:58 a.m. LVN 15 further stated the order required the medication to be given with meals, and she did not give it while Resident 16 was eating his breakfast. A review of Resident 16's MAR showed calcium acetate was not administered with meals as ordered on multiple occasions. On April 24, 2026, at 12:04 p.m., during an interview with the Director of Nursing (DON). The DON stated calcium acetate should have been given with meals as ordered to ensure it is effective. A review of the facility's policy and procedure titled, Administering Medications, dated April 2019, indicated, .Medications are administered in accordance with prescriber orders . 2a. On April 20, 2026, at 10:47 a.m., during a medication administration observation for Resident 17, LVN 2 checked the resident's blood pressure and pulse with a freestanding BP machine prior to (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration. The blood pressure was 112/72 and the pulse was 85. LVN 2 administered the resident's morning medications but did not administer lisinopril (medication for high blood pressure). On April 20, 2026, at 1:42 p.m., a review of Resident 17's physician order indicated: - Lisinopril 40 mg, give one tablet by mouth one time a day for hypertension. Hold for SBP (systolic blood pressure – top number of a blood pressure reading) < 110 or HR (heart rate – number of heartbeats per minutes) < 60, dated November 16, 2025 On April 20, 2026, at 1:42 p.m., a review of Resident 17's MAR, dated April 2026, indicated the LVN 2 documented code 4 (vital sign out of parameter) for lisinopril. However, no blood pressure or pulse values were documented in the MAR. On April 22, 2026, at 11:25 a.m., during a concurrent interview and record review with LVN 2, LVN 2 confirmed that she did not administer lisinopril and stated she believed the holding parameter was 115. 2b. On April 20, 2026, at 1:42 p.m., a further review of Resident 17's March and April 2026 MAR indicated lisinopril 40 mg was administered when the SBP was below 110 on the following dates: - March 3, 2026, at 0900 (9 a.m.), SBP 85; - April 8, 2026, at 0900 (9 a.m.), SBP 101; and - April 17, 2026, at 0900 (9 a.m.), SBP 105. On April 22, 2026, at 10:39 a.m., during a concurrent interview and record review with the DON, the DON confirmed lisinopril medication was not administered when SBP was above 110 but was administered when SBP was below 100, the ordered holding parameter. The DON stated nursing staff must follow physician orders, including holding parameters. A review of the facility's policy and procedure titled, Administering Medications, dated April 2019, indicated, .Medications are administered in accordance with prescriber orders . 3a. On April 21, 2026, at 4:21 p.m., during an inspection of Medication Cart 4 at MedBridge Nursing Station, a blister card of oxycodone 10 mg (a controlled substance pain medication) labeled for Resident 146 was reviewed with LVN 4. A review of Resident 146's physician order indicated: - oxycodone 5 mg, give 10 mg by mouth every 6 hours as needed for moderate pain (4-6 [pain scale]), dated November 24, 2025. A review of Resident 146's CDR and April 2026 MAR indicated: - On April 4, 2026, at 1743 (5:43 p.m.), one tablet was removed and documented on the CDR. However, there was no corresponding documentation of administrations or pain assessment on the MAR; and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On April 15, 2026, at 1708 (5:08 p.m.), one tablet was documented as administered on the MAR. However, there was no corresponding removal documented on the CDR. 3b. On April 21, 2026, at 4:21 p.m., during an inspection of Medication Cart 4 at MedBridge Nursing Station, a blister card of oxycodone 10 mg labeled for Resident 88 was reviewed with LVN 4. A review of Resident 88's physician order indicated an order for oxycodone 5 mg, give 2 tablet[s] by mouth every 4 hours as needed for severe pain (7-10), dated April 1, 2026. A review of Resident 88's CDR and April 2026 MAR indicated: - On April 1, 2026, at 1023 (10:23 a.m.) and April 8, 2026, at 1220 (12:20 p.m.), one tablet was removed and documented on the CDR. However, there was no corresponding documentation of administrations or pain assessments on the MAR; and - On April 4, 2026, at 1859 (6:59 p.m.), April 13, 2026, at 1015 (10:15 a.m.), April 13, 2026, at 1440 (2:40 p.m.), April 14, 2026, at 1648 (4:48 p.m.), and April 19, 2026, at 0353 (3:53 a.m.), oxycodone was documented as administered on the MAR. However, there was no corresponding removal documented on the CDR. On April 24, 2026, at 11:09 a.m., during a concurrent interview and record review with the DON in the DON's office, the DON confirmed discrepancies between the CDR and MAR for Resident 88 and 146. The DON stated nursing staff are expected to document removal of controlled substances on the CDR at the time of removal and document administration on the MAR after administration. A review of the facility's policy and procedure titled, Medication Administration, dated April 2019, indicated, .The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones .As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered.e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug . A review of the facility's policy and procedure titled, Controlled Substances, dated November 2022, indicated, .Reconciliating Controlled Substances .The system of reconciling .dispensing .of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records .Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count .The nurse coming on duty and the nursing going off duty make the count together and document and report any discrepancies to the director of nursing services .

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	04/24/2026

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with physician orders and the facility's policies and procedures, when a medication error rate of 16.13% (five medication errors out of 31 opportunities) was identified during medication pass observations, for two of five residents (Residents 17 and 176), when:1.For Resident 176, medications ordered to administer with food were not followed according to the physician's order and manufacturer's guidelines for administration. In addition, medications were administered outside of administration timeframe; and2.For Resident 17, Vitamin D was not administered according to the physician's order. In addition, Resident 17 was not instructed to rinse mouth after administration of an inhalation medication, according to the physician's order and manufacturer's guideline.These failures had the potential to compromise medication therapy, reduce therapeutic effectiveness, and increase the risk of adverse effects, including gastrointestinal irritation and oral candidiasis (a fungal infection of mouth).Findings:1. On April 20, 2026, at 9:45 a.m., during a medication administration observation with Licensed Vocational Nurse (LVN) 4, LVN 4 prepared Resident 176's medications scheduled for 9 a.m., without food or snacks.On April 20, 2026, at 11:06 a.m., during a record review of Resident 176's physician orders indicated the following:- Empagliflozin 10 mg (milligram - unit of measurement), give 1 tablet by mouth one time a day for DM (diabetes mellitus [high blood sugar]). Take with food, dated April 13, 2026;- Metoprolol Succinate (medication to treat high blood pressure) ER (Extended Release) 100 mg, give 1 tablet by mouth one time a day for hypertension.Take with food., dated April 13, 2026; and- Potassium Chloride ER 10 mEq (milliequivalent - unit of measurement), give 1 tablet by mouth one time a day for hypokalemia (low potassium level). Give medication with food or snack and/or with 4-8 oz of water or juice to prevent GI (Gastrointestinal) upset, dated April 13, 2026. A review of Resident 176's Medication Administration Record (MAR), dated April 2026, indicated all 9 a.m. medications were documented as administered, including the following:- Empagliflozin (used to treat diabetes and heart failure) 10 mg;- Metoprolol Succinate ER 100 mg; and- Potassium Chloride ER 10 MEQThese medications were not administered with food according to the physician's order and as documented in the MAR.On April 20, 2026, between 11:54 a.m. and 12:11 p.m., during a medication administration observation with LVN 4, LVN 4 administered the following previously omitted medications without food:- Metoprolol Succinate ER 100 mg;- Potassium Chloride ER 10 mEq;A review of the facility meal schedule indicated breakfast was served at approximately 7:30 a.m., and lunch had not yet been served at the time of administration. In addition, Empagliflozin, scheduled for 9 a.m., was not administered during the medication pass and was not subsequently administered. On April 21, 2026, at 4 p.m., during an interview with LVN 4, LVN 4 acknowledged the medications were administered without food and stated a snack should have been offered when meal trays were not available. A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for potassium chloride tablets, dated January 2025, retrieved from DailyMed indicated: .Potassium chloride tablets.should be taken with meals and with a glass of water or other liquid. This product should not be taken on an empty stomach because of its potential for gastric irritation .A review of the Prescribing Information for Metoprolol Succinate ER tablets, dated January 2024, retrieved from DailyMed indicated, .take metoprolol succinate extended-release tablets.as directed, preferably with or immediately following meals.2. On April 20, 2026, at 10:23 a.m., during medication administration observation for Resident 17, LVN 2 prepared and administered medications scheduled for 9 a.m., including inhalation therapies.On April 20, 2026, at 10:38 a.m., LNV 2 initiated administration of budesonide (an inhaled corticosteroid medication used to reduce airway inflammation) through a nebulizer (a device that turns liquid medication into a mist for inhalation into the lungs).On April 20, 2026, at 10:50 a.m., after completion of the nebulizer treatment, LVN 2 removed the nebulizer mask. LVN 2 did not instruct Resident 17 to rinse the mouth and spit out after administration.On April 20, 2026, at 1:42 p.m., during a review of Resident 17's records included a (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician's order indicated the following:- Budesonide inhalation suspension 1mg/2mL (milligram per milliliter - unit of measurement), 1 applicator inhale orally every 12 hours for wheezing/COPD (chronic obstructive pulmonary disease [COPD], a lung disease causing breathing problems)/Asthma. Rinse mouth after each use, dated March 27, 2026; and- Cholecalciferol 1000 unit, give 1 tablet by mouth one time a day for supplement, dated November 16, 2025.A review of Resident 17's MAR, indicated cholecalciferol (Vitamin D) 2000 units, scheduled for 9 a.m. was documented as administered. On April 22, 2026, at 11:25 a.m., during a concurrent interview and record review with LVN 2, LVN 2 confirmed the Vitamin D bottle was not present among the prepared medications. LVN 2 acknowledged the medication was not administered despite being documented as given in the MAR. LVN 2 also confirmed Resident 17 was not instructed to rinse the mouth and spit out after administration of budesonide via nebulizer. LVN 2 stated she was not aware rinsing the mouth is required following administration of nebulized corticosteroids and believed this instruction applied only to powder inhalation forms. On April 24, 2026, at 10:39 a.m., during an interview with the DON, the DON stated the nursing staff were expected to administer the medications as ordered, document administration after medications were given, and follow all administration instructions, including rinsing the mouth after budesonide use.A review of the Prescribing Information for Budesonide inhalation suspension, dated January 2026, retrieved from DailyMed indicated: .Candida Albican (type of fungus) infection of the mouth and throat may occur. Monitor patients periodically for signs of adverse effects on the oral cavity.Patients should rinse the mouth after inhalation of budesonide inhalation suspension .A review of the facility's policy and procedure titled, Administering Medications, dated April 2019, indicated, .Medications are administered in accordance with prescriber orders .The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones .

