

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Desert Regional Medical Center D/P Srf		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 North Indian Canyon Drive Palm Springs, CA 92262	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 when: 1. One bag containing a yellow and orange colored liquid was stored in the walk-in refrigerator unlabeled and undated. 2. One package of small, round and brown dessert item was stored in the portable walk-in freezer unlabeled and undated. 3. One sandwich was stored in the resident's refrigerator inside the nourishment room unlabeled, undated, and readily available for use. These failures had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) in a medically vulnerable population of 23 residents who receive food in the facility. Findings: 1. On August 18, 2025, at 10:15 a.m., a concurrent observation and interview was conducted with the Dietary Services Supervisor (DSS) in the walk-in refrigerator. A bag with yellow and orange liquid was observed unlabeled and undated. The DSS stated the bag contained liquid eggs which usually came in two bags in a box and further stated, the bag must have been taken out of the box. The DSS verified the bag did not have a label or date. The DSS stated all items stored in the refrigerator should be labeled with the name of the item and received and/or use-by dates to prevent any food borne illness to the residents. 2. On August 18, 2025, at 10:28 a.m., a concurrent observation and interview was conducted with the DSS in the portable walk-in freezer. One package of small, round and brown dessert items was observed unlabeled and undated. The DSS stated the package contained cheesecake which normally came in a box and must have been taken out of the box. The DSS stated it should have had a label with received and/or use-by date. On August 20, 2025, at 11:50 a.m., an interview was conducted with the Registered Dietitian (RD). The RD stated staff were expected to label all items stored in the refrigerator and freezer with the appropriate name and use by dates to ensure food was safe to serve to the residents and avoid foodborne illness. 3. On August 20, 2025, at 8:50 a.m., a concurrent observation and interview of the resident nourishment refrigerator was conducted with a Certified Nursing Assistant (CNA) 2. CNA 2 stated the refrigerator was designated for storing residents' snacks, drinks, and outside food brought in by family. A plate with two halved sandwiches was observed stored in the refrigerator covered, but unlabeled and undated. CNA 2 stated the sandwich should have been labeled and dated. CNA 2 stated without a proper label, there was no way to determine if the sandwich was safe for consumption, which could lead to foodborne illness. On August 20, 2025, at 11:50 a.m., an interview was conducted with the RD. The RD stated staff were expected to label all items stored in the nourishment refrigerator with the appropriate name and use-by dates to ensure food was safe to serve and avoid food borne illness. On August 21, 2025, at 3:15 p.m., an interview was conducted with the DON. The DON stated staff were expected to place a label or a residents' sticker on all items stored in the nourishment refrigerator. The DON stated without proper labeling, there was potential for food borne illness if expired or unsafe food was served to residents. A review of the facility's policy and procedure titled, Food and Supply Storage, dated January 2025, indicated, .all food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety .of the food .label and date unused portions and open packages. A review of the facility's policy and procedure titled, Food from outside Sources, (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dated December 2023, indicated, .this policy applies to the Skilled Nursing Facility (SNF) at Desert Regional Medical Center (DRMC).it is the policy of the SNF to provide guidelines concerning safety and appropriateness of food items.food brought in from outside sources shall be labeled with the patient's information and dated with the date the item was received.the facility shall retain a refrigerator designated for patient food, and all perishable.items shall be stored and discarded consistent with the indications on the container, if noted.foods held in refrigerated or other storage areas shall be covered.stored appropriately.clearly labeled and dated.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure proper disposal of garbage when multiple debris items were found on the ground outside of the designated container and not stored in the appropriate container. This failure had the potential to attract pests and cause infection control issues. Findings: On August 18, 2025, at 11:05 a.m., during a concurrent observation and interview with the Dietary Services Supervisor (DSS), in front of the dumpster storage area, multiple debris items including, wood scraps, pallets, and cardboard were observed on the ground and surrounding area. The DSS stated there should not be any debris, wood scraps, pallets, or cardboard on the ground and around the dumpster compactor machine. The DSS stated these items could attract pests and could cause infection control