

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

Printed: 08/27/2026
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 06/11/2026
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	
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 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 and interview, the facility failed to ensure food was served at temperatures and with palatability consistent with resident preferences for four of 21 residents reviewed for food service (Residents 11, 18, 39, and 40). This failure resulted in residents receiving meals that were not served at expected temperatures and had the potential to diminish resident satisfaction with meals and adversely affect residents' enjoyment of dining and food intake. Findings: On June 8, 2026, at 10:08 a.m., an interview was conducted with Resident 11 in his room. Resident 11 stated the food was bland. On June 8, 2026, at 11:38 a.m., an interview was conducted with Resident 18 in his room. Resident 18 stated the chicken was bland and most meals were served cold. On June 9, 2026, at 9:12 a.m., an interview was conducted with Resident 39 in his room. Resident 39 stated the food needed to be warmer when it arrived. On June 9, 2026, at 9:21 a.m., an interview was conducted with Resident 40 in her room. Resident 40 stated all meals were lukewarm. On June 10, 2026, at 11:48 a.m. a test tray evaluation was conducted with Dietary Manager (DM 1) in the activities room. The contents of the test tray consisted of regular chopped texture diet meal which included: Chicken, mashed potatoes, green beans, cold desert (fruit pears), and cold beverage apple juice. The temperatures obtained in degrees Fahrenheit (degrees F) were as follows: -Apple juice 53 degrees F -Cold pears chopped: 52 degrees F -Chicken chopped with chicken gravy: 116 degrees F -Mashed potatoes, 130 degrees F -Green beans chopped: 128 degrees F The food was found to be bland and lacking flavor. On June 10, 2026, at 11:52 a.m. an interview was conducted with DM 1. DM 1 stated cold food items should be maintained at 41 degrees F or below and hot food items at 135 degrees F or above; (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entr&eacute;e and vegetables did not meet these standards, as well as the dessert and cold beverage were warmer than expected. DM 1 stated her expectation was for all food items to meet temperature parameters which they did not. DM 1 indicated possible contributors were tray line timing and distribution from kitchen to unit and delivery speeds. DM 1 emphasized that meals not meeting temperature standards could negatively impact resident satisfaction. On June 10, 2026, at 11:56 a.m., a follow up interview was conducted with Resident 18. Resident 18 stated lunch could be warmer. A review of the facility document titled, Daily Service Resident Taste and Temperature Log dated, June 12, 2026, indicated, .line check.holding temperature.hot entrees, vegetables > (greater than) 135 degrees F (Fahrenheit &ndash; a unit of measurement) .cold items < (less than) 41 degrees F. A review of the facility policy and procedure, titled, Patient Food Services, dated May 2025, indicated, .the test tray evaluation process provides food service management with a tool that measures the quality level of the meal service and identifies areas of substandard service requiring corrective action.when arriving on the unit, waits the normal amount of time from preparation of tray to when tray is recognized to be delivered to mimic the time of regular delivery practices.This time should be between 30 and 45 minutes of preparation.takes the point-of-service-temperatures.satisfactory point-of-service temperature is based on state requirements or account's standards.rates the quality control factors (appearance, taste, temperature, etc.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician when blood glucose (sugar) levels were below 70 mg/dL (milligram per deciliter) as ordered by the physician, for two of three residents reviewed for notification of change (Residents 36 and 39). This failure had the potential to delay physician evaluation, treatment, and modification of medical interventions related to hypoglycemia (a blood sugar level below normal). Findings: 1. Resident 36's record was reviewed. Resident 36 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar level). The care plan titled, Unstable Blood Glucose, dated June 6, 2026, indicated, .Diabetes Mellitus.blood glucose will be managed as per physicians' orders.interventions.report to physician any hypoglycemic reactions for intervention. The physician's order dated June 7, 2026, indicated, .Humalog (type of insulin) sliding scale (a numerical scale for administration of insulin).rapid acting for Diabetes Mellitus (DM) .for blood glucose < 70 mg/dL.initiate hypoglycemia management (low blood sugar) and call physician. Resident 36's blood sugar levels for the month of June 2026, were reviewed and indicated the following