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	555339	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medications in accordance with the facility policy and procedures and the manufacturer's specifications when:1. An opened and uncapped ophthalmic (eye) medication for Resident 103 was stored without an opened date, with the dropper tip covered by tissue, in one of two reviewed medication rooms (Oasis Medication Room);2. Discontinued medications, including controlled substances (CS - medications with potential for abuse and dependence), for Residents 63 and 153 were stored in two of four reviewed medication carts (Dunes and Oasis Medication Carts); and3. Expired house supply medication and inhalers for Residents 140 and 145 were stored with active medications in two of four reviewed medication carts (Oasis and MedBridge Medication Carts).These failures had the potential for residents to receive deteriorated, discontinued, expired, or ineffective medication, which could result in medication errors and compromised treatment outcomes.Findings:1. On April 21, 2026, at 10:08 a.m., during an inspection of Oasis Medication Room with the Director of Nursing (DON), an opened bottle of latanoprost (Xalatan, an opthalmic medication used to treat glaucoma [a group of eye diseases that damage the optic nerve-the vital connection between the eye and brain-often caused by high fluid pressure within the eye]) 0.005 % (percentage - unit of measurement for the concentration of a medication) was observed stored in the medication refrigerator without an opened date. The dropper tip was uncapped and covered with tissue and stored inside the pharmacy-supplied amber bottle labeled for Resident 103.A review of April 2026 Medication Administration Record (MAR) indicated Resident 103 received the medication daily at bedtime as ordered.On April 21, 2026, at 10:08 a.m., during a concurrent observation, interview, and record review with the DON, the DON confirmed the storage condition was not appropriate and stated the dropper tip could be exposed to contamination.On April 23, 2026, at 4:23 p.m., during an interview with the Infection Preventionist (IP), the IP stated the eye drop should have been discarded if the cap was missing, as exposure of the dropper tip could result in contamination and potential eye infection such as conjunctivitis (pink eye, inflammation of the eye).2a. On April 21, 2026, at 2 p.m., during an inspection of Medication Cart #8 at Dunes Nursing Station with Licensed Vocational Nurse (LVN) 5, the following medications for Resident 153 were observed stored in the medication cart with other active medications:- Tramadol (Scheduled IV controlled substance pain medication) 50 mg (milligram - unit of measurement) blister card containing 11 tablets;- Tramadol 50 mg blister card containing 14 tablets;- Oxycodone - APAP (scheduled II controlled substance, narcotic pain medication containing oxycodone [opioid] and acetaminophen) 5-325 mg blister card containing 12 tablets;- Oxycodone - APAP 5-325 mg blister card containing 30 tablets;- Allopurinol (used to treat gout [painful form of arthritis]) 100 mg blister card containing three (3) tablets; - Sevelamer (phosphate binder used in kidney disease) 400 mg blister card containing three (3) tablets;- Sucralfate (used to treat stomach ulcers) 1 gm (gram - unit of measurement) blister card containing three (3) tablets;- Icosapent Ethyl (Vascepa, used to lower triglyceride [blood fats]) 1 gm blister card containing three (3) capsules;- Hydralazine (used to treat high blood pressure) 50 mg blister card containing six (6) tablets;- Clopidogrel (an antiplatelet medication used to prevent blood clots from forming) 75 mg blister card containing three (3) tablets;- Amlodipine (used to treat high blood pressure) 5 mg blister card containing three (3) tablets;- Escitalopram (used to treat depression) 10 mg blister card containing three (3) tablets;- Furosemide (used to reduce fluid buildup) 80 mg blister card containing two (2) tablets;- Montelukast (used to treat asthma) 10 mg blister card containing five (5) tablets;- Gabapentin (used for nerve pain) 100 mg blister card containing three (3) capsules;- Gabapentin 100 mg blister card containing six (6) capsules;- Atorvastatin (used to treat high cholesterol) 20 mg blister card containing six (6) tablets;- Atorvastatin 40 mg blister card containing 25 tablets;- Clonidine (used (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to treat high blood pressure) 0.1 mg blister card containing five (5) tablets;- Clonidine 0.1 mg blister card containing 27 tablets;- Clonidine 0.1 mg blister card containing seven (7) tablets;- Clonidine 0.1 mg blister card containing seven (7) tablets;- Clonidine 0.1 mg blister card containing 30 tablets;- Clonidine 0.1 mg blister card containing 28 tablets;- Carvedilol (used to treat high blood pressure) 0.125 mg blister card containing 27 tablets;- Carvedilol 0.125 mg blister card containing two (2) tablets;- Carvedilol 0.125 mg blister card containing seven (7) tablets;On April 21, 2026, at 2 p.m., during a concurrent observation, interview and record review with LVN 5, Resident 153's medical record indicated the resident was transferred to the hospital on April 12, 2026, and discharged from the facility on April 19, 2026. LVN 5 stated discontinued medications should have been removed from the medication cart for proper disposal.On April 21, 2026, at 2:35 p.m., during a concurrent observation, interview, and record review with the DON, the DON confirmed the findings and stated the discontinued medications should have been removed from medication storage areas after discharge.2b. On April 21, 2026, at 3:11 p.m., during an inspection of Medication Cart #9 at Oasis Nursing Station with LVN 6, the following discontinued controlled substance medications labeled for Resident 63 were observed stored with active medications:- Hydrocodone - Acetaminophen (Norco, a narcotic pain medication) 10-325 mg blister card containing six (6) tablets;- Hydrocodone - Acetaminophen 10-325 mg blister card containing 30 tablets; and- Hydrocodone - Acetaminophen 5-325 mg blister card containing 17 tablets. On April 21, 2026, at 3:11 p.m., during a concurrent observation, interview, and record review with LVN 6, LVN 6 stated the medications were discontinued on March 25, 2026.On April 24, 2026, at 10:57 a.m., during a concurrent interview and record review with the DON, the DON confirmed the findings during inspection of the medication carts at Dunes and Oasis Nursing Station of the discontinued medications. The DON stated the discontinued medications should have been removed from the medication cart once discontinued and stated the nursing staff were expected to remove discontinued medications promptly.A review of the facility's policy and procedure titled, Controlled Substances, dated November 2022, indicated, .Controlled substances remaining the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed .The consultant pharmacist or designee routinely monitors controlled substance storage records . 3a. On April 21, 2026, at 3:11 p.m., during an inspection of Medication Cart #9 at Oasis Nursing Station with LVN 6, an opened box of Famotidine (an over-the-counter [medication available without prescription] acid reducer medication) 10 mg house supply (medications available for general use for residents, rather than dispensed or labeled for a specific resident) was observed stored in the medication cart. The manufacturer's expiration date on the box indicated January 2026. Inside the box, four (4) tablets were observed with expiration date of November 2025 and ten tablets with expiration date of January 2026. LVN 6 confirmed the medications were expired and should have been removed from the medication cart and disposed of.3b. On April 21, 2026, at 4:21 p.m., during an inspection of Medication Cart #4 at MedBridge Nursing Station with LVN 5, an opened fluticasone propionate and salmeterol (brand name Advair Diskus - a dry powder inhaler used to treat chronic obstructive lung disease [COPD - a lung disease causing difficulty breathing]) 100 mcg/50 mcg (microgram, unit of measurement) labeled for Resident 145 was observed stored without an opened date. The pharmacy fill date indicated March 2, 2026. The inhaler device displayed a dose counter reading of 25, indicating remaining doses.A review of Resident 145's Medication Administration Record (MAR), dated March 2026 and April 2026, indicated the inhaler was administered daily from March 2, 2026, through April 21, 2026, as ordered by the physician.3c. On April 21, 2026, at 4:21 p.m., during an inspection of Medication Cart #4 in MedBridge Nursing Station with LVN 5, an opened fluticasone propionate and salmeterol 250 mcg/50 mcg labeled for Resident 140 were observed stored without an opened date. The pharmacy fill date on the label indicated March 20, 2026. The inhaler device displayed a dose counter reading of 23, indicating remaining doses.A review of Resident 140's MAR, dated March 2026 and April 2026, indicated the inhaler was administered twice a day from March 21, 2026, at 9 a.m., (continued on next page)

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	04/24/2026

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through April 21, 2026, at 9 a.m. A review of the manufacturer's labeling for Fluticasone propionate and salmeterol inhalation powder indicated: one foil strip of 60 blisters.Discard the inhaler 1 month after opening the foil pouch or when the counter reads 0 (after all blisters have been used), whichever comes first.On April 21, 2026, at 4:21 p.m., during a concurrent observation, interview and record review with LVN 5, LVN 5 confirmed the inhalers had exceeded 30 days from first use date and acknowledged the inhalers should have been removed from the medication cart. On April 24, 2026, at 11:09 a.m., during an interview and record review with the DON, the DON stated nursing staff are expected to document the opened date on the medications and use the beyond-use date (BUD - the date after opening after which a medication should not be used) cheat sheet available in every medication cart to determine expiration and remove expired medications.A review of the facility's policy and procedure titled, Administering Medications, dated April 2019, indicated, .The expiration/beyond-use date.is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container . A review of the facility's policy and procedure titled, Medication Labeling and Storage, dated February 2023, indicated, .discontinued, outdated or deteriorated medications ., the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .medication label includes .expiration date.

