

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555403	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Monterey Palms Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review the facility failed to provide the necessary care and services for two of six residents reviewed (Resident 1 and 2) when:1a. For Resident 1, nursing staff failed to notify the physician of changes in vital signs, as indicated in the physician orders, on December 6, December 13, December 16, and December 22, 2025;1b. For Resident 1, nursing staff failed to administer Milk of Magnesia (medication used for constipation) as indicated in the physician orders on December 1 - 2, December 5 - 6, December 12 - 13, December 15, December 18, and December 25, 2025; and 2. For Resident 2, the facility did not facilitate transportation to a scheduled chemotherapy (drug treatment that uses powerful medications to destroy cancer cells) appointment scheduled on June 22, 2026. These failures placed Resident 1 and Resident 2 at risk for delayed medical intervention and adverse clinical outcomes.Findings:1. On June 25, 2026, Resident 1's medical record was reviewed.The admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included left femur fracture (broken left thigh bone), hypertension (high blood pressure), congestive heart failure (heart muscle is too weak to pump blood efficiently), and abnormal findings of blood (blood components falls outside laboratory standard reference range). The admission record indicated Resident 1 was transferred to the acute care hospital on December 25, 2025.The history and physical dated November 28, 2025, indicated Resident 1 had the capacity to make decisions.The physician orders indicated the following:-November 26, 2025, Vital signs Q (Q-every) shift (Shift 1: 7:00 AM - 3:00 PM, Shift 2: 3:00 PM - 11:00 PM, Shift 3: 11:00 PM - 07:00 AM; and-December 2, 2025, .Monitor for s/s (signs/symptoms) of dehydration (condition of when the body loses more fluids than taken in; s/s - low blood pressure, fast heartrate, dry mouth, decrease in urination, confusion, sunken eyes, and skin that doesn't flatten).The vital sign history was reviewed for the month of December 2025, and indicated the following:On December 6, at 9:41 am, BP: 86/56 (hypotension - low blood pressure top number of BP is below 100);On December 13, at 9:34 am, BP: 90/45;On December 16, at 9:50 am, HR:108 (tachycardia -high HR at or above 100);On December 16, at 12:29 pm, HR:108;On December 16, at 7:22 pm, HR:100; [NAME] December 22, at 6:41 pm, HR:110.There was no documented evidence in Resident 1's medical record that the physician was notified of Resident 1's change in vital signs for the following dates December 6, December 13, December 16, and December 23, 2025, as indicated in the physician order to monitor for s/s of dehydration.The Medication Administration Record (MAR) for the month of December 2025, was reviewed. For .Monitor for s/s of dehydration. the MAR indicated nursing staff initialed Resident 1 had been monitored for s/s of dehydration on the following dates and shifts:On December 6, 2025, 7:00am - 3:00 pm;On December 13, 2025, 7:00am - 3:00 pm;On December 16, 2025, 7:00am - 3:00 pm & Shift 2: 3:00 pm - 11:00pm; [NAME] December 22, 2025, 11:00pm - 7:00 am.The MAR indicated nursing staff initialed monitoring Resident 1 for s/s of dehydration on the above dates. There was no documentation the physician was notified when (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1's vital signs indicated Resident 1 was experiencing possible dehydration. The SBAR (Situation Background Assessment Recommendation) dated December 17, 2025, at 10:58 pm, indicated .COC (change of condition) BUN (Blood Urea Nitrogen- lab test that measures kidney function and hydration status) 108 (normal range 7-20) .situation dehydration risk. Narrative Note RECEIVED A CALL FROM (named lab) REPORTING PT (patient) HAVE A CH (sic) BUN 108. MD (physician) Notified. The physician order dated December 18, 2025, indicated .sodium chloride 0.9% (normal saline commonly used for fluid replacement) .2 liters .for dehydration .On June 30, 2026, at 1:05 pm, a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated the facility process for changes in vital signs are for nursing to document the change in vital signs and notify the physician for orders and implement the order. LVN 1 stated Resident 1's vital signs on December 6, December 13, December 16, and December 22, 2025, indicated s/s of dehydration and should have been reported to the physician. On June 30, 2026, at 5:09 pm, a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the facility process for reporting resident COC (change in condition) are for nursing staff to document the COC, notify the physician of the COC, document and implement the physician order. The DON stated Resident 1's vital signs on December 6, December 13, December 16, and December 22, 2025, indicated s/s of dehydration and should have been reported to the physician. The DON stated the facility process was not followed. On July 21, 2026, at 2:08 pm, a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated she was Resident 1's assigned nurse on December 4 and December 6, 2025. LVN 2 stated the facility process for monitoring for s/s of dehydration are to observe the resident for dry lips, tenting of skin (skin that doesn't flatten back right away after being pinched), low urinary output, confusion, low blood pressure and high heart rate. LVN 2 stated the physician order was to monitor Resident 1 for s/s of dehydration. LVN 2 stated Resident 1's vital signs on December 4 and December 6, 2025, indicated s/s of dehydration. LVN 2 stated there was no documented evidence that the physician was notified of Resident 1's vital signs and that she should have notified the physician. 