issues. On August 20, 2025, at 12:15 p.m., during an interview with the Registered Dietitian (RD), the RD stated the dumpster compactor machine area should be kept clean and inspected daily to ensure no garbage, wood scraps, or cardboard boxes were left on the ground. The RD further stated this could result in pest infestation and infection control issues. On August 21, 2025, at 3:15 p.m., during an interview with the Director of Nursing (DON), the DON stated the dumpster compactor machine area should be kept clean and free of garbage, wood scraps, and cardboard boxes to prevent potential pest infestation and infection control issues. A review of the U.S. FDA Food Code 2022, Section 5-501.115, Maintaining Refuse Areas and Enclosures, indicated, .storage area and enclosure for refuse, recyclables, or returnables shall be maintained free of unnecessary items, as specified under S 6-501.114, and clean. Section 5-501.116 (B), Cleaning Receptacles, indicated, .soiled receptacles and waste handling units for refuse, recyclables, and returnables shall be cleaned at a frequency necessary to prevent them from developing a buildup of soil or becoming attractants for insects and rodents.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure for six of 11 residents reviewed for Advance Directive (AD - written statement of a person's wishes regarding medical treatment) (Residents 1, 5, 10, 29, 32 and 39) that: 1. Resident 5's AD was accessible in the resident's chart; and 2. The facility followed up with Residents 1, 20, 29, 32 and 39 and/or Resident Representative (RP) regarding formulation of an AD. This failure had the potential to result in the ADs for Residents 1, 5, 10, 29, 32 and 39 not being readily accessible to staff and physicians, which could lead to the residents' wishes regarding medical treatment being unknown and ultimately not honored. Findings: 1. On August 19, 2025, at 10:05 a.m., an interview was conducted with Resident 5. Resident 5 stated he could not recall if he had been given information about ADs and would like more information. A review of Resident 5's admission Facesheet indicated Resident 5 was admitted to the facility on [DATE]. A review of Resident 5's Minimum Data Set (MDS - an assessment tool), dated July 19, 2025, indicated Resident 5 had a Brief Interview of Mental Status (BIMS - a tool to assess cognitive function of an individual) score of 15 (cognitively intact). A review of Resident 5's admission History Adult dated July 18, 2025, indicated he had an AD. A further review of Resident 5's records did not indicate that a copy of the resident's AD was accessible in his records. In addition, there was no documented evidence that Resident 5 and/or RP were followed up regarding the AD. On August 20, 2025, at 4:12 p.m., a concurrent interview and record review of Resident 5's admission History Adult form was conducted with the Director of Nursing (DON). The DON stated upon admission the licensed nurses were responsible for reviewing the admission packet with each resident and/or RP and verifying whether the resident had an AD. The DON stated, if the resident had an AD, a copy should be requested and made available in the facility. The DON further stated, since Resident 5's admission History Adult from indicated he had an AD, his expectation was for staff to obtain a copy and place it in the resident's chart. The DON stated, because a copy was not received, staff should have a narrative note during weekly follow-up indicating that the AD was being followed up. The DON stated, Resident 5's AD was not on file and stated there was a chance the facility would not be able to honor his wishes for care. 2. On August 19, 2025, at 10:12 a.m., an interview was conducted with Resident 10. Resident 10 stated he was not sure if he had an AD and would like more information. A review of Resident 10's admission Facesheet indicated Resident 10 was admitted to the facility on [DATE]. A review of Resident 10's MDS dated [DATE], indicated Resident 10 had a BIMS score of 14 (cognitively intact). A review of Resident 10's admission History Adult dated July 19, 2025, indicated he did not have an (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AD. A further review of Resident 10's records indicated there was no documented evidence that Resident 10 or RP were provided with follow-up information or education about the right to formulate an AD. On August 20, 2025, at 4:15 p.m., a concurrent interview and record review of Resident 10's admission History Adult form was conducted with the DON, the DON stated there was no documentation to indicate that AD resources were discussed with Resident 10 and/or his RP during weekly follow-up, or that follow-up information was provided. 