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	555339	A. Building B. Wing	04/24/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure a physician-prescribed fortified diet (diet with added extra nutrients to increase the calories and/or protein density to promote improvement in residents' nutrition status) was provided, for four of four sampled residents (Residents 26, 84, 64, and 114) during lunch on April 20, 2026.This failure had the potential to have a negative impact on the residents' nutritional status and further compromise residents' medical status. Findings:On April 20, 2026, at 10:29 a.m., the undated Fortified diet Spreadsheet (the document used to guide dietary staff adding extra calories on food items) was reviewed in the facility kitchen. The Fortified Spreadsheets indicated, Monday Lunch: Hamburger:1 oz extra gravy; Wheat Roll: Extra 1/2 oz melted margarine.On April 20, 2026, at 12:16 p.m., a concurrent observation, interview, and review of Resident 64's meal ticket (contain Resident name and physician diet order) were conducted with Certified Nursing Assistant (CNA) 16 at Dunes dining room. CNA 16 read Resident 64's meal ticket and stated Resident 64 was on Fortified diet. CNA 16 checked Resident 64's served entree and stated she did not see any melted margarine and gravy on the served foods.On April 20, 2026, at 12:22 p.m., a concurrent observation, interview, and review of Resident 114 meal ticket review were conducted with Licensed Vocational Nurse (LVN) 8 at Dunes dining room. LVN 8 read Resident 114's meal ticket and stated Resident 114 on Fortified diet. LVN 8 checked Resident 114's served meal and claimed she did not see melted margarine served on food and extra gravy served on meat.On April 20, 2026, at 12:24 p.m., a concurrent observation, interview, and review of Resident 84's meal ticket were conducted with LVN 8 at Dunes dining room. LVN 8 read Resident 84's meal ticket and stated Resident 84 on Fortified diet. LVN 8 checked Resident 84's served meal and stated there was no melted margarine and gravy served. On April 20, 2026, at 12:30 p.m., a concurrent observation, interview, and review of Resident 26's meal ticket were conducted with LVN 8 at Dunes dining room. LVN 8 read Resident 26's meal ticket and stated Resident 26 on Fortified diet. LVN 8 checked Resident 26's served meal and stated there was no melted margarine served and extra gravy served on meat.On April 21, 2026, at 3:41 p.m., a concurrent interview and a Fortified diet Spreadsheet review were conducted with the Dietary Director (DD). The DD stated Cooks should follow the Fortified diet Spreadsheet providing extra calories from extra melted margarine and gravy to Fortified diet on Monday (April 20,2026) during lunch. The DD explained Resident on Fortified diet was prescribed by doctor to get extra calories to help gain weight and/or promote wound healing. The DD stated residents who were on Fortified diet did not get melted margarine and/or extra gravy with lunch on Monday means he or she did not get extra calories.During a review of Residents 26, 84, 64 and 114's physician's diet order indicated they were on Fortified diet.During a review of the facility policy and procedure titled, FORTIFICATION OF FOOD: INCREASING CALORIES AND/OR PROETEIN IN THE DIET, dated 2023, the P&P indicated, .POLICY: The enrichment of foods will be done on an individual basis for the residents who cannot consume adequate amounts of calories and/or protein to sustain their weight or nutrition status. PURPOSE: The goal is to increase the calories and/or protein density of the foods commonly consumed by the resident to promote improvement in their nutrition status. PROCEDURE.The physician.order a Fortified Diet.Calories and/or protein will be added to selected foods. The Facility Registered Dietitian or Food and Nutrition Service Director will select the fortification method from the.Fortified Menu Plan (Fortified Spreadsheet). Food and Nutrition Services staff will be familiar with the fortification process for each item chosen to be used at the facility.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its policy on Meal Service to provide appetizing food at appropriate temperatures according to residents' preferences, for five of 163 sampled residents (Residents 5, 17, 21, 52, and 54). In addition, meal trays were not served timely.These failures placed residents at potential risk for decrease nutritional intake which may affect the residents' overall nutrition status.Findings: A review of the facility Resident council minutes on January 13, 2026, indicated, Nursing: Concerns: Nursing not serving meals timely.On April 20, 2026, at 3:55 p.m., an interview was conducted with Resident 52. Resident 52 stated, Lunch is 11:00 a.m. but do not get meal tray until 11:30 a.m. or later.On April 21, 2026, at 9:03 a.m., an interview was conducted with Resident 21. Resident 21 stated, All served meals are cold.On April 21, 2026, at 9:06 a.m., an interview was conducted with Resident 5. Resident 5 stated, Served foods are cold; always missing food items from my meal trays; Served foods are unidentifiable.On April 21, 2026, at 9:56 a.m., an interview was conducted with Resident 54. Resident 54 stated, Food has no taste. Food gets here late, so it's cold. Food itself- not good. Worst every meal. They offer sandwich which is lousy too.On April 21, 2026, at 10:27 a.m., an interview was conducted with Resident 17. Resident 17 stated, Meat is overcooked; sometimes cold; flavor not good and always late.A review meal cart delivery schedule indicated, 800 meal cart (are holding some of resident meal trays from room [ROOM NUMBER] until 906) arrived on floor at 8:30 a.m.On April 22, 2026, at 8:47 a.m., meal cart 800 which contained the test meal tray was observed with the Dietary Director (DD) leaving the kitchen and was parked outside room [ROOM NUMBER] hallway at 8:49 a.m. The meal cart stayed in room [ROOM NUMBER] hallway waiting for the nursing staff to grab the meal trays from Meal cart 800 and deliver it to the residents. At 8:58 a.m., observed Certified Nursing Assistant (CNA) 9 started removing first meal tray from Meal cart 800. At 9:09 a.m., CNAs completed delivery of all meal trays in the Meal cart 800 to residents. On April 22, 2026, at 9:10 a.m., a test meal was performed for food temperature and palatability (refers to the taste and/or flavor of the food) of the Regular diet, Pureed diet and Fortified Mince and Moist diet with the DD, at Dunes dining room. The following temperatures were obtained from the test meals by the DD:Regular diet: sausage: 116.1ˆ (degrees Fahrenheit -a unit for measurement), whole milk: 52.2 ˆ, Cranberry juice: 55.9 ˆ.Puree diet: whole milk: 50.4 ˆ; Cranberry juice 63 ˆ.Fortified Mince and Moist diet: whole milk: 51.6 ˆ; Orange juice 56.3 ˆ.Temperature findings were verified with the DD. It was noted sausage, whole milk and juice were not served at recommended temperatures per facility policy.On April 22, 2026, at 10:04 a.m., an interview was conducted with the DD. The DD stated it took a long time for the meal trays sitting in the Meal Cart 800 in the hallway waiting for nursing staff to pass the residents' meal trays which resulted in residents receiving food at inappropriate temperatures and also not serving meals timely. The DD stated serving food at inappropriate temperatures and delayed delivery meal trays placed residents in unhappy situation which could lead to decrease meals intake and may affect the residents' overall nutrition status like weight loss.During a review of the facility policy Meal Service, revised January 2023, indicated .5.Trays will be delivered as completed to a designated area at a predetermined time for Nursing to pick up.7. Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot .Recommended Temperature at Delivery to resident .Milk/Cold Beverage ˆ 45 ˆ; Hot entree ˆ 120 ˆ, . While, with the exception of three items (sausage, milk and juice), food temperatures were in accordance with facility policy, it did not fully meet resident needs.

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	04/24/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen, for 163 out of 163 sampled residents who received foods from the kitchen, when:1. A Dietary Aide did not clean dirty meal carts per facility policy and procedure;2. Calcium buildup found on hot waterspouts in the kitchen;3. Two expired sandwiches found stored inside the nourishment refrigerator;4. Dust observed on several pieces of equipment and area in the kitchen; and5. Chipped paint was observed on the water drain found under the 3-compartment sinks.These failures had the potential to result in cross contamination (bacteria are unintentionally transferred from one substance or object to another with harmful effect) and foodborne illnesses (are illnesses that result from ingesting contaminated foods). Findings: 1. On April 21, 2026, at 9:33 a.m., a concurrent observation and interview were conducted with Dietary Aide (DA) 1 in dishwashing area. DA 1 was observed using detergent to wash the dirty meal carts and then sanitized them with sanitizer. DA 1 confirmed he only used detergent to wash the dirty meal carts and sanitized with sanitizer.On April 22, 2026, at 10:04 a.m., an interview was conducted with the Dietary Director (DD). The DD stated according to the facility policy and procedure, the Dietary staff should wash the dirty meal cart with detergent, then rinse off the detergent, and with final step was to sanitize with sanitizer. The DD stated the detergent chemical would interact with the sanitizer chemical without rinsing off the detergent, which could cause the sanitizer to be ineffective. The DD further explained the ineffective sanitizer would not kill the bacteria and germ on the meal carts which could lead to cross contamination.During a review of the facility's policy and procedure titled, FOOD CARTS, dated 2023, the policy indicated, CLEANING PROCEDURE.Prepare.detergent, clean cart .with a clean cloth.Then rinse with clean warm water.Prepare.sanitizing solution.and spray or wipe down cart.2. On April 20, 2026, at 10:10 a.m., a concurrent observation and interview were conducted with the DD at coffee station inside the kitchen. The hot waterspout was observed to have white grime buildup. The DD stated the white grime was calcium (hard water) buildup and needed to be cleaned up otherwise white grime could fall into the water.During a review of the facility's policy and procedure titled, Sanitation, dated 2023, the policy indicated, .All equipment shall be maintained as necessary and kept in working order. PROCEDURE.All equipment shall be kept clean.3. On April 20, 2026, at 3:46 p.m., a concurrent observation and interview were conducted with the DD in Medbrige nourishment room. There were two house made sandwiches (Chicken Salad Sandwich and Peanut Butter and Jelly Sandwich) labeled with used by date of April 19, 2026, stored in the nurses' station nourishment refrigerator. The DD stated those sandwiches were expired and should be discarded.During a review of the facility's policy and procedure titled, STORAGE OF FOOD AND SUPPLIES, dated 2023, the policy indicated, .POLICY: food and supplies will be stored properly and in a safe manner.No food will be kept longer than the expiration date on the product.4. According to the FDA Federal Food Code 2022, Non-food contact surfaces of equipment shall be kept free of accumulation of dust, dirt, food residue, and other debris.The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents and other pests.During the initial kitchen tour on April 20, 2026, beginning at 9:49 a.m., there were multiple areas and pieces of equipment that were not clean to sight and/or touch which included the following:-Black debris found on door frame leading to Dunes dining room; -Brown debris found on storage shelves located at the coffee station;-Pot and pans storage shelves found with brown debris and observed clean kitchenware were stored on the shelves; -Black and /or brown debris found on fire suppression system which was next to the stove;-Black and /or brown debris found on main entrance door frame; and-Black debris found on walk-in refrigerator fan cover.In a concurrent interview with the DD, the DD confirmed the above findings. The DD stated (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	black and/or brown debris were dust. The DD stated dust could cause cross contamination and the dietary staff should keep the kitchen clean.During a review of the facility's policy and procedure titled, Sanitation, dated 2023, the policy indicated, .All equipment shall be maintained as necessary PROCEDURE.All equipment shall be kept clean.5. On April 20, 2026, at 10:20 a.m., a concurrent observation and interview were conducted with the DD in the kitchen. The water-drain under the 3-compartment sinks (sink that use for wash, rinse and sanitize kitchenware) was observed to have chipped paint. The DD stated the drain's chipped off white paint could create pores which could trap dirt (black grime) and bacteria. The DD stated the drain needed to be replaced.During a review of the facility's policy and procedure titled, Sanitation, dated 2023, the policy indicated, .All equipment shall be maintained as necessary and kept in working order. PROCEDURE.All equipment shall be kept clean, maintained in a good repair and shall be free from.corrosions, open seam, cracks, and chipped areas.

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	04/24/2026

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an assessment and/or an evaluation for self-administration of medication was completed, for one of 173 residents reviewed for self-administration assessment (Resident 141), when eye drop medications were found at bedside, readily available for use.This failure places Resident 141 at risk for unsafe self-administration of medications and not monitored for potential side effects and drug interactions.Findings:On April 21, 2026, at 12:04 p.m., an observation with a concurrent interview was conducted with Resident 141. Resident 141 was observed in bed, alert, and interviewable. Resident 141's bedside table was observed to have a small box of eye medication labeled as Sodium Chloride Hypertonicity Solution 5% (a sterile, over-the-counter drop used to temporarily relieve corneal edema (swelling of the eye's transparent outer layer due to fluid buildup) by drawing excess water out of the cornea) 15 ml (millimeter - unit of measurement) and an opened bottle of artificial tears eye drop. In a concurrent interview, Resident 141 stated she had both eye medications by her bedside for a long time and the staff was aware she used both eye drops on herself.On April 22, 2026, at 9:36 a.m., a second observation with a concurrent interview was conducted with Resident 141. Resident was in bed, alert, and interviewable. Both eye drops were observed on her bedside table next to her breakfast tray. Resident 141 stated:- The eye drops were hers and the staff knew about it. She did not recall how long she had been using it;- She administered both eye medications to herself when her eyes get itchy, and because she had glaucoma (type of eye disease). She used the eye drops once or twice a week, it depends, if she remembers it; and- The licensed nurses administer another eye medication for her glaucoma.On April 22, 2026, at 10:05 a.m., an observation, with a concurrent interview was conducted with License Vocational Nurse (LVN) 1. LVN 1 was observed to enter Resident 141's room and saw the two eye drop medications on top of Resident 141's bedside table. LVN 3 stated:- She was the licensed nurse assigned to Resident 141 on April 20 and 21, 2026 morning shift;- She did not recall seeing the two eye drop medications on top of Resident 141's table. The Sodium Chloride Hypertonicity Solution 5% 15 ml and artificial tears were both opened and used;- Resident 141 did not have a physician's order for the two eye drop medications and it was not supposed to be left at bedside; and-Resident 141 did not have an assessment for safe self-administration of medication and should have one.On April 22, 2026, Resident 141's record was reviewed. Resident 141 was admitted to the facility on [DATE], with diagnoses including glaucoma.A review of Resident 142's History and Physical, dated April 13, 2026, indicated Resident 141 had the capacity to understand and make decisions.A review of Resident 141's Order Summary Report, included a physician's order, dated April 11, 2026, which indicated to administer Latanoprost Ophthalmic Solution 0.005% (medication used to treat glaucoma) one drop to both eyes at bedtime.Resident 141 did not have a physician's order for the Sodium Chloride Hypertonicity Solution 5% 15 ml and artificial tears. In addition, there was no documented evidence, an assessment and/or an evaluation was conducted to determine if Resident 141 was able to self-administer medication safely.On April 22, 2026, at 10:48 a.m., an interview with a concurrent review of Resident 141's record was conducted with the Director of Nursing (DON). The DON stated:- Resident 141 should have an assessment for safe self-administration of medications, which included if the resident was alert, oriented, and able to open the bottle by herself;- If Resident 141 wanted to take the medication herself, the licensed nurses should have assessed first then call the doctor for orders; and- Resident 141 did not have a physician's order for Sodium Chloride Hypertonicity Solution 5% 15 ml and artificial tears. The DON stated that both eye drops and a self-administration order were needed prior to Resident 141 to self-administer both eye drops.A review of the facility's policy and procedure titled, Self-Administration of Medications, dated February 2021 indicated, .Residents have the right to self-administer medications if the interdisciplinary team has determined that is clinically appropriate and safe for the resident to do so.As part of the (continued on next page)