1b. On June 25, 2026, Resident 1's medical record was reviewed. The physician orders indicated the following: -December 1, 2025, docusate sodium [OTC-over the counter] capsule; 100 mg (mg-unit of measurement) 1 capsule oral twice daily for bowel regimen; and -December 1, 2025, Milk of Magnesia [OTC] 400 mg/5 ml (ml-unit of measurement) 30 ml oral as needed. Give 30 ml by mouth x 1 (x1 - one time) as needed if no bowel movement in 2 days; and -December 2, 2025, .Monitor for constipation (difficulty or inability to have a bowel movement) from opioid use (type of pain medication that has side effects of constipation) every shift and follow up with MD (medical doctor) order as indicated. The Vitals Report for the month of December 2025 indicated the following: -December 1, at 1:31 am, Bowel Movement Size: None-December 2, at 2:19 pm, Bowel Movement Size: None-December 3 & 4, indicated no recording of bowel movement-December 5, at 11:00 am, Bowel Movement Size: None-December 6, at 2:30 pm, Bowel Movement Size: None-December 7, 8, 9, & 10, indicated no recording of bowel movement-December 11, at 3:25 am, Bowel Movement Size: None-December 11, at 9:32 pm, Bowel Movement Size: Large-December 11, at 9:33 pm, Bowel Movement Size: Large-December 12, at 10:01 am, Bowel Movement Size: None-December 13, 11:06 am, Bowel Movement Size: None-December 14, 9:36 am, Bowel Movement Size: None-December 15, 5:35 am, Bowel Movement Size: None-December 16 & 17, indicated no recording of bowel movement-December 18, 8:23 pm, Bowel Movement Size: None-December 19, at 1:58 pm, Bowel Movement Size: Medium-December 20, at 10:31 pm, Bowel Movement Size: Small-December 21, at 6:31 am, Bowel Movement Size: Medium-December 22, 23, and 24, indicated no recording of bowel movement-December 25, 2025, Bowel Movement Size: NoneThe (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Administration Record (MAR) for the Month of December 2025 was reviewed. There was no documented evidence that nursing staff administered the Milk of Magnesia in the month of December 2025, as ordered by the physician. On July 21, 2026, at 2:08 pm, during a concurrent interview and record review, LVN 2 stated the facility process for documentation of bowel movements (BM) are for nursing to document each shift if a resident had a bowel movement or did not have a bowel movement. LVN 2 stated the physician order for Resident 1, indicated administer Milk of Magnesia as need if no bowel movement in 2 days. LVN 2 stated the vitals report indicated Resident 1 did not have a BM on December 1, 2, 5, 6, 12, 13, 15, 18, and December 25, 2025. LVN 2 stated there was no documented entry of a bowel movement on December 3, 4, 7, 8, 9, 10, 16, 17, 22, 23, and December 24, 2025. LVN 2 stated there was no documented evidence within the MAR that nursing administered the Milk of Magnesia. LVN 2 stated nursing staff should have administered the Milk of Magnesia per the physicians order. On July 21, 2026, at 4:30 pm a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the expectations of nursing staff are to document at the end of each shift if the resident had a bowel movement. The DON stated the expectation is nursing staff are to notify the physician of a resident not having a bowel movement after 3 days. The DON further stated nursing staff should have administered the Milk of Magnesia per the physicians orders and notified the physician of Resident 1's change in bowel pattern. A review of the facility policy and procedure titled, Changes in Resident Conditions, undated, indicated .The resident, attending Physician, are notified when changes in condition or certain events occur. attending Physician resident representative are notified by the Licensed Nurse. when there is a significant change in the resident's physical, mental or psychosocial status. Changes in condition will be documented in the Change of Condition form or Nurses' Progress notes. 