3. On August 19, 2025, at 10:25 a.m., an interview was conducted with Resident 29. Resident 29 stated she was not sure if she had an AD or if she had been given information about it. A review of Resident 29's admission Facesheet indicated Resident 29 was admitted to the facility on [DATE]. A review of Resident 29's MDS dated [DATE], indicated Resident 29 had a BIMS score of 15 (cognitively intact). A review of Resident 129's admission History Adult dated July 23, 2025, indicated she did not have an AD. A further review of Resident 29's records indicated there was no documented evidence that Resident 29 or RP were provided with follow-up information or education about the right to formulate an AD. On August 20, 2025, at 4:19 p.m., a concurrent interview and record review of Resident 29's admission History Adult form was conducted with the DON. The DON stated there was no documentation indicating that Resident 29 and/or RP were provided with weekly follow-up regarding an AD. 4. On August 18, 2025 at 3:10 p.m. an interview was conducted with Resident 1. Resident 1 stated he does not remember if he was offered the opportunity to formulate an advance directive or if information was provided. Resident 1 stated he is unsure if he wants an advance directive at this time. A review of Resident 1's admission Facesheet indicated an admission date of July 14, 2025. A review of Resident 1's History and Physical dated July 17, 2025, indicated Resident 1's assessment included cognitive impairment (brain functioning that affects thinking). A review of Resident 1's admission History Adult, dated July 14, 2025, indicated Resident 1 did not have an advance directive. On August 20, 2025, at 4:27 p.m., a concurrent interview and record review of Resident 1's admission History Adult form was conducted with the DON. The DON stated there was no documented weekly follow up which indicated Resident 1 and/or RP were provided with follow up regarding AD. 5. A review of Resident 32's admission Facesheet indicated an admission date of July 30, 2025. A review of Resident 32's History and Physical dated August 2, 2025, indicated Resident 32's (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment included dementia (brain disorder that causes a decline in cognitive (thinking) abilities). A review of Resident 32's MDS indicated Resident 32 had a BIMS score of 14 (cognitively intact). A review of Resident 32's admission History Adult, dated July 31, 2025, indicated Resident 32 did not have an AD. On August 20, 2025, at 4:77 p.m., a concurrent interview and record review of Resident 32's admission History Adult form was conducted with the DON. The DON stated there was no documented weekly follow up which indicated Resident 32 and/or RP were provided with follow up regarding AD. 6. A review of Resident 39's admission Facesheet indicated and admission date of August 11, 2025. A review of Resident 39's History and Physical dated August 13, 2025, indicated Resident 39's assessment included post-traumatic stress disorder (PTSD &ndash; mental health condition that occurs after experiencing a traumatic event) secondary to MVA (motor vehicle accident) / trauma. A review of Resident 39's MDS indicated Resident 39 had a BIMS score of 15 (cognitively intact). A review of Resident 39's admission History Adult, dated August 11, 2025, indicated Resident 39 did not have an AD. On August 20, 2025, at 4:20 p.m., a concurrent interview and record review of Resident 39's admission History Adult form was conducted with the DON. The DON stated upon admission the licensed nurses were responsible for going over the admission packet with each resident and/or RP and verify if the resident had an AD. The DON stated, if they did not have one, a Social Service Director (SSD) consult would be initiated, and the SSD would follow up and provide information and education on how to formulate one. The DON stated there was no documented weekly follow up which indicated Resident 39 and/or RP were provided with follow up regarding AD. The DON further stated if there was no AD on file there was a potential for the facility to not be able to honor their wishes for care. A review of the facility's policy and procedure titled, Advance Directives, revised December 2023, indicated, .this policy.to outline criteria for use of advance directives in the SNF.on admission the nurse will assess and ask the patient or patient representative if he or she has established an advanced directive, and request a copy if available.along with patient preferences for treatment this shall be incorporated in the plan of care.in the event that the patient or patient's representative wishes to establish a new advance directive.the social worker will provide the advance directive document and coordinate with the.Ombudsman to be one of the witnesses.the interdisciplinary team on an ongoing basis will assess and incorporate the patient's changing preferences.