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	04/24/2026

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation comprehensive assessment, the interdisciplinary team (IDT - a group of healthcare professionals) assesses each resident's cognitive and physical abilities to determine whether self-administering of medications is safe and clinically appropriate for the resident.The IDT considers the following factors when determining.The medication is appropriate for self-administration.The resident is able to read and understand medication labels.The resident can follow directions and tell time to know when to take the medication.The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff.The resident has physical capacity to open medication bottles, remove medications from a container.The resident is able to safely and securely store a medication.If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and care plan.Self-administered medications are stored in a safe and secure place, which is not accessible by other residents.Any medications found at bedside that are not authorized for self-administration are turned over to her nurse in charge to return to the family or responsible party.

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	555339	A. Building B. Wing	04/24/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic (drug that affects brain activities associated with mental processes and behaviors) medications, for one of five resident reviewed for unnecessary medications (Resident 18), when there was no documented evidence non-pharmacological interventions (NPIs) were attempted, implemented, monitored, or documented as clinically contraindicated. These failures had the potential to place the resident at risk of unnecessary psychotropic medication use and adverse side effects, including sedation and falls.Findings:1. On April 22, 2026, a review of Resident 18's admission Record, indicated Resident 18 was admitted to the facility on [DATE], with diagnoses including unspecified psychosis (a psychotic disorder characterized by a loss of contact with reality), schizoaffective disorder (a chronic mental illness characterized by dramatic changes in thoughts, moods, and behaviors, mixed symptoms of schizophrenia [hallucinations and delusions] and mood disorder [depression and mania]), major depressive disorder (depression), and anxiety disorder.A review of Resident 18's Order Summary Report, indicated the following physician orders:- Risperidone (generic for Risperdal, an antipsychotic medication to treat various mental and thought disorder including altered sense of reality) 2 mg (milligram - unit of measurement), give 1 tablet by mouth three times a day for psychosis m/b [manifested by] verbalization of hallucination, dated October 3, 2024;- Mirtazapine (generic for Remeron, an antidepressant medication to treat depression) 15 mg, give 15 mg by mouth at bedtime for depression m/b poor appetite, dated December 3, 2025; and- Buspirone (generic for Buspar, an antianxiety medication to treat anxiety) 10 mg, give 1 tablet by mouth three times a day for anxiety m/b verbalization overly worried about health, dated December 3, 2025.A review of Resident 18's Care Plan Report, for antipsychotic medication, dated October 3, 2024, antidepressant medication, dated November 22, 2024, and anti-anxiety medication, dated December 4, 2025, indicated, .Attempt non-pharmacological approaches prior to medication administration.A review of Resident 18's Medication Administration Record (MAR), dated April 2026, indicated Resident 18 received risperidone, mirtazapine, and buspirone as ordered. However, there was no documented evidence non-pharmacological interventions were attempted, implemented, monitored, or evaluated for effectiveness.On April 23, 2026, at 4:04 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON confirmed there was no documented evidence NPIs were attempted, implemented, monitored, or documented as clinically contraindicated for Resident 18. The DON stated the NPI order set available in the PCC system (PointClickCare, a cloud-based electronic health record and care coordination platform designed specifically for the long-term and post-acute care settings) was not added to the resident's chart, resulting in NPIs not being implemented for Resident 18. The DON stated NPI implementation is required for residents receiving psychotropic medications unless clinically contraindicated.On April 23, 2026, at 5:30 p.m., during a concurrent interview and record review with Psychiatric Nurse Practitioner (PNP), the PNP stated he was not aware NPIs had not been implemented for Resident 18. The PNP stated implementation of NPIs would benefit the residents and provide useful clinical information for evaluating the resident's behavioral symptoms and response to treatment. The PNP also stated information regarding behavioral symptoms and effectiveness of NPIs would assist in clinical decision-making, including determining the timing of gradual dose reduction (GDR) and potential medication adjustment. A review of the facility's policies and procedures titled, Psychoactive/Psychotropic Medication Use, dated April 2025, indicated, .behavioral interventions, unless contraindicated, will be used to meet the individual needs of the resident .Psychotropic medication management for the resident will involve the facility interdisciplinary team consideration of the following .identifying person-centered non-pharmacological interventions, unless contraindicated, to meet the individual needs of the resident, and minimize or discontinue the use of Psychotropic medication .

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	04/24/2026

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

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services needed to perform ADLs (Assisted Daily Living - fundamental self-care task required for a person to live independently, such as bathing, dressing, eating, and using the toilet) for one of eight sampled residents reviewed (Resident 36), when Resident 36 was not offered supervision and/or assistance on her upper and lower body dressing.This failure resulted in Resident 36 wearing the same clothing outfit from April 20, 2026, to April 26, 2026. In addition, this failure placed Resident 36 at risk of reduced abilities in activities of daily living (ADLs) due to the lack of appropriate assistance needed to prevent such decline.Findings:The following observations and interviews, were conducted with Resident 36, who was observed to be wearing a matching blue printed flannel top and bottom from April 20, 2026 to April 22, 2026:- On April 20, 2026, at 12:14 p.m., Resident 36 was observed ambulating in the hallway using a Front Wheel [NAME] (FWW). Resident 36 stated she did not get her lunch tray yet and she will go for a stroll;- On April 21, 2026, at 12:30 p.m., Resident 36 was observed ambulating using a FWW near the nurse station. Resident stated she has not received her lunch tray yet and she was going for a stroll.-On April 22, 2026, at 10:02 a.m., Resident 36 was observed walking with a FWW near the nurse station. She was observed searching for a snack and asked staff if she could have one. In a concurrent interview, Resident 36 was asked about whether she had another set of clothes to change into. Resident 36 stated, I do not know, and walked away.-On April 22, 2026, at 2:02 p.m., Resident 36 was asleep in her room without a blanket. Resident 36 was dressed in the same outfit during both the morning and the later observation.-On April 22, 2026, at 2:15 p.m., an interview with a concurrent observation was conducted with Certified Nursing Assistant (CNA) 10. CNA 10 stated the following:- She was the CNA assigned to provide care to Resident 36 on April 22, 2026, morning shift and she did not recall what time she checked on the resident during her first rounds;- Resident 36 was independent with her hygiene and ADLS, she does her own upper body and lower body dressing. Resident 36 was cooperative and she was not aware she had behavior of refusing assistance with her ADLs; and- She did not help her get dressed today, and she couldn't remember whether she had worn the matching blue printed flannel top and bottoms when she arrived this morning.During a concurrent observation, CNA 10 opened Resident 36's closet. The closet was empty except for two knitted sweaters. CNA 10 stated, This is all that she has.On April 22, 2026, at 2:18 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated she was the licensed nurse assigned to Resident 36 in the morning shift of April 22, 2026. LVN 2 stated Resident 36 had history of refusing assistance with her ADLs including showers, but she did not receive a report today that she refused these services.On April 22, 2026, at 2:35 p.m., an interview with concurrent record review was conducted with the Director of Nursing (DON). The DON stated the following:- Resident 36 had a personal belonging inventory list indicating she has clothing including blouses, shirts, slacks, socks, jeans, and shoes;- Resident 36 was confused and forgetful, the staff should report if she has missing personal items including clothing;- Resident 36's MDS - Minimum Data Set (an assessment tool), dated February 19, 2026, indicated Resident 36 needed supervision with ADLS including dressing and hygiene;- The CNAs should supervise and/or assist Resident 36 with her ADLs; and- The staff knew Resident 36 had a behavior of refusing showers and assistance with ADLs however, there was no care plan developed or initiated to address these behaviors. The DON stated these behaviors should have been care planned.On April 22, 2026, at 3:10 p.m., an interview with a concurrent record review of Resident 36's CNA tasks record (record of ADLS performed by the resident and CNA) was conducted with CNA 11. CNA 11 stated the following:- The nurses knew that Resident 36 often refused assistance with her ADLs, but there was no record from the CNAs assigned to her between April 20, 2026, and April 22, 2026, indicating she declined (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with ADLs like dressing. CNA 11 stated the CNAs documented Resident 36 was independent with her ADLs, meaning she did the task herself and did not need assistance.- Resident 36 has dementia (a progressive, irreversible decline in mental ability severe enough to interfere with daily life, reasoning, and memory) and she required supervision and/or assistance with her ADLs.On April 22, 2026, Resident 36's record was reviewed. Resident 36 was admitted to the facility on [DATE], with diagnosis including dementia.A review of Resident 36's MDS, dated February 19, 2026, indicated resident had a BIM Score (tool used to assess cognitive function) of 03 (0-7 score indicated severe impairment). The MDS further indicated resident needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) on oral hygiene, shower/bathing, Upper body dressing and lower body dressing, and personal hygiene.A review of Resident 36's care plan, dated May 14, 2025, indicated, .Focus.ADL .Resident at risk for mobility decline and requires assistance related to.ALTERED MENTAL STATUS, DEMENTIA.Goal.Will have needs anticipated and met by staff.Encourage to participate in ADLs to promote independence.There was no documented evidence that resident's behavior of refusing assistance with ADL was identified and addressed by the staff.A review of the CNA ADL Task Record, dated April 20, 2026, to April 22, 2026, indicated the CNAs assigned to Resident 36 documented in all shifts, resident was between independent to supervision on upper body and lower body dressing.A review of the facility's policy and procedure titled, Activities of Daily Living (ADL), Supporting, dated March 2018, indicated, .Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL).Residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good nutrition, grooming, and personal hygiene.appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance in the plan of care, including appropriate support and assistance with.hygiene (bathing, dressing, grooming, and oral care.If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate.Interventions to improve or minimize a residents functional abilities will be in accordance with the resident's assessed needs, stated goals, and recognized standards of practice.The resident's response to interventions will be monitored, evaluated, and revised as appropriate .