BS levels were below 70 mg/dL: - June 10, 2026, 63 mg/dL There was no documentation indicating Resident 36's physician had been notified of the blood glucose level below 70 mg/dL, as ordered. On June 10, 2026, at 3:20 p.m., a concurrent interview and record review were conducted with Registered Nurse 1 (RN 1). RN 1 stated when a resident's blood glucose levels below 70 mg/dL, the licensed nurse was expected to notify the physician in accordance with the physician orders. RN 1 stated on June 10, 2026, Resident 36's blood glucose level was 63 mg/dL. RN 1 stated there was no documentation indicating the physician had been notified regarding Resident 36's blood glucose level. RN 1 further stated she became aware of the low blood glucose level and should have notified the physician. On June 10, 2026, at 4:06 p.m., a concurrent interview and record review was conducted with Registered Nurse Supervisor (RNS 1). RNS 1 stated the licensed nurse should have notified the physician regarding Resident 36's low blood glucose level of 63 mg/dL in accordance with the physician's order and facility protocol. RNS stated she could not find documentation indicating the physician had been notified. 2. A review of Resident 39's record was conducted. Resident 39 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus. The care plan titled, Unstable Blood Glucose, dated June 7, 2026, indicated, .Diabetes Mellitus.blood (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	glucose will be managed as per physicians' orders.interventions.report to physician any hypoglycemic reactions for intervention. The physician's order dated June 8, 2026, indicated, .Humalog (type of insulin) sliding scale (a numerical scale for administration of insulin) .rapid acting for Diabetes Mellitus (DM) .for blood glucose < 70 mg/dL.initiate hypoglycemia management (low blood sugar) and call physician. Resident 39's blood sugar levels for the month of June 2026, were reviewed and indicated the following blood sugar level was below 70 mg/dL: June 9, 2026, 61 mg/dL There was no documentation indicating Resident 39's physician had been notified of the blood glucose level below 70 mg/dl, as ordered. On June 11, 2026, at 9:43 a.m., a concurrent interview and record review was conducted with RN 2. RN 2 stated when a resident's blood glucose level is below 70 mg/dL, the licensed nurse should notify the physician. RN 2 stated, Resident 39's blood glucose level was 61 mg/dL on June 9, 2026. RN 2 stated there was no documentation the physician had been notified regarding the low blood glucose level. RN 2 stated it was important to notify the physician so the physician would be aware of the resident's condition and determine whether additional intervention was necessary. On June 11, 2026, at 12:55 p.m., a concurrent interview and record review were conducted with RNS 2. RNS 2 stated licensed nurses were required to follow physician orders and notify the physician for blood glucose levels below 70 mg/dl. RNS 2 stated physician notification should be documented, including when the physician was notified and any orders received. RNS 2 stated there was no documentation indicating the physician had been notified regarding Resident 's blood glucose level of 61 mg/dL. RNS 2 stated it was important to notify the physician to ensure the physician was aware of the event and could determine whether additional treatment or changes in management were needed. A review of the facility policy and procedure titled, Glucometer checks and insulin slide scale orders dated September 21, 2023, indicated, .Notify treating physician for blood glucose levels less than 70mg% .the following standardized Hypoglycemic treatment protocol shall be utilized with all insulin slide scale orders.treat blood sugar less than 70mg/dL and patient is alert and able to swallow, give 15 grams of fast acting carbohydrate (4oz fruit juice/non-diet soda, 8oz nonfat milk.cannot take PO (by mouth).treat blood sugar less than 70 mg/dL and patient cannot take PO, give 25ml of D50 (dextrose) as IV (intravascular) push (or 1 mg Glucagon SQ (subcutaneous) or IM (intramuscular) if no IV established. A review of the facility policy and procedure titled, Abnormal and irregular laboratory or diagnostic results, dated December 21, 2023, indicated, .abnormal/irregular results of diagnostic tests.we be communicated in a routine manner to the responsible physician.findings reported to the patients provider shall be appropriately addressed and documented in the patients medical chart.findings that are not critical but are regarded as abnormal/irregular shall be conveyed to the provider as soon as practical, generally within 24 hours or during physician rounds.