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician's orders for fluid restriction were followed for two of two residents (Residents 29 and 40) reviewed for nutrition and hydration. These failures had the potential to: 1. cause further electrolyte (minerals that help with water balance in the body) imbalance for Resident 29, and 2. exacerbate heart failure for Resident 40. Findings: 1. A review of Resident 29's admission Facesheet, indicated Resident 29 was admitted on [DATE], with diagnoses which included acute kidney injury and hyponatremia (low salt levels in the body). A review of Resident 29's Minimum Data set (MDS - and assessment tool) dated July 23, 2025, indicated Resident 29 had a Brief Interview for Mental Status (BIMS - designed to quickly evaluate a resident's cognitive function) use score of 15 (cognitively intact). A review of Resident 29's Orders indicated restrict fluids, 1200 ml (unit of measurement) per 24 hours with order date of July 23, 2025. A review of Resident 29's care plan Fluid Maintenance Problem r/t., initiated on 7/23/25, indicated resident had an electrolyte imbalance and on fluid restrictions, 1200cc (unit of measurement). interventions. record I (input) and O (output). ensure nursing staff is aware of fluid restriction 1200ml. A review of Resident 29's Oral Intake Flowsheet for July and August 2025, indicated Resident 29's oral intake exceeded the 1,200 ml fluid restriction order on the following dates: - July 24, 2025 &ndash; 1,580ml - July 27, 2025 &ndash; 1,400ml - July 29, 2025 &ndash; 1,600ml - July 30, 2025 &ndash; 1, 880ml - August 1, 2025 &ndash; 1,340ml - August 6, 2025 &ndash; 1,410ml - August 11, 2025 &ndash; 1, 540ml - August 13, 2025 &ndash; 2,100ml and; - August 18, 2025 &ndash; 1, 320ml On August 18, 2025, at 2:30 p.m., an observation outside of Resident 29's room, indicated a sign posted on the wall showing fluid restriction 1,200 ml. On August 18, 2025, at 2:32 p.m., during a concurrent observation and interview, Resident 29 was (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed with a water pitcher on the bedside table. Resident 29 stated she was aware of her fluid restriction but was not sure how much she would drink from the pitcher. On August 19, 2025, at 11:54 a.m., during a concurrent observation and interview, Certified Nursing Assistant (CNA)1 stated she was aware of Resident 29's fluid restriction and stated she would fill the pitcher halfway, about 500 ml. CNA 1 stated she looked inside the pitcher and recorded the amount at the end of her shift, then informed the nurses. On August 19, 2025, at 2:15 p.m., during an interview with CNA 2, CNA 2 stated she provided a pitcher of water at the start of her shift, but for residents on fluid restriction she would give a cup of approximately 240 ml and refill as needed, reporting totals to the nurses. On August 20, 2025, at 1:17 p.m., during a concurrent record review of Resident 29's oral intake values and interview with Registered Nurse (RN) 1, RN 1 stated Resident 29 was being treated for hyponatremia and had an order for 1, 200 ml fluid restriction. RN 1 stated the oral intake exceeded the ordered amount on July 24, 27, 29, and 30, and August 1, 6, 11, 13, and 18, 2025. RN 1 stated it was important to closely monitor fluid intake to ensure compliance with physician orders to prevent further electrolyte imbalance. On August 21, 2025, at 3:27 p.m., during a concurrent record review of Resident 29's oral intake values and interview with the DON, the DON verified Resident 29's oral intake exceeded the 1,200 ml fluid restriction. The DON stated, staff were expected to measure and account for the total intake and report to the physician as needed. The DON further stated it was important to follow physician orders to ensure the resident's hydration status was monitored and electrolyte balance maintained. 2. A review of Resident 40's admission Facesheet indicated an admission date of August 14, 2025, with diagnoses which included congestive heart failure (CHF - a heart condition causing fluid buildup in the body). A review of Resident 40's Active Order Profile indicated a fluid restriction of 1500 ml per 24 hours, ordered on August 14, 2025. A review of Resident 40's Oral Intake indicated: -August 17, 2025: 2,200 ml -August 18, 2025: 2,460 ml On August 19, 2025, at 8:45 a.m., an observation was conducted outside of Resident 40's room, where a sign was posted on the wall indicating Fluid Restriction: 1,500 ml. On August 19, 2025, at 8:46 a.m., an interview was conducted with Resident 40. Resident 40 stated he was placed on fluid restriction due to difficulty breathing. On August 19, 2025, at 4:07 p.m., a concurrent interview and record review was conducted with CNA 4. CNA 4 stated he was aware Resident 40 was on a fluid restriction, and residents on fluid restriction should not be given more than 400 ml of water in the pitcher during the day. CNA 4 stated, Resident 40 exceeded the 1,500 ml fluid restriction on August 17 and August 18, 2025. CNA 4 stated it was important to follow physician orders to ensure Resident 40's condition did not worsen. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 20, 2025, at 10:55 a.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 40 consumed more fluids than allowed according to the physician's orders for fluid restriction and staff should have followed the physician's orders. LVN 1 stated it was important to follow physician orders because excess fluids could cause fluid overload, worsening heart problems, and difficulty breathing. On August 21, 2025 at 1:15 p.m., an interview was conducted with the DON. The DON stated the staff expectation was to follow the physician's orders for fluid restriction. A review of the facility's policy and procedure titled, DES SNF &ndash; NUTRITION AND HYDRATION, dated January 23, 2025, indicated, .patients are provided and offered adequate nutrition and hydration, consistent with physician's orders.		

