STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555403	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Palms Health Care Center	44610 Monterey Avenue Palm Desert, CA 92260

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three residents (Resident 1) was treated with dignity and respect when a staff member called the resident a liar after the resident alleged the staff member had purposely hit his elbow away while providing resident care.This failure resulted in Resident 1 becoming upset and angry. Findings:On January 29, 2026, at 4:20 p.m., an interview was conducted with Resident 1, who stated he could not remember the exact date, but Certified Nursing Assistant (CNA) 1 was providing perineal (area of skin between the anus and genitals) care for him when he asked CNA 1 if CNA 1 would hand him a wipe. When he (Resident 1) reached for the wipe CNA 1 Hit his elbow out of the way. Resident 1 stated it was more than a push. Resident 1 stated he told CNA 1, You hit my elbow, and CNA 1 responded by yelling You're a liar. Resident stated (CNA 1) Got mad at me, and it was upsetting, it made me mad. Resident 1 stated he was not sure of the exact date but he reported the incident to Registered Nurse (RN) 1, and the Administrator spoke to him regarding the incident soon after. A review of Resident 1's, Progress Notes, dated, January 15, 2026, at 10:57 a.m., indicated, . (Nurse) . FROM HOSPICE . REPORTED RESIDENT STATED (CNA 1) HIT HIS ELBOW WHILE PROVIDING . (RESIDENT 1) HAD NOT REPORTED TO ANY IN-HOUSE STAFF . (ADMINISTRATOR) NOTIFIED . On January 30, 2026, at 4:35 p.m., a telephone interview was conducted with CNA 1. CNA 1 stated on January 10 or 11, 2026, he was providing perineal care for Resident 1. CNA 1 stated Resident 1 was turned on his side, and CNA 1 put his hand on Resident 1's hip, at which time Resident 1 stated, Why did you hit me? CNA 1 stated he, Got a little angry, at Resident 1 and said to Resident 1, Your lying. CNA 1 further stated he told Resident 1, I go way out of my way for you, and you come out with this non-sense, lying that I hit you. A review of Resident 1's, Patient Information, indicated, resident was admitted to the facility on [DATE], with a diagnosis of Hemiplegia/Hemiparesis (One sided paralysis/weakness) following a stroke. A review of Resident 1's,Brief Interview for Mental Status (BIMS-a cognitive assessment), indicated a score of 12, moderate cognitive deficit. On February 9, 2026, at 11:07 a.m., a telephone interview was conducted with the Administrator (Admin), who stated he is the facility's abuse coordinator and he investigates allegations of abuse. The Admin stated staff receive abuse training upon hire, monthly and per episode of alleged abuse. The Admin further stated when a resident becomes angry or accusatory towards staff, the staff member should give the resident space by walking away, leaving the room, letting the resident calm down, and reporting right away to their charge nurse. The Admin stated on January 15, 2026, RN1 reported Resident 1's abuse allegations to him, at which time, he immediately reported these allegations to all required parties, started an investigation, and interviewed Resident 1 and CNA 1 the same day. The Admin further stated his investigation indicated the abuse allegations were unsubstantiated as CNA 1 denied hitting Resident 1's elbow during care. The Admin stated he was unaware CNA 1 called Resident 1 a liar, when Resident 1 accused CNA 1 of hitting his elbow, as CNA 1 did not report this information during the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation. The Admin stated CNA 1 should have walked away from Resident 1 and should not have engaged in responding to Resident 1 by calling him a liar. The Administrator further stated CNA 1 did not make the right decision by engaging with Resident 1 instead of walking away, as CNA 1 should have given Resident 1 space and time to calm down. A facility Policy and Procedure titled, Mood and Behavior Management Techniques, undated, indicated .The unit staff will incorporate Behavior Management techniques to improve the patient's/resident's Quality of life .Procedure.If the patient/resident is escalating verbally and /or behaviorally, respond using a professional approach .Examples include.Employ a rational response; detach from patient/resident agitation .Stay focused on topic; redirect, ignore the challenge.Utilize examples below to address non-threatening behaviors .Do not argue.If you are not successful with the above approaches.walk away and wait 5-10 minutes .