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	555339	A. Building B. Wing	04/24/2026

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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. **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 two of five residents reviewed for skin management (Resident 95 and 66), when:1.For Resident 95, right anterior wrist skin redness with elevation was identified in a timely manner and was referred to the physician for treatment orders; and2.For Resident 66, the itching with redness on his neck, was identified in a timely manner and was referred to the physician for treatment orders.These failures caused discomfort for Residents 95 and 66 in the affected areas, and had the potential to increase their risk for complications due to delayed treatment. Findings: 1.On April 20, 2026, at 3:30 p.m., an observation with a concurrent interview was conducted with Resident 95. Resident 95 was observed to have a defined circular area of erythema (redness), elevated, dry with visible scaling, and mild textural changes to the top part of right wrist. In a concurrent interview, Resident 95 stated she had a spider bite to her right anterior wrist that was red and elevated. Resident 95 stated the staff applied cream, however, the affected area had not improved. Resident 95 stated she had the spider bite for approximately two to three months and it has not gotten better since then. Resident 95 stated the affected area burned when she scratched it and it has gotten worse. On April 22, 2026, at 1:54 p.m., an interview with a concurrent record review was conducted with Licensed Vocational Nurse (LVN) 11. LVN 11 stated the following: - He was not aware of any skin concerns for Resident 95; -There was no documentation in the nursing notes that Resident 95's current right wrist redness was identified, assessed, and referred to the physician for treatment orders; -Any alteration in skin condition should be assessed, documented, reported to the physician, and followed up with treatment orders the day of identification; and -Anything that goes unreported, can affect the resident's overall well-being and skin issues not addressed or monitored can make the resident at risk for infection. On April 22, 2026, at 2:34 p.m., an observation with a concurrent interview was conducted with LVN 2 and Resident 95. LVN 2 stated Resident 95 had a red, raised, circular area to top of right wrist. LVN 2 further stated, It looked like a bug bite to me. LVN 2 stated new skin condition should be assessed, notify the physician, and wound care team for appropriate treatment. On April 22, 2026, at 2:41 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 10. CNA 10 stated she was the primary CNA for Resident 95 on April 22, 2026, and at morning handoff from previous CNA she did not receive a report regarding any new or existing skin condition on Resident 5's right wrist. CNA 10 stated there was no new skin issues were reported during the resident's shower on April 20, 2026. On April 22, 2026, at 2:59 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 12. LVN 12 stated Resident 95's right wrist skin condition had been present for a couple of months and she was unable to recall documentation of follow-up, current treatment orders, or ongoing monitoring of the right wrist condition. (continued on next page)

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	04/24/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 24, 2026, at 9:03 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated that when a resident reported a new skin concern, licensed nurses were expected to immediately assess the condition, create a Change of Condition Report, notify the physician, document the skin condition, and initiate a care plan, and treatment orders the same day it was identified. The DON stated there was no documentation done for Resident 95 indicating the right anterior wrist skin new skin problem was identified by the licensed nurses. On April 24, 2026, Resident 95's record was reviewed. Resident 95 was admitted to the facility on [DATE], with diagnosis including diabetes mellitus (a condition that affects blood sugar levels), chronic osteomyelitis of the left foot (a bone infection) and muscle weakness. A review of Resident 95's History and Physical, dated April 15, 2026, indicated Resident 95 had the capacity to understand and make decisions. A review of Resident 95's Shower/Bath Sheet, dated April 20, 2026, indicated Resident 95 had no apparent skin issues and no new skin issue or change. A review of Resident 95's Nursing Comprehensive Skin Evaluation/Assessment, dated April 22, 2026, indicated,.Assessment Type.Change in Condition.Length.5.0.Width 3.5.right wrist.dry reddened skin.Additional Notes.patient has new alteration on right wrist skin is dry slightly red/pink in color no drainage no odor. A review of the facility's policy and procedure titled, Acute Condition Changes – Clinical Protocol, dated March 2018, indicated, .assess and report.changes in a resident's condition.including changes in skin condition.contact physician.collect pertinent details.monitor and document the resident/patient's progress and responses to treatment. 2. On April 21, 2026, at 9:02 a.m., during a concurrent observation and interview in Resident 66's room, Resident 66 was observed with redness and irritation on the right side of the neck and was constantly scratching the area. Resident 66 stated his neck had been itching and thought it was probably from the shaving cream. Resident 66's record was reviewed. Resident 66 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (loss of muscle function on one side of the body) affecting the left side. A review of Resident 66's History and Physical, dated September 5, 2025, indicated the resident has the capacity to understand and make decisions. A review of Resident 66's shower sheet, for April 20, 2026, indicated no documentation of a new rash, redness, or itching to the neck from April 20 to April 22, 2026, and no documentation that Resident 66's neck was assessed or monitored for skin changes. On April 22, 2026, at 11:32 p.m., during a concurrent interview and review of Resident 66's shower sheet with Certified Nursing Assistant (CNA) 2, CNA 2 stated she checked residents' skin during showers and daily care and if she observed any new skin issues, she should notify the licensed nurse and document it in the shower sheet. CNA 2 stated she did not notice any skin issues with Resident 66 but had observed him scratching his neck. CNA 2 stated there was no documentation that Resident 66 had any skin issues. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 22, 2026, at 1:38 p.m., during a concurrent observation and interview with Resident 66, Resident 66 stated the itchiness and irritation on the right side of his neck had started on April 20, 2026, and he believed it was caused by a cheap razor. On April 22, 2026, at 1:42 p.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 9 1 in Resident 66's room, LVN 9 stated skin checks were performed every shift and staff were expected to document skin changes. LVN 9 stated for new skin conditions, the licensed nurse should report the change to the treatment nurse who would complete an assessment, document the change of condition in the progress notes, monitor the resident for 72 hours, notify the physician and the resident's representative, and revise the care plan to prevent worsening of the condition. LVN 9 stated Resident 66 had redness and rashes on the right side of his neck. LVN 9 further stated there was no documented assessment and no revisions of the care plan related to Resident 66's new neck skin condition.

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	555339	A. Building B. Wing	04/24/2026

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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** Based on observation, interview, and record review, the facility failed to ensure residents are free from accidents, for two of three residents reviewed for accidents (Residents 177 and 140), when:1.For Resident 177, 1:1 monitoring (staff who provides continuous, direct observation for a single patient to ensure safety) was implemented as ordered by the physician.This failure had the potential to place Resident 177 at high risk for harm and accidents; and2.For Resident 140, was not allowed to keep the cigarette and lighter by bedside according to the facility's policy and procedure.This failure had the potential to place Resident 140 at high risk of accidents.Findings:1.On April 20, 2026, at 9 a.m., an observation was conducted in Resident 177's room. Resident 177 was observed asleep in bed alone in his room. The call light was observed on top of the resident's dresser and was not within resident's reach. A call bell was observed on top of the resident's bedside table next to his bed. There was no staff observed present in Resident 177's room.A review of Resident 177's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included left sided hemiplegia (left sided weakness).A review of Resident 177's History and Physical, undated, indicated Resident 177 had capacity to understand and make decisions.A review of Resident 177's Progress Notes, dated April 6, 2026, at 12:28 p.m., indicated, .SSM (Social Services Manager) contacted Riverside Crisis Team, regarding patient made suicidal attempt ideation, grabbed call light cord and wrapped it around his neck, then grabbed butter knife and motioned to cut his throat. 1:1 sitter in place.A review of Resident 177's care plan, dated April 6, 2026, indicated, .The resident has a psychosocial well- being problem/ suicidal attempt r/t (related to) Anxiety, Family discord, Ineffective coping.Interventions.1:1 sitter to monitor safety.A review of Resident 177's Physician's Order, dated April 6, 2026, indicated, 1:1 sitter every shift.On April 20, 2026, the following observations and interview were conducted:- At 11:15 a.m., Resident 177 was observed alone in the room, ringing the call bell for assistance and yelling for help in Spanish. A Licensed Nurse was observed down Resident 177's hallway and did not respond to his call for assistance. There was no staff member present inside Resident 177's room;- At 11:17 a.m., Certified Nurse Assistant (CNA) 5 entered Resident 177's room. Resident 177 was yelling for assistance in Spanish. Certified Nursing Assistant (CNA) 5 left the room and walked down the hallway to speak with a licensed nurse. No staff remained in the room with the resident;- At 11:20 a.m., observed Resident 177 remained in the room without staff present. In a concurrent interview with CNA 5, she stated Resident 177 was in pain and she notified the charge nurse; and- At 11:55 a.m., an interview was conducted with CNA 5. CNA 5 stated she was assigned as a sitter for Resident 177 due to his behavior of attempting to harm himself, including wrapping the call light cord around his neck and so they kept the call light away and not within the resident's reach for safety. CNA 5 further stated she started her shift as a sitter on April 20, 2026, at 12 p.m. and did not know who was assigned prior to her shift.On April 21, 2026, the following observations and interviews were conducted: - At 9:47 a.m., Resident 177 was observed in the room, in bed, without a staff member present;- At 9:55 a.m., an interview was conducted with Licensed Vocational Nurse (LVN) 5. LVN 5 stated Resident 177 should have a sitter 24 hours per day due to safety concerns, including risks for self-harm. LVN 5 stated that without a sitter present, the resident could potentially attempt to harm himself. LVN 5 stated Resident 177 was alone in his room and did not have sitter present at that time;- At 10 a.m., an interview was conducted with CNA 1. CNA 1 stated Resident 177 used a bell instead of a call light because he had previously used the call light cord to tie it around his neck. CNA 2 stated Resident 177 should have a sitter present in the room; and- At 10:15 a.m., an interview was conducted with CNA 6. CNA 6 stated she was the sitter assigned to Resident 177 during the morning shift of April 21, 2026. CNA 6 stated she was out of Resident 177's room from approximately 9 a.m. to 10 a.m. and did not ensure a 1:1 sitter coverage at bedside. CNA 6 (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she informed another staff member she was going on break, however, she did not confirm that another staff member relieved her or remained with the resident. CNA 6 further stated Resident 177 required 1:1 supervision due to behavior of being aggressive and was at risk of harming himself if left alone. CNA 6 stated Resident 177 should not be left unattended for safety.On April 24, 2026, at 9:03 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 1 had a physician order for a 1:1 sitter on April 6, 2026, due to behavior of harming self, including wrapping the call light cord around his neck. The DON stated the assigned sitter was expected to always remain at bedside, and if the sitter needed to leave, another staff must provide continuous observation.A review of the facility's policy and procedure titled, Responsibilities of a Sitter, dated July 2017, indicated, .Purpose.To ensure a safe environment for patients identified as a potential risk to themselves or others. This policy outlines guidance to ensure the safety and well- being of residents requiring close supervision and assistance.Patients at high risk for falls, confusion, impaired mobility, or other safety concerns may require a 1:1 sitter.The sitter will provide continuous bedside observation and basic assistance with activities of daily living (ADL).Seek assistance from the nursing staff or supervisor as needed.Communicate effectively with the nursing staff and other staff members and follow the care plan and instructions provided by the charge nurse or nursing supervisor.2. On April 20, 2026, at 12:40 p.m., during a concurrent observation and interview with Resident 140, Resident 140 was observed lying in bed with oxygen via nasal cannula (a small flexible tube inserted into the nostrils to deliver oxygen). A purse was observed at the resident's bedside, with cigarettes and a lighter were present inside the purse. Resident 140 stated she was supervised when smoking and that she was able to light her own cigarettes.Resident 140's record was reviewed. Resident 140 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (disease that causes difficulty breathing).A review of Resident 140's Smoking Assessment, dated March 25, 2026, indicated, .Resident is a smoker.Smoking adaptive equipment needed. Smoking Apron.Level of Assistance.Supervision required.May smoke with supervision.Patient requires O2 (oxygen) therapy as needed. Refuses to use smoking apron.A review of Resident 140's care plan dated March 26, 2026, indicated .Focus.Resident is a smoker.Goal.safety.Interventions.Cigarettes and lighter will be stored in the nurse's station.A review of Resident 140's History and Physical, dated March 30, 2026, indicated the resident has fluctuating capacity to understand and make decisions.On April 20, 2026, at 12:45 p.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 2, LVN 2 stated some residents were allowed to keep cigarettes at the bedside if they were alert and oriented. LVN 2 stated residents who were not alert and oriented were not allowed to keep cigarettes at the bedside. LVN 2 stated Resident 140 had cigarettes and a lighter at bedside and stated she was not sure if Resident 140 should have a lighter at bedside, given the resident's use of oxygen.On April 20, 2026, at 12:58 p.m., Registered Nurse Supervisor (RNS) 1 was interviewed. RNS 1 stated a smoking assessment should be completed on admission to determine whether residents could safely smoke. RNS 1 stated she was responsible for completing smoking assessments. RNS 1 stated residents on oxygen could not keep lighters at the bedside. RNS 1 stated a smoking assessment for Resident 140 was completed on March 25, 2026, and that the assessment indicated Resident 140 was at risk for smoking related injury due to oxygen use. RNS 1 stated Resident 140 should not have had a lighter at bedside.On April 23, 2026, at 10:50 a.m., the Assistant Director of Nursing (ADON) was interviewed. The ADON stated residents who used oxygen, were alert and oriented and who did not violate the smoking rules could keep a lighter at the bedside. The ADON stated Resident 140's care plan indicated the resident should not keep lighters at the bedside for safety reasons. The ADON stated Resident 140 having cigarettes and a lighter at the beside was not consistent with the resident's care plan and smoking assessment.A review of the facility's policy and procedure titled Smoking Contract (name of facility), undated, indicated, .maintain safe resident smoking practices.Any smoking-related.restrictions, and concerns.are noted on the care plan, and all personnel caring for the resident shall be (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alerted.Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc, except under direct supervision.