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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 medication administration practices were implemented to meet the needs of the residents when: 1. One nurse was observed to not use the pill cutter to cut a medication tablet in half and instead, by hand to prepare and administer for one of four residents (Resident 10) 2. One nurse was observed to leave the resident's room before the resident finished one medication solution for one of four residents (Resident 42) 3. One blood pressure medication with hold parameters was administered not in accordance with the physician order and without clarification of the order for one of five residents reviewed (Resident 32) These failures had the potential for residents to receive inadequate medication therapy.1. On August 19, 2025, at 8:10 a.m., during a medication pass observation with RN 5, it was noted RN 5 prepared one of Resident 10's medication, citalopram (medication to treat mood disorder) 20 mg (milligram - unit of measurement) tablet, by breaking the tablet in half using gloved hands. Resident 10's medical record was reviewed on August 19, 2025, and the following was noted: The resident was a [AGE] year-old who was admitted to the facility on [DATE], with diagnoses including hip fracture and other fractures of left thigh bone; There was a physician order on August 2, 2025, for citalopram 20 mg, 1/2 tablet to be given to the resident daily for depression (mood disorder) manifested by verbalization of distress; There was a physician order on August 7, 2025, for pill cutter with the direction to use as directed; The medication administration record in the resident's medical record indicated citalopram 10 mg (1/2 tablet) was given daily. On August 19, 2025, at 11:20 a.m., during an interview, RN 5 acknowledged RN 5 used the gloved fingers to break the citalopram tablet in half and agreed the pill cutter should have been used. RN 5 stated the pill cutter was not available in the resident's medication cassette and normally it would be used to cut the pill in half. On August 21, 2025, 11:15 a.m., during an interview, the DON stated, to be accurate, the tablet should have been cut in half using the pill cutter. The facility's policy and procedure titled, Medication Administration, approved, 09/22/2022, was reviewed, and it indicated: .All medications shall be administered utilizing appropriate safe administration technique .to help prevent and/or reduce the occurrence of medication-related errors . 2. On August 19, 2025, at 8:30 a.m., during a medication pass observation with RN 5, it was noted RN 5 prepared one of Resident 42's medication, Healthylax (brand name: Miralax, medication to treat or prevent constipation) 17 gram powder packet, by mixing it with approximately 6 ounces of water in a cup. RN 5 gave the cup to Resident 42, who was observed to take the mixed medication solution in the cup using the straw and to place the cup on the bedside tray. RN 5 administered the rest of the morning medications to Resident 42. RN 5 instructed the resident to continue to sip the medication solution in the cup before leaving the resident's room. After RN 5 left the resident's room, it was observed the cup with the mixed solution on the bedside tray was still approximately half full. Resident 42's medical record was reviewed on August 19, 2025, and the following was noted: The resident was a [AGE] year-old, who was admitted to the facility on [DATE], with diagnoses including rib fracture; There was a physician order on August 13, 2025, for the generic for Miralax 17 gram powder packet to be given to the resident daily to prevent constipation;The medication administration record in the resident's medical record indicated the full dose of the generic for Miralax 17 gm was administered on August 19, 2025. On August 19, 2025, at 11:20 a.m., during an interview, RN 5 acknowledged RN 5 left the room before Resident 42 finished taking Healthylax. RN 4 stated RN 5 should have stayed until the administration of healthylax solution was completed. On August 21, 2025, at 11:15 a.m., during an interview, the DON agreed the Healthylax solutions should have been fully consumed by the resident before RN 5 left the resident's room. The facility's policy and procedure titled, Medication Administration, approved, 09/22/2022, was reviewed, and it indicated: .All medications .will be administered in a safe manner following The Five Rights .The correct dosage of (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Desert Regional Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 North Indian Canyon Drive Palm Springs, CA 92262	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the drug will be verified . 