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a person-centered baseline care plan for one of three residents reviewed for unnecessary medications (Resident 39) when interventions related to anticoagulation therapy were not included in the resident's baseline care plan. This failure had the potential to result in staff not consistently implementing and monitoring interventions related to anticoagulation therapy (treatment with blood-thinning medication), including monitoring for adverse effects and changes in the resident's condition. Findings:A review of Resident 39's record was conducted. Resident 39 was admitted to the facility on [DATE], with diagnoses which included atrial fibrillation (abnormal heart rhythm).The physician's order dated June 7, 2026, indicated, .apixaban (a blood thinner used to reduce the risk of blood clots and stroke in residents with atrial fibrillation) .Indication.atrial fibrillation.A review of Resident 39's baseline care plan indicated there were no care plan problems, goals, or interventions related to anticoagulation therapy. Additionally, there was no documented evidence that the physician's order for apixaban was incorporated into the baseline care plan.On June 11, 2026, at 9:43 a.m., a concurrent interview and record review were conducted with RN 2. RN 2 stated it was the licensed nurse's responsibility to initiate baseline care plans upon admission. RN 2 stated Resident 39's baseline care plan should have included anticoagulation therapy because the resident had an active physician order for apixaban RN 2 stated there was no baseline care plan initiated for anticoagulation therapy and that one should have been initiated. RN 2 stated it was important to initiate a baseline care plan for anticoagulation therapy to allow licensed nurses to address Resident 39's current needs by implementing interventions and to assist in meeting the resident's goals.On June 11, 2026, at 12:55 p.m., a concurrent interview and record review were conducted with RNS 2. RNS 2 stated the licensed nurse was responsible for initiating a baseline care plan upon admission. RNS 2 stated baseline care plans were developed upon admission based on the resident's history, current conditions, and physician orders. RNS 2 stated Resident 39's baseline care plan should have included anticoagulation therapy because the resident had an active physician order for apixaban. RNS 2 stated there was no baseline care plan initiated for anticoagulation therapy for Resident 39 and there should have been. RNS 2 stated it was important to initiate a baseline care plan for anticoagulation therapy to implement interventions with specific measures to meet the resident's desired goals.A review of the facility policy and procedure titled, Patient Care Plan, dated January 23, 2025, indicated, .plan of care is initiated upon the admission of a patient to include.Initial goals based on admission orders.physician orders.		

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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 interview and record review, the facility failed to ensure physician ordered hypoglycemia management (treatment for low blood glucose [blood sugar]) was implemented and documented for two of three residents reviewed for diabetic management (Residents 36 and 39). This failure had the potential to result in inadequate management of hypoglycemic episodes (an episode of low blood glucose) and negatively affect residents' health and well-being. Findings: 1. Resident 36's record was reviewed. Resident 36 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar level). The care plan titled, Unstable Blood Glucose, dated June 6, 2026, indicated, .Diabetes Mellitus.blood glucose (sugar) will be managed as per physicians' orders.interventions.report to physician any hypoglycemic reactions for intervention. The physician's order dated June 7, 2026, indicated, .Humalog (type of insulin) sliding scale (a numerical scale for administration of insulin) .rapid acting for Diabetes Mellitus (DM) .for blood glucose < 70 mg/dL.initiate hypoglycemia management (low blood sugar) and call physician. The physician's order dated June 9, 2026, indicated, .glucose Dextrose 4. 16g (grams, a unit of measurement) = (equals) 4 tabs (tablets) chew once PRN (as needed) for abnormal blood glucose: indication hypoglycemia for blood glucose less than 70 mg/dl symptomatic and if patient can tolerate PO (by mouth) . Resident 36's blood glucose levels for the month of June 2026, were reviewed and indicated the following blood glucose levels were below 70 mg/dL: - June 10, 2026, 63 mg/dL There was no documentation indicating Resident 36's was provided interventions to address the blood glucose level below 70 mg/dL or that hypoglycemia management was implemented in accordance with physician orders and facility protocol. June 10, 2026, at 3:20 p.m., a concurrent interview and record review were conducted with Registered Nurse 1 (RN 1). RN 1 stated when a resident experiences a blood glucose level below 70 mg/dl, the licensed nurse should implement hypoglycemia interventions, such as medication, juice, or snacks, in accordance with physician orders and facility protocol. RN 1 stated there was no documentation