STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555742	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Mountain Care Center	47-763 Monroe Avenue Indio, CA 92201

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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41596 Based on interview and record review, the facility failed to ensure treatments were provided upon admission for one of three sampled residents' (Resident 1) wounds located on the right lower extremity (back of the right leg) and left achilles. This failure has the potential to result in worsening of the wounds, which could negatively affect the health status of Resident 1. Findings: A review of Resident 1's admission record indicated the resident was admitted to the facility on [DATE], and discharged on [DATE], with diagnoses that included non-traumatic intracerebral hemorrhage (bleeding in the brain), diabetes mellitus (inability to control blood sugars), and end stage renal disease. A review of Resident 1's admission skin assessment dated [DATE], indicated under the section labeled Skin Integrity, (signed by Wound Nurse 2 on March 16, 2024), Patient admitted into facility with the following: -Unstageable pressure injury to sacrococcyx (tail bone) 13.0x10.0xUTD (measurements). Light serosanguineous (a mixture of blood and clear to yellowish fluid body fluid) exudate noted. Edges well defined. Wound is 20% slough 80% eschar (blackish substance that forms over pressure wounds). Foul smell noted. -Surgical incision to sternum 20.0x0.1xSF with 39 intact staples. No exudate noted. Edges well approximated. Peri wound (around the wound) intact. -5 scabs to upper abdomen. No exudate noted. -Multiple discolorations to BUE (bilateral upper extremities-both arms). -AV (Arterioventricular- irregular connection between an artery and a vein) shunt to LUA (Left upper arm). -1.5x1.5xUTD diabetic ulcer to left achilles. Scant serosanguineous exudate. Edges well defined. (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
	555742	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Mountain Care Center	47-763 Monroe Avenue Indio, CA 92201

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 - Few	-Diabetic ulcer to posterior right lower extremity (back of right leg). 100% eschar (dead tissue that forms over healthy skin and then, over time, falls off (sheds). Edges well defined. Scant serosanguineous exudate noted. A review of the physician orders for March 2024, indicated the following: - March 16, 2024 (2 days after admission), Povidine-iodine External Swab 10%(Povidine-Iodine) Apply to left achilles topically everyday shift for diabetic ulcer for 14 days. Cleanse diabetic ulcer to left achilles with NS (normal saline) pat dry, paint with betadine, leave open to air. -March 16, 2024 (2 days after admission), Povidine -Iodine External Swab 10% (Povidine-Iodine) Apply to posterior RLE (right lower extremity) topically everyday shift for diabetic ulcer for 14 days Cleanse diabetic ulcer to posterior right lower extremity with NS, [NAME] dry, apply povidine iodine soaked gauze, cover with abd (abdominal) pad, wrap with kerlix and secure with tape. A review of the Treatment Administration Record, for March 2024, indicated the treatment for the diabetic ulcers on the left achilles and the right lower extremity were initiated on March 16, 2024, two days after admission. On March 28, 2024, at 12:38 p.m., during an interview with Licensed Vocational Nurse (LVN1), she stated admission skin assessments are done within 24 hours of admission. She stated medications and treatments are done by the next day and medications typically arrive by first medication pass because there are several deliveries throughout the day. She stated any treatments are done by the next day. On March 28, 2024, at 12:53 p.m., during a concurrent interview and record review with the Wound Nurse (WN1), she stated skin assessments are done at admission. She stated the admitting nursewould document any skin issues with measurements. She stated the treatment nurse would do their assessment within 24 hours of admission and provide treatment if there were wounds. She stated within 24 hours, orders and treatments should be in place. She reviewed the records for Resident 1 and confirmed the resident was admitted without measurements of his wounds. She confirmed the wound nurse ' s measurements were done on day 3. Reviewed MD progress note on the resident's second day in the facility. She confirmed the resident had treatment orders on day 3. She stated the physician needed measurements to order treatment for the wounds. She stated the consequences of the delayed measurements and orders is a delay in treatment of the resident's wounds. On March 28, 2024, at 3:30 p.m., during an interview with LVN 2, she stated admission assessments would include a general skin assessment. She stated she believes admission assessments were to be completed within 24 hours. She further stated if a resident was admitted on [DATE]th, she would expect the admission assessment to be completed by March 15th. She stated an admission assessment completed on March 16th is not appropriate. She stated that would be 48 hours after admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555742	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Mountain Care Center	47-763 Monroe Avenue Indio, CA 92201

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 - Few	On March 28, 2024, at 4:30 p.m., during a concurrent interview and record review with the Director of Nursing (DON), she stated the facility's practice regarding admission assessment timeframes is that they are completed within 24 hours. She stated it is the facility's policy to complete the admission assessment within 24 hours. She stated if wounds were present on admission, the admission nurse would note the wounds, but the treatment nurse would assess and measure the wounds within 24 hours. Regarding Resident 1, she stated the treatment nurse assessed the resident's wounds within 24 hours. She reviewed the skin portion of the resident's admission assessment indicating the portion was locked on March 16, 2024. She stated it was completed prior to March 16, 2024, but could not provide proof that it was done. On March 28, 2024, at 4:58 p.m., during an interview with WN 2, he stated the admitting nurse would complete the admission assessment and, if a wound was present, he would do his wound assessment the following day. He stated he would document any bruises, rashes or wounds. He further stated he would document the size, description of the wound bed, drainage, and the peri-wound area. He stated he did the resident's assessment on March 15, 2024, but locked the assessment on March 16, 2024. He stated there was an order received on March 15, 2024, but he clarified the order on March 16, 2024. He could not explain why the order was not clarified on March 15, 2024. Reviewed the physician order for Resident 1's wound dated March 15, 2024, and stated the order was not complete. He stated the wound order would usually specify the steps involved for treating the wound. He could not state if the physician order was carried out appropriately. Reviewed the 1's progress notes indicating the physician was onsite on March 15, 2024. The WN 2 was asked why the order was not clarified on March 15, 2024, and he stated the physician needed the wound's measurements to prescribe treatment. A review of the facility's policy and procedure titled Skin and Wound Assessment revised January 2022 indicated, The nurse responsible for assessing and evaluating the resident's condition on admission and readmission is expected to take the following actions: A. Complete comprehensive admission assessment/evaluation and Braden Scale to identify risk and to identify any alterations in skin integrity noted at that time .A licensed nurse (which may be the Wound Nurse) must assess/evaluate a resident's skin on admission .A licensed nurse (which may be the Wound Nurse) must assess/evaluate each wound that exists on the resident. This assessment/evaluation should include but not be limited to: measuring the wound, staging the wound, describing the nature of the wound (e.g., pressure, stasis, surgical wound), describing the location of the wound, describing the characteristics of the wound .Once the wound has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's order .