| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555742 | A. Building<br>B. Wing | 07/30/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Desert Mountain Care Center | 47-763 Monroe Avenue<br>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) |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113<br><br>Based on observation, interview, and record review, the facility failed to ensure a comfortable and home like environment was provided when:<br><br>1. The room and hallway temperatures exceeded 81degrees Fahrenheit (F), for five of seven sampled resident (Resident 1, 2, 3, 4, and 7). In addition, the facility failed to report an unusual occurrence of disruption of services when the facility's airconditioning unit was not working. This failure resulted in discomfort and had the potential to for the resident to experience dehydration (loss of body fluids), heat stress (condition where the body is under stress from overheating), and heat stroke (when the body cannot control its temperature); and<br><br>2. The carpets in the resident's hallways and through-out the facility were observed to be dirty with multiple areas of dark black circular stains. This failure had to potential to affect resident's physical and emotional condition.<br><br>Findings:<br><br>On July 25, 2024, at 2:20 p.m., an unannounced visit was conducted to investigate a complaint related to the facility's physical environment.<br><br>1. On July 25, 2024, at 2:30 p.m., the thermostat temperature in the nursing station was observed to register at 83 degrees F.<br><br>On July 25, 2024, at 2:50 p.m. an observation and concurrent interview was conducted with Resident 1. Resident 1 was observed sitting in her wheelchair outside her room. Resident 1 stated it was too hot and she has been sleeping with her bra off because it has been too hot. Resident 1 stated it was horrible. Resident 1 stated she had told maintenance, and they brought her a portable fan five days ago.<br><br>Resident 1's facility medical record was reviewed. Resident 1 was admitted [DATE], with diagnoses which included hemiplegia (paralysis of one side of the body), hemiparesis (partial weakness). Resident 1's Minimum Data Set, (MDS - an assessment tool), dated June 3, 2024, indicated Resident 1 had a BIMS (Brief Interview for Mental Status) score of 15 was cognitively intact.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On July 25, 2024, at 3 p.m., an observation and concurrent interview was conducted with Resident 2. Resident 2 was observed lying in bed with a sheet covering and floor fans blowing. Resident 2 stated hot when he was asked how he was doing. Resident 2 stated he was told the facility was working on the aircon. Resident 2 stated the facility brought him a fan but it blew hot air and did not work for him.<br><br>Resident 2's facility medical record was reviewed. Resident 2 was admitted on [DATE], with diagnoses which included intracerebral hemorrhage (ruptured blood vessels causes bleeding in the brain), dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (group of lung disease that blocks air flow). Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS score of 15 (cognitively intact). Review of Resident 2's History and Physical, dated April 20, 2024, indicated Resident 2 had the capacity to understand and make decisions.<br><br>On July 25, 2024, at 3:15 p.m., an observation and concurrent interview was conducted with Resident 3. Resident 3 was observed sitting up on the side of his bed watching television. Resident 3 stated his room environment was good except for the darn heat. Resident 3 stated the heat is brutal. He stated he told maintenance, and they brought him a fan. He stated the fan just blew hot air and he was not comfortable.<br><br>Resident 3's facility medical record was reviewed. Resident 3 was admitted on [DATE] with diagnoses which included cauda equina syndrome (when a bundle of nerves at the end of the spinal cord is damaged), dorsalgia (lower and mid back pain), and asthma (spasm in the lungs making it difficult to breathe). Resident 3's MDS, dated [DATE], indicated Resident 3 had a BIMS (brief interview for mental status) score of 15 (cognitively intact). Review of Resident 3's History and Physical, dated September 9, 2023, indicated Resident 3 had the capacity to make decision.<br><br>On July 25, 2024, at 3:23 p.m. an observation and concurrent interview was conducted with Resident 4. Resident 4 was observed lying in bed wearing only a brief with a sheet covering him. Resident 4 stated he was hot. Resident 4 stated the nurse brought him a fan, but it was still hot.<br><br>Resident 4's facility medical record was reviewed. Resident 4 was admitted on [DATE], with diagnoses which included cerebral infarction (lack of oxygen to the tissues of the brain), and atrial fibrillation (irregular rapid heart rate). Resident 4's MDS, dated July16, 2024, indicated Resident 4 had a BIMS score of 15 (cognitively intact). Review of Resident 4's History and Physical, dated July 8, 2024, indicated Resident 4 had the capacity to make decision fluctuates.