3. On August 19, 2025, Resident 32's medical record was reviewed, and the following was noted: The resident was a [AGE] year-old, who was admitted to the facility on [DATE], with diagnoses including elevated CK level (indication of muscle or heart damage) and troponin level (indication of damage to heart muscle); There was a physician order on August 9, 2025, for losartan (medication to treat high blood pressure) 50 mg with the direction to give the resident one tablet daily for hypertension (high blood pressure) and the parameter to hold the dose if systolic blood pressure (SBP) is less than 120 (top number in a blood pressure reading in millimeter of mercury, mmHg) or blood potassium level (a test to monitor conditions of kidney and heart, measured in millimoles per liter, mmol/L) is greater than 5; The blood pressure was measured and documented in the resident's medical record daily. However, the potassium level was obtained and documented on August 5 and August 18, 2025; The medication administration record in the resident's medical record indicated losartan 50 mg was documented as administered daily, except on August 12, 2025 for SBP of 115; There was corresponding documentation of SBP for each daily administration of losartan. There was no daily potassium level corresponding to the daily administration of losartan. On August 20, 2025, at 3:53 p.m., during an interview, Pharmacist 1 stated, after reviewing the potassium level being included in the parameters for losartan, it would be prudent to have the parameter associated with the blood pressure medication. Pharmacist 1 stated the potassium level was not expected to be ordered daily for nursing home residents. When asked how the nurse was expected to carry out the physician order with such parameter associated with losartan, Pharmacist 1 stated the losartan dose should be given according to the parameter based on the last blood potassium level available. Pharmacist 1 stated it would not make sense to have daily level of potassium available for residents in the nursing home. Pharmacist 1 stated Pharmacist 1 would not question and clarify the order with the physician regarding the parameter that included checking for potassium level, which is not available daily, prior to administering the daily losartan dose. On August 20, 2025, at 4:25 p.m., during an interview, the DON stated the DON had not seen a parameter that included checking for potassium level prior to administering the blood pressure medication. The DON stated the included parameter for the order would not be a wise practice by the provider. The DON stated if the potassium level was that important the DON would expect the physician to order more frequent levels of potassium. The DON stated the order should have been clarified. The facility's policy and procedures titled, Medication Regimen Review, (MRR) approved, 03/20/2025, was reviewed, and it indicated: .Irregularity refers to any event that is inconsistent with usual, proper, accepted, or right approaches to providing pharmaceutical services .A pharmacist performs a MRR at a minimum of once a month on all patients, and more frequently if necessary. This review .Includes a review of all clinical records .Specifies findings that are irregularities to generally accepted practice .		

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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. Based on observation, interview, and record review, the facility failed to provide food with appetizing taste according to residents' preferences for four of 23 sampled residents (Residents 10, 23, 40, and 41). This failure had the potential to decrease the nutritional intake and negatively affect the nutrition status of Residents 10, 23, 40 and 41. Findings: On August 18, 2025, the following interviews were conducted: - At 1:26 p.m., Resident 41 stated, chicken is like leather. - At 1:36 p.m., Resident 40 stated, chicken is dry and tough to chew. - At 1:40 p.m., Resident 10 stated, food not good, meat entrees taste dry and rubbery. - At 3:31 p.m., Resident 23 stated, food is hit miss, no taste, mushy texture. On August 20, 2025, at 12:15 p.m., during a concurrent observation and interview with the Registered Dietitian (RD), a test tray (to evaluate the quality of a meal during a meal service and identify any areas for improvement) of pork loin (pureed diet) and baked chicken (regular diet) was evaluated during meal service. The chicken was observed to be bland, dry and with gritty texture. The RD stated the chicken was dry, overcooked and lacked seasoning. The RD stated dietary staff were expected to follow standardized recipes and maintain proper temperature hold times to ensure food was flavorful and not dry or overcooked. The RD further stated unappetizing food could lead to residents refusing meals, which could contribute to malnutrition (a condition in which the body does not get the right amount of nutrients). A review of the facility's policy and procedure [NAME] - Essential Duties and Responsibilities, revised February 2014, indicated, .preparation of high-quality food items according to standardized recipes or instructions in an efficient manner.serve meals or prepare.using correct portioning.ensuring food is at the correct temperature and is attractive and tasty.