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	555339	A. Building B. Wing	04/24/2026

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nutritional care and services were provided, for one of one sample resident reviewed for nutrition (Resident 12) when:1. The facility failed to monitor the effectiveness of nutrition interventions for Resident 12. This failure had the potential to result in delay in identifying and evaluating the necessity of an alternative nutrition approach; and2. The facility Registered Dietitians failed to follow its policy, WEIGHT CHANGE PROTOCOL to determine if meal intake of Resident 12 would be sufficient to meet Resident 12's nutritional needs. This failure had the potential to result in delay in identifying and evaluating the necessity of an alternative nutrition approach.These failures resulted in Resident 12 experiencing a 12 pound (8.5 percent) significant weight loss during a 4-months period from December 7, 2025, to April 9, 2026, and which could further impair nutrition and health status. Findings:During a review of Resident 12's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), indicated Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included heart failure (clinical condition in which the heart cannot pump enough blood and oxygen to meet the body's needs), dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and Type II Diabetes (disease that result in too much sugar in the blood).During a review of Resident 12 's Minimum Data Set (MDS - a resident assessment tool), indicated the following:- December 19, 2025, indicated Resident 12 had a BIMS (Brief Interview for Mental Status) score of 6 which indicated severely impaired cognition;- March 19, 2026, indicated Resident 12 had a weight loss of 5 % or more in the last month or loss of 10% or more in the last 6 months, and was not on physician-prescribed weight-loss regimen (a program that is supervised by a medical professional that specializes primarily in weight loss for individuals that have a hard time losing weight despite their efforts).During a review of Resident 12's Order Summary Report, included a physician's order, dated January 28, 2026, indicated, Diet: Controlled Carbohydrate (CCHO) Diet (a meal plan for diabetic residents), No added salt (NAS) diet, Mince and moist texture (food texture that requires a reduced amount of chewing), Oral Nutrition supplement [(ONS)Nutrition drinks that has high calories and protein] three times a day with meals, Fortified diet (diet with added nutrients to increase the calories and/or protein density to promote improvement in residents nutrition status) for weight lossDuring a review of Resident 12's weight record, the weight indicated the following:-December 7, 2025: 165.4 lbs. (pounds-a unit for measurement);-January 9, 2026: 153 lbs.;-January 15, 2026: 152 lbs.;-January 22, 2026: 150.6 lbs.;-January 30, 2026: 151.4 lbs.;-February 5, 2026: 146 lbs.;-February 7, 2026: 146 lbs.;-February 13, 2026: 152.2 lbs.;-February 19, 2026: 153 lbs.;-February 26, 2026: 153.4 lbs.;-March 5, 2026: 154.8 lbs.;-March 8, 2026: 154.8 lbs.;-March 20, 2026: 154.3 lbs.;-April 9, 2026: 151 lbs.Based on the weight history from December 7, 2025 to April 9, 2026, it was noted Resident 12 lost 14 lbs. (8.5 percent %) in 4 months, is considered as significant weight loss.During a review of Resident 12's Annual Nutrition Assessment, dated September 12, 2025, completed by Registered Dietitian (RD) 1, indicated Resident 12's height: 66 inch, Weight (wt.) 9/6/26: 163 lbs. RD 1 marked all Nutrition intake: 0% -25 % of meals, 26 -50 % of meals, 51 -75 % of meals, 76 -100 % of meals with comments: PO intake variable, 0-100%, average ~ 50-75% per meal record. No intolerance issue noted sometimes 0 -25 % x 1 meal/day and remaining 75 -100 %.During a review of Resident 12's Interdisciplinary Team (IDT- an interdisciplinary team comprised of professionals from various disciplines who work in collaboration) -Weekly Weight Nutrition Note], dated January 13, 2026, indicated, Current Weight: 153 lbs., .Pt remains on a CCHO NAS diet with variable intake. Pt had 12.4 lbs. (#) wt. loss in a month (7.5 %).Recommendations: .Glucerna three time per day (TID) with all meals, weekly wts and wt. variance.During a review of (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 12's IDT -Weekly Weight Nutrition Note, completed by RD 2, dated January 18, 2026, indicated, Current Weight: 152 lbs., .Pt remains on a CCHO NAS diet with variable intake. Pt had a 1 # wt (weight) loss in a week .Glucerna was added TID with meals to increase calories. Recommendations: Continue with weekly wts and wt variance.During a review of Resident 12's IDT -Weekly Weight Nutrition Note, completed by RD 2, dated January 26, 2026, indicated, Current Weight: 150.6 lbs., .Pt remains on a CCHO NAS diet with Glucerna with meals and a variable intake. Pt had a 1.4 # wt loss in a week.Recommendations: Fortify pt's diet for additional calories.During a review of Resident 12's IDT -Weekly Weight Nutrition Note, completed by RD 2, dated February 2, 2026, indicated, Current Weight: 151.4 lbs., .Pt remains on a CCHO NAS diet with Glucerna with meals and a variable intake. Pt had a 0.8 # wt gain in a week which is beneficial .Pt also started on a fortified diet for additional calories. Pt is receiving excess calories to promote wt gain.Recommendations: Continue with weekly wts and wt variance.During a review of Resident 12's IDT -Weekly Weight Nutrition Note completed by RD 2, dated February 8, 2026, indicated, Current Weight: 146 lbs., .Pt remains on a CCHO NAS diet with Glucerna with meals and a variable intake. Pt had a 5.4 # wt loss in a week . Recommendations: MD to consider changing appetite stimulator to 400 mg twice per day (BID) for 90 days and continue with weekly wts and wt variance.During a review of Resident 12's IDT -Weekly Weight Nutrition Note, completed by RD 2, dated February 15, 2026, indicated, Current Weight: 152.2 lbs., .Pt remains on a CCHO NAS diet with Glucerna with meals and a variable intake. Pt had a 6.2 # wt gain in a week . MD increased appetite stimulator to 400 mg BID. This is a beneficial wt gain. Recommendations: Continue with weekly wts and wt variance.During a review of Resident 12's IDT -Weekly Weight Nutrition Note completed by RD 2, dated February 23, 2026, indicated, Current Weight: 153 lbs., .Pt remains on a CCHO NAS diet with Glucerna with meals and a variable intake. Pt had a 0.8 # wt gain in a week .Recommendations: Continue with weekly wts and wt variance.During a review of Resident 12's IDT -Weekly Weight Nutrition Note, completed by RD 2, dated March 1, 2026, indicated, Current Weight: 153.4 lbs., .Pt remains on a CCHO NAS diet with Glucerna with meals and a variable intake. Pt had a 0.4 # wt gain in a week which is beneficial.Recommendations: Continue with weekly wts and wt variance.During a review of Resident 12's IDT -Weekly Weight Nutrition Note, completed by RD 2, dated March 8, 2026, indicated, Current Weight: 154 lbs., .Pt remains on a CCHO NAS diet with Glucerna with meals and a variable intake. Pt had a 1.4 # wt gain in a week and a 9 # wt gain in a month (6.2%) which is beneficial.Recommendations: Continue with weekly wts and wt variance.During a review of Resident 12's IDT -Weekly Weight Nutrition Note, completed by RD 2, dated March 15, 2026, indicated, Current Weight: 152.2 lbs., .Pt remains on a CCHO NAS diet with Glucerna with meals and a variable to good intake. Pt had a 2.6 # wt loss in a week .Recommendations: Continue with weekly wts and wt variance.During a review of Resident 12's IDT -Weekly Weight Nutrition Note, dated March 22, 2026 completed by RD 2, indicated, Current Weight: 154.3 lbs., .Pt remains on a CCHO NAS diet with Glucerna with meals and a variable to good intake. Pt had a 2.1 # wt gain in a week .Recommendations: Continue with weekly wts and wt variance.1.On April 21, 2026, at 8:55 a.m., a concurrent observation and meal ticket review were conducted with Resident 12 at bedside. Resident 12's meal ticket (contain Resident name, room number, physician diet order, Allergies, and food dislike) indicated, Fortified CCHO, NAS, Minced and Moist, 8 fluid ounce ONS. Resident being served 8 fluid ounce ONS, egg and Mince and Moist bread served as entree, a bowl of cream of wheat, 8 fluid ounce whole milk, 4 fluid oz apple juice.On April 21, 2026, at 9:25 a.m., a concurrent observation and interview were conducted with Resident 12 at bedside. Resident 12 finished entree, ONS and milk. Resident 12 stated she was full, so she did not touch cream of wheat and apple juice. On April 21, 2026, at 3:34 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 12. CNA 12 stated she had been taking care of Resident 12 for a year. CNA 12 stated she documented ONS intake as part of meal consumption. CNA 12 stated she did not individually document the amount intake of ONS.On April 21, 2026, at 3:41 p.m., a concurrent interview and Resident 12 electronic medical record (EMR) review were conducted with Licensed Vocational Nurse (LVN) 8. LVN 8 unable locate in EMR (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the amount intake of ONS for Resident 12.On April 21, 2026, at 3:54 p.m., a concurrent interview and Resident 12 electronic medical record (EMR) review were conducted with the Director of Nursing (DON). The DON stated the IDT weight variance was held every Tuesday. The DON stated she and RD 2 were the committee of IDT weight variance. The DON stated that since January 15, 2026, Resident 12 was being monitored weekly on IDT weight variance due to weight loss. The DON stated the nutrition interventions for Resident 12 were ONS with meal three times per day and Fortified diet. The DON was unable to locate in EMR the amount intake of ONS for Resident 12. The DON stated Certified Nursing Assistants should document ONS intake individually, not as part of fluid intake or meal intake. The DON was unable to answer how much Resident 12 drank from ONS. The DON was unable to answer whether Resident 12 like the ONS. The DON acknowledged that without monitoring and documenting ONS, it was unable to determine the effectiveness of nutritional interventions.On April 22, 2026, at 10:15 a.m., a phone interview and Resident 12 electronic medical record (EMR) review were conducted with RD 3. RD 3 stated nutrition interventions should be documented and monitored for effectiveness. RD 3 stated if the nutrition interventions were not effective, Consultant RDs could modify or change the nutrition interventions. RD 3 stated her expectation was Consultant RDs should communicate with the IDT regarding nursing did not document and monitor nutrition interventions.On April 22, 2026, at 1:04 p.m., confirmed with MDS (Minimum Data Set) Coordinator (MDSC) that there were no policy and procedure regarding monitoring and documenting nutrition interventions including oral nutrition supplement intake.During a review of the facility's policy and procedure titled, WEIGHT CHANGE PROTOCOL, dated 2023, it indicated, .The Facility RD will assess, nutritionally diagnosis, suggest interventions, monitor, and evaluate the success of the interventions.INTERVENTIONS .diet supplement (ONS) .EVALUATION .Interventions are change if not effective.2. On April 21, 2026, at 3:54 p.m., a concurrent interview and electronic medical record (EMR) review were conducted with the DON. Concurrent review Resident 12's Annual Nutrition assessment dated [DATE], completed by RD 1, where it was marked all Nutrition intake: 0% -25 % of meals, 26 -50 % of meals, 51 -75 % of meals, 76 -100 % of meals with comments: PO intake variable, 0-100%, average ~ 50-75% per meal record. No intolerance issue noted sometimes 0-25 % x 1 meal/day and remaining 75 -100%. Review IDT weight variance completed by RD 2 on January 13, 2026, January 18, 2026, January 26, 2026, February 2, 2026, February 8, 2026, February 15, 2026, February 23, 2026, March 1, 2026, March 8, 2026 indicated, Pt remains on a CCHO NAS diet with Glucerna with meals and a variable intake and March 15, 2026, and March 22, 2026, indicated, Pt remains on a CCHO NAS diet with Glucerna with meals and a variable to good intake. After the DON review RD1 and RD 2 meal intake documentation, the DON stated the statements indicating meal intakes were so vague. The DON stated by documenting with big range 0 -100 % meal intake, variable intake, variable to good intake, there was no way to tell whether Resident 12 meal intake was adequate to meet her nutritional needs, there was no way to address how much Resident 12 consumed from the diet or approximate how many calories Resident 12 obtained from meal consumption.On April 22, 2026, at 10:15 a.m., a phone interview and Resident 12 electronic medical record (EMR) review were conducted with RD 3. Concurrent review Resident 12's Annual Nutrition assessment dated [DATE], completed by RD 2, RD 2 marked all Nutrition intake: 0% -25 % of meals, 26 -50 % of meals, 51 -75 % of meals, 76 -100 % of meals with comments: PO intake variable, 0-100%, average ~ 50-75% per meal record. No intolerance issue noted sometimes 0-25 % x 1 meal/day and remaining 75 -100%. Review IDT weight variance completed by RD 2 on March 15, 2026, and March 22, 2026, indicated, Pt remains on a CCHO NAS diet with Glucerna with meals and a variable to good intake. RD 3 stated it was hard to determine whether Resident 12 meal intake was adequate to meet her nutritional needs with range 0 -100 % and variable to good intake.During a review of the facility's policy and procedure titled, WEIGHT CHANGE PROTOCOL, dated 2023, it indicated, .The Facility RD will assess, nutritionally diagnosis, suggest interventions, monitor, and evaluate the success of the interventions.Assessment Nutrition content of the diet provided and percent of intake for multiple days.Determine if the: .intake of the resident will be sufficient to meet needs .During a (continued on next page)