indicating what interventions had been provided for Resident 36's blood glucose level of 63 mg/dl. RN 1 stated the licensed nurse should have documented the interventions performed and the resident's response. RN 1 stated there was no documentation indicating the hypoglycemia protocol was followed for Resident 36 on June 10, 2026. June 10, 2026, at 4:06 p.m., a concurrent interview and record review was conducted with the Registered Nurse Supervisor (RNS 1). RNS 1 stated the licensed nurse should have documented the hypoglycemia management provided including medications, non-pharmacological interventions, and the resident's response. RNS 1 stated she was unable to locate documentation indicating what (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions were implemented to address Resident 36's blood glucose level of 63 mg/dL. RNS 1 stated facility protocol required documentation of interventions and follow-up related to hypoglycemic events. RNS 1 stated the nurse did not administer first-line medication like glucagon and did not document any hypoglycemic interventions. RNS 1 emphasized that proper documentation and reporting are required, and Resident 36 was at risk for continued hypoglycemia due to lack of appropriate intervention. 2. A review of Resident 39's record was conducted. Resident 39 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar level). The care plan titled, Unstable Blood Glucose, dated June 7, 2026, indicated, .Diabetes Mellitus.blood glucose will be managed as per physicians' orders.interventions.Oral medications.as ordered. The physician's order dated June 7, 2026, indicated, .Humalog (type of insulin) sliding scale (a numerical scale for administration of insulin) .rapid acting for Diabetes Mellitus (DM) .for blood glucose < 70 mg/dL.initiate hypoglycemia management (low blood sugar) and call physician. The physician's order dated June 7, 2026, indicated, .glucose Dextrose 4. 16g (grams, a unit of measurement) = (equals) 4 tabs (tablets) chew once PRN (as needed) for abnormal blood glucose: indication hypoglycemia for blood glucose less than 70 mg/dL symptomatic and if patient can tolerate PO (by mouth) . Resident 39's blood sugar levels for the month of June 2026, were reviewed and indicated the following blood sugar level was below 70 mg/dL: June 9, 2026, 61 mg/dl There was no documentation indicating Resident 39 was provided interventions to address the blood sugar level below 70 mg/dl or that hypoglycemia protocols were initiated and followed. On June 11, 2026, at 9:43 a.m., a concurrent interview and record review were conducted with RN 2. RN 2 stated it was the licensed nurse's responsibility to address blood glucose levels below 70 mg/dL by implementing the ordered medications or providing juice in accordance with the hypoglycemia protocol. RN 2 stated there was no documentation Resident 39 was provided interventions to address the blood glucose level below 70mg/dL or that the hypoglycemia protocol was implemented in accordance with physician orders on June 9, 2026. RN 2 stated it was important to follow physician orders and hypoglycemia protocols to appropriately manage symptoms and the resident's current condition. RN 2 further stated it was important to document the interventions provided to explain what was done for the resident. RN 2 stated licensed nurses should have followed the hypoglycemia protocol. On June 11, 2026, at 12:55 p.m., a concurrent interview and record review were conducted with RNS 2. RNS 2 stated there was no documented evidence indicating Resident 39's low blood glucose level on June 9, 2026, was treated in accordance with the physician's order and hypoglycemia protocol. RNS 2 stated the licensed nurse should have documented the interventions provided. RNS 2 stated it was important to follow physician orders and hypoglycemia protocols because they constituted the resident's medical treatment plan. RNS 2 further stated it was important to document the interventions implemented to reflect what was done to manage the low blood sugar level. RNS 2 stated the licensed nurses should have assessed the resident, implemented treatment, documented (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions, reassessed the resident, and documented outcomes. A review of the facility policy and procedure titled, Glucometer checks and insulin slide scale orders dated September 21, 2023, indicated, .Notify treating physician for blood glucose levels less than 70mg% .the following standardized Hypoglycemic treatment protocol shall be utilized with all insulin slide scale orders.treat blood sugar less than 70mg/dL and patient is alert and able to swallow, give 15 grams of fast acting carbohydrate (4oz fruit juice/non-diet soda, 8oz nonfat milk.cannot take PO (by mouth).treat blood sugar less than 70 mg/dL and patient cannot take PO, give 25ml of D50 (dextrose) as IV (intravascular) push (or 1 mg Glucagon SQ (subcutaneous) or IM (intramuscular) if no IV established.		