2. On June 25, 2026, Resident 2's medical record was reviewed. The admission record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included Intraductal carcinoma in situ of right breast (cancer in the milk ducts of the breast), malignant neoplasm of unspecified ovary (cancer in the ovaries). The history and physical completed by the physician on June 4, 2026, indicated Resident 2 the capacity to make decisions. The (named hospital) AVS (After Visit Summary) dated June 18, 2026, indicated a chemotherapy appointment for Monday, June 22, 2026, at 8:00 am. There was no documented evidence that the facility arranged transportation for Resident 2's chemotherapy appointment for Monday, June 22, 2026. A phone interview was conducted with the (named physician's office) receptionist. The receptionist confirmed Resident 2 did not attend the chemotherapy appointment scheduled for Monday, June 22, 2026. On June 30, 2026, at 1:05 pm, a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated the facility process for appointments are when a resident has been newly admitted or readmitted to the facility nursing staff are expected to read the hospital discharge AVS and work with social services to schedule transportation for those appointments. The AVS dated June 18, 2026, was reviewed. LVN 1 stated the AVS indicated Resident 1 had a scheduled appointment for Monday, June 22, 2026, and Tuesday June 23, 2026. LVN 1 stated there was no documented evidence that transportation was scheduled for Resident 1's appointment on Monday, June 22, 2026, and that transportation should have been scheduled as indicated in the AVS. On June 26, 2026, at 4:31 pm, an interview was conducted with the Social Service Assistant (SSA). The SSA stated the facility process for appointments are for nursing staff to review the AVS and inform social services of the appointments indicated on the AVS. The SSA stated she was not informed by nursing staff to schedule transportation for Resident 2 on June 22, 2025. Social services was only informed to schedule transportation on June 23, 2025. On June 30, 2026, at 2:45 pm, a concurrent interview and (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure communication with the physician was entered into the resident's chart for one of six residents reviewed (Resident 2) when nursing staff did not document communication with the physician regarding Resident 2's low hemoglobin (Hgb-red blood cells can't carry enough oxygen to your tissues) laboratory result.This failure had the potential for Resident 2 to have a delay in care due to information not being readily available in the resident's medical record.Findings:On June 25, 2026, Resident 2's medical record was reviewed.The admission record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included Intraductal carcinoma in situ of right breast (cancer in the milk ducts of the breast), malignant neoplasm of unspecified ovary (cancer in the ovaries).The history and physical completed by the physician on June 4, 2026, indicated Resident 2 the capacity to make decisions. The laboratory result dated June 15, 2026, indicated Resident 2's had a critical low Hgb result of 6.7 (normal Hgb values 11-15).The nursing progress note dated June 16, 2026, at 12:29 pm, indicated .Patient was receiving physical therapy when she became dizzy, light headed and weak. PT (physical therapy) reported patients heart rate was 120.vitals BP: 95/53 O2 Sat: 95% on RA, 100 Pulse, 98.4 temp.but appearing slightly pale.Patient was noted to have hemoglobin at 6.7.on 6/16/26, Provider was aware. Notified provider that patient now has symptomatic anemia.New orders to send to ER for further eval and management.There was no documented evidence in Resident 2's medical record that nursing staff communicated with the physician regarding Resident 2's critical low Hgb or that nursing staff received orders from the physician regarding Resident 2's critical low Hgb.On June 30, 2026, at 1:05 pm, a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated the facility process for critical labs are to notify the physician and the family and complete an SBAR (Situation Background Assessment Recommendation). LVN 1 Stated there was no documented evidence of a SBAR or progress note for Resident 2's critical lab value dated June 15, 2026. LVN 1 further stated there was no documented evidence that the physician was notified of Residents 2's critical low Hgb result. LVN 1 stated nursing staff should have notified the physician and documented the notification and physician's orders.On June 25, 2026, at 2:45 pm, a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the expectation for nursing staff is to notify the physician with critical labs and document the notifications and new orders, if any, in the residents chart (medical record). The DON stated there was no documented evidence in Resident 2's medical record that nursing staff notified the physician of the Hgb 6.7 on June 15, 2026.On June 25, 2026, at 3:30 pm, the DON presented the nurse physician phone that indicated nursing staff text messaged the physician on the facility's nurse physician phone on June 15, 2026, at 8:16 pm, informing the physician of Resident 2's low Hgb of 6.7 and response from the physician to inform Oncology (physician who treats cancer) tomorrow (June 16, 2026) at Resident 2's chemotherapy appointment for orders to repeat Hgb or transfusion (medical procedure which blood is injected directly into the vein). The DON stated the text message between the nurse and the physician was never documented into Resident 2's chart and should have been documented in Resident 2's chart to be readily available for nursing review.A review of the facility policy and procedure titled, General Documentation Guidelines/Utilization of Forms (FOR LICENSE NURSES AND IDT REVIEWS) dated August 2025, indicated .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record.		