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	04/24/2026

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility policy and procedure titled, Weight Assessment and Intervention, Revised September 2008, it indicated, Policy Statement: The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Policy Interpretation and Implementation .Analysis 1. Assessment information shall be analyzed by the multidisciplinary team and conclusion shall be made regarding the .Approximate calories, protein, and other nutrient needs compared with the resident's current intake .During a review of the facility policy and procedure titled, Assisting the Resident with Meals dated 2013, it indicated, Purpose The purpose of this procedure is to provide appropriate assistance for residents during meals.Documentation The person performing this procedure should record the following information in the resident's medical record.3. How much of the meal the resident consumed (i.e., 25 %, 50 %, 75 % etc.)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure resident's nasal cannula (a medical device used to deliver supplemental oxygen) was changed on a weekly basis according to the facility's policy and procedure, for one of six residents reviewed (Resident 62).This failure had the potential to result in increased risk of infection.Findings:On April 21, 2026, at 10:45 a.m., a concurrent observation and interview was conducted with Resident 62 in his room. Resident 62 was observed receiving oxygen via nasal cannula at 2 liters per minute (L/min - unit of measurement). The nasal cannula was labeled with a date of 4/12/26 (April 12, 2026), which indicated when it was last changed. In a concurrent interview with Resident 62, he stated he used oxygen continuously. A review of Resident 62's admission Record, indicated an admission date of September 29, 2024, with diagnoses which included shortness of breath.A review of Resident 62's History and Physical, dated November 29, 2025, indicated Resident 62 had fluctuating capacity to understand and make decisions.A review of Resident 62's Physician Orders, dated March 9, 2026, indicated, .Change oxygen tubing/cannula every evening shift every Sun.A review of Resident 62's care plan, dated March 10, 2026, indicated, .Focus.Oxygen: Resident requires the use of oxygen [x] continuous.Interventions.Change.O2 (oxygen) tubing as indicated.On April 21, 2026, at 10:50 a.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 9. LVN 9 stated nasal cannulas are changed weekly on Sundays by the licensed nurses. LVN 9 validated Resident 62's nasal cannula was dated April 12, 2026, which indicated when the nasal cannula was last changed. LVN 9 stated Resident 62's nasal cannula should have been changed April 19, 2026. LVN 9 stated it was important to change the nasal cannula weekly to prevent infection.On April 22, 2026, at 2:40 p.m., an interview was conducted with the Infection Preventionist (IP). The IP stated licensed nurses are responsible for changing nasal cannulas weekly on Sundays. The IP stated the licensed nurse should have changed Resident 62's nasal cannula on April 19, 2026. The IP stated it was important to change Resident 62's nasal cannula weekly to prevent infection.A review of the facility policy and procedure titled, Prevention of Infection Respiratory Equipment, dated November 2011, indicated, .Change the oxygen cannula and tubing every seven (7) days.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pain was assessed and managed, for one of three residents reviewed for pain management (Resident 20) when the licensed nurse did not assess, intervene, and obtain physician orders after the resident verbalized pain.This failure had the potential to result in unrelieved pain, discomfort, decreased quality of life, and decline in physical and psychosocial well-being.Findings:On April 21, 2026, at 8:21 a.m., during an interview with Resident 20, Resident 20 stated he requested pain medication (an acetaminophen) for arm and shoulder pain during the night shift in March 2026. Resident 20 stated the licensed nurse on the night shift informed him there was no physician order for (name of acetaminophen). Resident 20 stated he has previously been given (name of acetaminophen) without any issue.Resident 20's record was reviewed. Resident 20 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease (irreversible kidney damage).A review of Resident 20's care plan dated February 23, 2026, indicated, .Focus.Pain: Experiencing [x] acute pain.Goal.Will express/exhibit pain relief after.administration of medication as needed.Interventions.Administer medication as ordered.A review of Resident 20's Medication Administration Record (MAR), for the month of March 2026, indicated Resident 20 reported pain, 7 out of 10 during the night shift of March 24, 2026. There was no documented evidence that non-pharmacological interventions were implemented, and pain medication was not ordered.There was no documented evidence Resident 20 was provided pain medication on March 24, 2026, following his complaint of pain. In addition, there was documented evidence of follow-up with the physician addressing Resident 20's pain.A review of Resident 20's Progress Notes, dated March 31, 2026, at 3:33 a.m., indicated, .notified MD (medical doctor) that pt (patient) c/o (complain of) pain and discomfort and has no orders for pain medication. MD notified March 25th @ (at) 358HRS (3:58 a.m.) with no response. MD notified AGAIN TODAY March 31st @0333HRS (3:33 a.m.) regarding an order for acetaminophen, awaiting MD's response AGAIN. Will continue frequent visual checks on pt.A review of Resident 20's physician order dated April 2, 2026, indicated Tylenol 325 milligram (mg - unit of measurement), give two tablets by mouth every six hours as needed for mild pain.On April 23, 2026, at 8:08 a.m., during an interview with Licensed Vocational Nurse (LVN) 10, LVN 10 stated she recalled Resident 20 complained of pain on March 24, 2026, and requested pain medication. LVN 10 stated she did not administer any pain medication because there was no physician order. LVN 10 stated she notified the physician, however, the physician did not respond. LVN 10 stated she did not notify the Director of Nursing (DON) when the physician did not respond. On April 23, 2026, at 8:45 a.m., during an interview with Registered Nurse Supervisor (RNS) 2, RNS 2 stated she informed Resident 20 on March 24, 2026, that there was no order for (name of acetaminophen). RNS 2 stated the facility process required licensed nurses to contact the physician and document the attempt, and if there was no response, to notify the DON. RNS 2 stated non-pharmacological interventions should have been provided to keep the resident comfortable. RNS 2 stated she should have followed up with the physician and notified the DON to address Resident 20's pain.On April 24, 2026, at 10:30 a.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated licensed nurses were expected to assess and address residents' pain and notify the physician. The ADON stated if the physician did not respond, the licensed nurses should have contacted the on-call physician. The ADON stated the licensed nurses should have followed the facility's process for pain management and ensured Resident 20's pain was addressed according to professional standards of practice.A review of the facility's policy and procedure titled, Emergency and/or Alternative Physician Care, dated 2001, indicated, .staff will follow designated protocols.reporting information to attending physicians and covering practitioners.staff will use appropriate procedures to contact physicians, depending on arrangements.A review of the facility's policy and procedure titled, Pain Assessment and Management, dated October 2022, indicated, .Pain management interventions are consistent with the (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's goal for treatment which are defined and documented in the care plan.Contact the prescriber immediately if the resident's pain.not adequately controlled.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure laboratory service was provided as ordered by the physician, for one of one residents reviewed (Resident 8), when the urinalysis (a small sample of your urine for signs of infection, kidney disease, or diabetes)/C&S (culture and sensitivity - a laboratory procedure that identifies infectious germs [culture] and determines the most effective antibiotic [sensitivity] to treat the infection) was not obtained as ordered by the physician.This failure had the potential for delayed care and treatment and could affect Resident 8's overall health condition.Findings:On April 21, 2026, at 11:10 a.m., Resident 8 was observed alert, resting in bed. Resident 8 was observed with a urinary/foley catheter (flexible, thin tube placed into the bladder to drain urine when you cannot pee normally). In a concurrent interview, Resident 8 stated his urinary catheter was placed due to safety reasons because he could not stand up to go to the restroom on his own. Resident 8 stated he would get urinary tract infections (an infection caused by bacteria entering the bladder or urethra) often.On April 22, 2026, Resident 8's record was reviewed. Resident 8's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included neuromuscular dysfunction of bladder (occurs when nerve damage prevents the brain and bladder from communicating properly, making it hard to store or empty urine) and urinary tract infection.A review of Resident 8's COC (Change of Condition)/eINTERACT ASSESSMENT FORM, dated March 8, 2026, at 11:44 p.m., indicated, .patient was noted with hematuria (blood in the urine) to foley catheter.MD notified.ordered 200 cubic centimeters (cc - unit of measurement) flush every shift.x2 (two) days.and UA with C&S.A review of Resident 8's physician order, dated March 8, 2026, indicated, .collect UA with C&S one time only for to rule out UTI (urinary tract infection) for 1 Day.A review of Resident 8's Minimum Data Set (MDS - an assessment tool), Section H: Bladder and Bowel, dated March 9, 2026, indicated, .indwelling catheter.A review of Resident 8's MDS, dated March 31, 2026, indicated Resident 8 had a BIMS (Brief Interview of Mental Status-a cognitive assessment tool) score of 6 (severe cognitive impairment).Further review of Resident 8's record indicated there was no documented evidence that the UA with C&S was collected as ordered by the physician on March 8, 2026. In addition, there was no documentation that the laboratory was notified of the new physician order for the UA with C&S.On April 23, 2026, at 8:33 a.m., a concurrent interview and review of Resident 8's record was conducted with LVN (Licensed Vocational Nurse) 14. LVN 14 stated the following:-Resident 8 had a urinary/foley catheter due to obstructive uropathy (a blockage in the urinary tract that stops urine from flowing normally);-The process after obtaining lab (laboratory) orders from the physician, was to enter the order in the resident's electronic medical record, notify the laboratory of the new orders by entering the order in the laboratory software;-The LN was responsible to notify the laboratory of the new lab orders, then obtain the specimen (a sample to be tested) as soon as possible;-After the specimen was obtained, the LN was to notify the laboratory that the specimen was ready for pick up;-Verified this process was not followed for Resident 8's order for UA with C & S;-Verified there was no order placed in the laboratory software to notify the lab of the UA C&S ordered on March 8, 2026.On April 23, 2026, at 4:25 p.m., during a concurrent interview and review of Resident 8's record conducted with the Director of Nursing (DON), the DON stated after obtaining an order for UA with C & S, the licensed nurse would collect the urine specimen, label with the resident's name, put it in the specimen refrigerator, and notify the laboratory that the specimen is ready for pick up. The DON stated Resident 8 had a COC on March 8, 2026, and UA with C & S was ordered by the physician. The DON further stated there was no UA with C & S placed in the laboratory software to notify the laboratory for specimen pick up. The DON stated the licensed nurse should have obtained the urine specimen right away for it to be available for pick up. A review of the facility's policy and procedures (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Physician Orders, Accepting, Transcribing, and Implementing (Noting), indicated, .licensed nursing personnel will ensure .that written (noting), telephone, and verbal orders, will be recorded .and implemented .