<br><br>On July 25, 2024, at 4 p.m. an observation and concurrent interview was conducted with Resident 7. Resident 7 was observed sitting in her wheelchair at the side of her bed watching television. Resident 7 stated the last few nights she slept with a light sheet because the heat was uncomfortable. Resident 7 stated she told the nurse and the nurse was complaining too. Resident 7 stated she asked for a fan about three to four days and she had not gotten it yet.<br><br>Resident 7's facility medical record was reviewed. Resident 7 was admitted on [DATE], with diagnoses which included hypertension (high blood pressure), cerebral infarction (lack of oxygen to the tissues of the brain), and right femur fracture (a broken thigh bone). Resident 7's MDS, dated [DATE], indicated Resident 7 had a BIMS score of 14 (cognitively intact). Review of Resident 7's History and Physical, dated June 22, 2024, indicated Resident 7 had fluctuating capacity to make decision.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On July 25, 2024, at 4:16 p.m., a concurrent observation and interview was conducted with the Plant Director (PD). The PD stated he and the Maintenance Assistant (MA) provided maintenance for the air conditioners (AC). The PD stated the AC units were working off and on for about 3 weeks and finally stopped working about a week and half ago. Th PD stated the two units affecting the resident rooms in unit 100 and unit 300 were not working. The PD stated floor fans and portable ac units was provided to the residents. The PD stated the internal temperature should be between 71 to 81 degrees Fahrenheit. The PD was observed to check eight resident's room, and the common hallway area with the infrared handheld thermometer gun with the following results:<br><br>- Nursing station; 83 F;<br><br>- room [ROOM NUMBER]; 84 F;<br><br>- room [ROOM NUMBER]; 86 F;<br><br>- room [ROOM NUMBER]; 84 F;<br><br>- room [ROOM NUMBER]; 87 F;<br><br>- room [ROOM NUMBER]; 86 F; and<br><br>- Hallways; 83 F.<br><br>On July 25, 2024, at 5:00 p.m., an interview was conducted with the Staffing Coordinator (SC). The SC stated she received complaints from the residents about the heat. The SC stated the AC unit had been out this week. She stated the facility provided floor fans, and portable AC units. She stated some of the risk resident could suffer due to the excessive heat is dehydration or the resident could become sick.<br><br>On July 26, 2024, at 2:45 p.m., an interview with the Administrator (ADM) was conducted. The ADM state he became aware of the AC issues around July 15 or July 16, 2024, when the residents began to complain about the heat in the rooms. The ADM stated the PD reported the AC compressor was broken. He stated ideally the average temperature in the resident's room should be 71 -81 F. He stated the facility did not call the California Department of Public Health because they thought it was cool enough after providing portable AC units and floor fans. The ADM stated the risks for resident could include their comfort and possible heat rashes.<br><br>On July 30, 2024, at 11:45 a.m., the ADM was interviewed. The ADM acknowledged it is an unusual occurrence when the AC was broken and not functioning as expected. He stated the facility should have reported the unusual occurrence to the CDPH.<br><br>A review of the facility's policy and procedure titled Quality of Life; Temperature, Excessive, revised May 2007, indicated, .To provide air condition if possible. Facilities initially certified for Medicare or Medicaid after October1, 1990, must maintain a temperature range of 71 - 81 F .<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the facility's policy and procedure titled Unusual Occurrence-CA, revised July 2007, indicated, . that an unusual occurrence will be reported accurately and completely on a timely basis reported .the unusual occurrence shall be reported by the facility within twenty-four (24) hours either by telephone or telegraph to the local health officer and the Department .Unusual Occurrences .Occurrences which threaten the welfare, safety or health of patients, personnel, or visitors .<br><br>2. On July 25, 2024, at 2:30 p.m., during the facility tour, the carpet at the entrance, the nurse's station, resident's hallway in Unit 100 and resident's hallway in Unit 300 were observed dirty, with areas of black circular stains.<br><br>On July 25, 2024, at 3:33 p.m., Resident 5's family member (FM) was observed visiting Resident 5. Resident 5's FM stated when she entered the facility, the carpet was dirty and that it was not acceptable.<br><br>On July 25, 2024, at 4:16 p.m., a concurrent observation and interview with the Plant Director (PD) was conducted. The PD stated he did the carpets himself and the carpets were done a week ago. Stated the stains always come back within a week of cleaning them. Stated he has cleaned the carpets once a week for the last year and this has been his process. The PD stated an outside agency cleaned the carpets a couple of months ago, but the stains continue to come back. The PD stated the carpets did not look good, stated it was not acceptable. Stated the facility is in the process of installing new flooring.<br><br>On July 26, 2024, at 9:00 a.m., a telephone interview was conducted with the complainant. The complainant stated when she would come to the facility to visit her relative it was always dirty. She stated the carpets and rooms were just dirty. She stated the carpets were very, very dirty.