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop a comprehensive, person-centered care plan to address a physician-ordered fluid restriction for one of one resident (Resident 40) reviewed. This failure resulted in Resident 40's fluid restriction not being incorporated into the plan of care, which had the potential to exacerbate resident's congestive heart failure (a condition which causes fluid buildup in the body) and compromise his overall health status. Findings: On August 19, 2025 at 8:45 a.m., an observation was conducted outside of Resident 40's room. A sign indicating a fluid restriction of 1500 milliliters (ml) was posted on the wall. On August 19, 2025 at 8:46 a.m., an interview was conducted with Resident 40. Resident 40 stated he was placed on fluid restriction due to difficulty breathing. A review of Resident 40's admission Facesheet indicated an admission date of August 14, 2025. A review of Resident 40's History and Physical, dated August 16, 2025, indicated an assessment of systolic congested heart failure. A review of Resident 40's Active Order Profile indicated an order dated August 14, 2025, for fluid restriction of 1500 ml per 24 hours. On August 20, 2025 at 10:54 a.m., a concurrent interview and record review was conducted with LVN 1. LVN 1 stated Resident 40 has a history of congestive heart failure and a fluid restriction for the 1500 ml was ordered on August 14, 2025. LVN 1 stated licensed nurses are responsible for initiating care plans. LVN 1 stated, no care plan had been initiated for fluid restriction. LVN 1 stated a care plan for fluid restriction should have been initiated to ensure the plan of care was followed. On August 21, 2025 at 1:15 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation is that when a licensed nurse received an order, it should be care planned for continuity of care. A review of the facility's policy and procedures titled, DES SNF - PATIENT CARE PLAN, dated January 23, 2025, indicated, .develop and implement an effective and person-centered care plan that includes instructions. The plan of care is initiated upon the admission of the patient to include at a minimum. Physician orders.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to follow its policy and procedure for the two-step tuberculosis (TB - an infectious disease which affects the lungs or other parts of the body) screening, a requirement for the annual health examinations, for two of eight staff members reviewed. This failure had the potential to place staff and vulnerable residents at risk for exposure to infection. Findings: On August 21, 2025, the facility's employee files were reviewed. Two employee files indicated the following: 1. Certified Nurse Assistant 4 (CNA 4) - No documentation was found indicating the annual tuberculosis screening was completed in 2022. 2. Registered Nurse 2 (RN 2) - No documentation was found indicating the annual tuberculosis screening was completed in 2024. On August 21, 2025, at 10:20 a.m., a concurrent interview and record review was conducted with the Senior Human Resources Generalist (SHRG). The SHRG stated these two staff members did not complete their annual tuberculosis screenings timely. The SHRG stated there was no email communication for CNA 4 in 2022 or for RN 2 in 2024, regarding missed annual tuberculosis screenings and both were allowed to continue working. The SHRG stated it was important for staff to complete the annual tuberculosis screenings timely to prevent the risk of infection exposure and ensure resident safety. The SHRG further stated staff should not be allowed to work until their annual tuberculosis screenings were completed. On August 21, 2025, at 10:25 a.m., a concurrent interview and record review was conducted with the SHRG. The SHRG stated RN 2 was required to complete a two-step tuberculosis testing due to not completing a tuberculosis screening in 2024. The SHRG stated RN 2 did not complete the second step, which was scheduled on January 29, 2025. On August 21, 2025, at 3:41 p.m., a concurrent interview and record review was conducted with RN 2. RN 2 stated he did not complete the annual tuberculosis screening in 2024 and was not aware he was required to complete a two-step screening in January 2025. RN 2 stated he should have followed up on the January 30, 2025, email reminder to complete the second step. RN 2 stated tuberculosis screenings should be completed annually. On August 21, 2025, at 4:02 p.m., a concurrent interview and record review of the facility's policy and procedure titled, DES HR 46 ANNUAL HEALTH REVIEW, dated October 19, 2023, with the Human Resource Manager (HRM) was conducted. The HRM stated no policy outlining further action when staff fail to comply with the TB screening. The HRM stated staff should be removed from the schedule if they are not compliant, but this practice was not currently being implemented. The HRM stated the outcome of noncompliance could be potential exposure of residents, who are vulnerable population and staff. On August 21, 2025, at 4:38 p.m., a concurrent interview and record review with the Director of Nursing (DON) was conducted. The DON stated CNA 4 did not complete the annual tuberculosis screening in 2022, and RN 2 did not complete the annual tuberculosis screening in 2024 or the second step of the two-step tuberculosis screening in January 2025. The DON stated the risk of exposure was high and could have potentially transmitted a communicable disease to residents. A review of the facility's policy and procedures titled, DES HR 46 ANNUAL HEALTH REVIEW, dated October 19, 2023, indicated, .Employees need to complete their annual health review by the following dates. TB test must be completed yearly within month of hire. Annual Questionnaire, labs, and monitoring. Due on Anniversary of date of hire. If employees are not complete by the end of the month of hire (unless on LOA), a report is sent to Human Resources (HR) for further action per HR policy. If the employee remains non-compliant at 60 days, the matter will be referred to HR for appropriate action which may include suspension until completed or termination.		