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	555339	A. Building B. Wing	04/24/2026

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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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dental care services and follow up treatment were provided, for one of three residents reviewed for dental (Resident 128), when there was no follow up dental consult for denture impressions after tooth extractions completed by the dentist on July 31, 2025.This failure had the potential to result in poor nutrition, and further decline in overall health. Findings:On April 21, 2026, at 11:04 a.m., Resident 128 was observed alert, resting in bed, with head of the bed elevated. Resident 128 was observed with only one tooth to the left, top front of her mouth and two teeth to the right, lower front of her mouth. Resident 128 was observed without any teeth or dentures to upper or lower posterior (back) gums. In a concurrent interview, Resident 128 stated she did not have dentures and that she wanted dentures.On April 22, 2026, Resident 128's medical record was reviewed. Resident 128 was admitted to the facility on [DATE], with diagnoses which included rheumatoid arthritis (disease where the immune system mistakenly attacks the joints) and enterocolitis (inflammation of the small intestine and colon).A review of Resident 128's Nursing admission Evaluation/Assessment dated January 19, 2025, indicated, .dental.teeth.own teeth.A review of Resident 128's Minimum Data Set (MDS - an assessment tool), Section K: Swallowing/Nutritional Status, dated January 26, 2025, indicated, .swallowing disorder.holding food in mouth/cheeks.residual food in mouth after meals.A review of Resident 128's physician orders indicated the following:- NAS (no added salt) diet, IDDSI 6: Soft and Bite Sized texture, IDDSI 0: Thin consistency, date ordered on January 20, 2026.A review of Resident 128's MDS Section L: Oral/Dental Status, dated January 27, 2026, indicated, .broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): yes.A review of Resident 128's MDS, dated April 7, 2026, indicated Resident 128 had a BIMS (Brief Interview of Mental Status-a cognitive assessment tool) score of 12 (moderate cognitive impairment).A review of Resident 128's Dental Progress Notes, documented by the dentist, dated July 17, 2025, indicated, .Exam: severe xerostomia (a significant reduction in saliva flow, leading to intense discomfort, difficulty swallowing/speaking, and high risks of dental decay and infections).only Tx (treatment) possible.ext (extractions) upper/lower.FUD (full upper dentures)/FLD (full lower dentures).inmed (immediate). and, .after examination .the following dental treatment is recommended .TAR (Treatment Authorization Request) .extraction upper .lower .FUD/FLD, inmed .check mark: yes, please provide the recommended treatment .signed by resident.A review of Resident 128's Progress Notes, dated July 17, 2025, at 4:31 p.m., indicated, .(name of dentist), recommending full tooth extraction for full dentures, patient agreeable to treatment and extraction will begin next thursday (sic) . A review of Resident 128's Dental Progress Notes, documented by the dentist, dated July 31, 2025, indicated, .ext # (number) 23 (Tooth 23: Lower Left Lateral Incisor), 24 (Tooth 24: Lower Left Central Incisor), 25 (Tooth 25: Lower Right Central Incisor) .done.A review of Resident 128's Dental Hygienist Progress Notes, documented by the Registered Dental Hygienist (RDH), dated February 13, 2026, indicated Resident 128 had missing teeth at the upper and lower mouth.Further review of Resident 128's record indicated there was no documented evidence the status of the resident's dentures was followed up with the dental provider.On April 22, 2026, at 10:21 a.m., a concurrent observation and interview was conducted with Certified Nurse Assistant (CNA) 15. CNA 15 stated Resident 128 did not have any dentures since admission. CNA 15 verified with Resident 128 that she does not have dentures and that she wanted dentures. CNA 15 stated the CNA providing morning care should notify the charge nurse that the resident did not have any teeth or dentures because the resident was at risk for not chewing and swallowing food properly and was at risk for choking. On April 23, 2026, at 2:42 p.m., a concurrent interview and record review was conducted with the Registered Dental Hygienist (RDH). A review of Resident 128's Dental Hygiene Progress Note, dated February 13, 2026, the RDH verified that the striking out line through numbers indicated no teeth; and Rt indicated root tip; and shaded markings on (continued on next page)

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	555339	A. Building B. Wing	04/24/2026

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	numbers indicated broken or chipped teeth; and an X on numbers indicated missing teeth. The RDH stated Resident 128 was missing too many teeth to chew and breakdown food properly to swallow safely. On April 24, 2026, at 9:45 a.m., a concurrent interview and record review was conducted with the Social Services Manager (SSM). The SSM stated after a dentist appointment, the dentist will review the plan with the SSM. The SSM stated she would obtain consent for the recommended treatment and fax the consent to the dental office. The SSM stated she did not follow up with the dentist for Resident 128 after July 31, 2025 dental appointment and tooth extraction. The SSM stated she should have followed up within 1-2 weeks after July 31, 2025. The SSM stated that it was not an acceptable timeframe for Resident 128 to wait 9 months for her dentures.A review of Resident 128's Care Plan, dated January 20, 2026, indicated, .Nutritional Risk (Moderate): Resident is at moderate nutritional risk related to chipped tooth. Will have no signs/symptoms of chewing difficulties.Dental appt (appointment) if needed.A review of the facility's policy and procedure titled, Dental Services, revised December 2016, indicated, .routine and emergency dental services are available to meet the resident's oral health services.in accordance with the resident's assessment and plan of care.social services repr

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review, the facility failed to ensure special adaptive equipment was provided to be used during meals as ordered by physician, for one of three sampled residents (Resident 62).This failure had the potential to slow down Resident 62's progress to eat independently.Findings: On April 20, 2026, at 12:18 p.m., a concurrent observation and Resident 62 meal ticket (contain Resident name, room number, physician diet order, Allergies, Adaptive Equipment, and food dislike) review were conducted with Resident 62 at Dunes dining room. Resident 62 was observed holding a spoon with right hand shaking tremendously feeding himself. Food particles were observed dropping all over on Resident 62's clothing protector and floor. Resident 62's meal ticket was concurrently reviewed and indicated, Buildup fork, Buildup knife, Buildup spoon. Resident 62 did not receive Buildup fork, Buildup knife, Buildup spoon to be used on his meal tray.On April 20, 2026, at 12:19 p.m., a concurrent interview and Resident 62 meal ticket review were conducted with Restorative Nursing Assistant (RNA) 1 at Dunes dining room. RNA 1 stated Resident 62 was missing the Buildup fork, Buildup knife, and Buildup spoon. RNA 1 stated Resident 62 should have received buildup utensils to help him perform self-feeding.On April 21, 2026, at 12:09 p.m., a concurrent interview and electronic medical record (EMR) review were conducted with the Occupational Therapist (OT). During a concurrent review of Resident 62's EMR, the OT stated Resident 62 had trembling hands due to his diagnosis of Parkison's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). The OT stated the physician ordered weighted utensils with meals for Resident 62 to help him eat easily and prevent spilling of foods. The OT stated the dietary staff should follow the physician's order and provide weighted utensils with meals.On April 21, 2026, at 3:41 p.m., an interview was conducted with the Dietary Director (DD). The DD stated the dietary staff should follow the meal ticket providing weighted utensils with meals for Resident 62 otherwise Resident 62 would have a hard time feeding himself and food would fall off plate.During a review of the Resident 62's physician orders, dated October 23, 2024, indicated, Weighted Utensils with meals due to tremor.During a review of the facility policy and procedure titled, SELF-FEEDING DEVICES, dated 2023, the policy indicated, .POLICY: Residents will receive self-feeding devices to maintain or improve their ability to eat or drink independently. PROCEDURE:1. The PT, OT, or ST and/or designed person will evaluate residents for the need of a self-feeding device . Residents needing devices will receive them with each meal or snack, on their meal trays. Tray cards (meal ticket).will record which device is needed.Commonly Used Self-Feeding Devices: Weighted Utensil: Used for residents who tend to shake or have poor coordination.

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	04/24/2026

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on interview and record review, the facility failed to ensure safe and sanitary storage, and consumption of food items brought to the residents by family and visitors was implemented according to the facility's policy and procedure.This failure had the potential to lead to food-borne illness in medically compromised population of residents who can consume food. Findings: On April 21, 2026, at 9:22 a.m., an interview was conducted with Licensed Vocational Nurse (LVN) 8. LVN 8 stated food brought in by family and/or visitors for the residents could be stored in the nourishment refrigerator for three days. On April 21, 2026, at 10:23 a.m., an interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated food brought in by family and/or visitors for the residents could be stored in the nourishment refrigerator for seven days. On April 21, 2026, at 10:25 a.m., an interview was conducted with LVN 4. LVN 4 stated food brought in by family and/or visitors for the residents could be stored in the nourishment refrigerator 24 hours to three days. During a review of the facility policy and procedure titled, BRINGING IN FOOD FOR A RESIDENT dated 2023, the policy indicated, Food or beverage items without a manufacturer's expiration date will be dated upon arrival in the facility and thrown away two days after the date marked.