<br><br>On July 26, 2024, 9:25 a.m., a concurrent observation and interview with the Maintenance Assistant, (MA) was conducted. The carpet in the hallways outside of resident's rooms and the adjacent nurse's station were observe to be stained and dirty, which the MA acknowledged. The MA stated the carpets were cleaned but the stains did not go away. The MA stated it's not acceptable.<br><br>On July 26, 2024, at 2:45 p.m., an interview with the ADM was conducted. The ADM stated maintenance on the carpet outside the resident's rooms was done in May by an outside company. He stated the PD cleans the carpets weekly. The ADM stated the carpets were horrible and they were bad.<br><br>A review of the facility's policy and procedures titled Physical Environment-Environmental Conditions \| Environmental Rounds, revised November 2019, indicated .It is the policy of this facility that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public . |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113<br><br>Based on observation, interview, and record review, the facility failed to provide incontinent care, for two of twelve residents reviewed, (Residents 11 and 12), when the residents was left in their soiled diaper for a long period of time.<br><br>This failure resulted in a delay of care needs and had the potential of a negative impact on their self-esteem.<br><br>Findings:<br><br>On July 26, 2024, at 10:55 a.m., a concurrent observation and interview with Resident 11 was conducted. Resident 11 was observed lying in bed watching television. Resident 11 stated she had been at the facility for two weeks and she was left wet for over 10 minutes last week until someone finally came to assist her.<br><br>Resident 11's facility medical record was reviewed. Resident 11 was admitted on [DATE], with diagnoses which included myocardial infarction (blockage of blood flow to the heart), pneumonia (infection that inflames the air sacs of the lungs), cirrhosis of the liver (chronic liver damage), hear failure (chronic condition which the heart don't pump blood well), hypertension (high blood pressure), and anxiety (feelings of fear and uneasiness). Resident 11's MDS, dated [DATE], indicated Resident 11 had a BIMS (Brief Interview for Mental Status) score of 14 (cognitively intact). Review of Resident 11's History and Physical, dated July 19, 2024, indicated Resident 11 had the capacity to make decision.<br><br>On July 26, 2024, at 11:00 a.m. a concurrent observation and interview with Resident 12 was conducted. Resident 12 was observed sitting in the middle of her bed wearing a diaper and a top, with call light on. Resident 12 stated in the past staff took 30 minutes to an hour to change her brief. Resident 12 stated she was currently waiting to get changed and had pressed the call light 15 minutes earlier. Observed the call light was not answered by 11:20 a.m.<br><br>Resident 12's facility medical record was reviewed. Resident 12 was admitted on [DATE], with diagnoses including Wernicke's Encephalopathy (syndrome of unusual memory disorder), dysphonia (having abnormal voice). Resident 12's History and Physical, dated July 1, 2024, indicated Resident 12 had the capacity to make decisions.<br><br>Resident 12's care plan initiated on January 27, 2024, indicated, .Activities of Daily Living (ADL) self-care performance deficit related to severe sepsis, generalized weakness, Wernicke's Encephalopathy, incontinent of B&B (Bowel and Bladder). Resident 12 MDS indicated the resident was incontinent of bladder and required extensive assistance in toileting.<br><br>On July 26, 2024, at 12:49 p.m., an interview with Certified Nursing Assistant (CNA) 2 was conducted. CNA 2 stated she was assigned to Resident 12 today. She stated she was with another client when Resident 12 called for assistance. She stated she informed the nursing staff, however when she finished assisting the other client, she noticed resident 12's call light was still on.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On July 26, 2024, at 1:17 p.m., an interview with the Director of Nursing (DON), was conducted. The DON stated the facility had a call system in the nursing station that triggers and turns red when a resident calls for assistance. The DON stated it's the responsibility of everyone to assist the residents when needed. Stated she was not aware that Resident 12 was waiting over 30 minutes for care. Stated Resident 12 has never complained to her that she was left in soiled clothing or line.<br><br>A review of the facility's policy and procedure titled Care and Treatment- Resident Care, Monitoring of, revised May 2007, indicated .each resident .receives or is provided the necessary care and services enabling him/her to attain or maintain the highest practicable physical mental, and psychosocial well-being, in accordance with the comprehensive assessment and care plan.<br><br>A review of the facility's policy and procedure titled Quality of Care- ADL Care, revised November 2021, indicated .it is the policy of this facility that residents are given treatment and services to maintain or improve his/her abilities .Residents who are unable to carry out activities of daily living (ADL) will receive assistance as needed . |