

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555742	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Desert Mountain Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000</p> <p>Based on interview and record review, the facility failed to ensure an unusual occurrence was reported to the California Department of Public Health (CPDH) according to their policy and procedure, when Resident 1 eloped (departed the health care facility unsupervised and undetected) from the facility.</p> <p>This failure had the potential to result in a delay in an investigation of the incident and implementation of corrective actions.</p> <p>Findings:</p> <p>On August 9, 2024, at 3:09 p.m., an unannounced visit was conducted at the facility to investigate a complaint regarding elopement.</p> <p>On August 9, 2024, at At 3:45 p.m., a concurrent observation of Resident 1 was conducted with the Licensed Vocational Nurse (LVN). Resident 1 was observed lying in bed with his head of bed elevated, awake, able to converse. Resident 1 was wearing shorts and had an indwelling foley catheter (thin hollow tube inserted into the bladder through the urethra to collect urine). Beside the bed was a walker. The LVN stated Resident 1 was able to walk around using his walker, and had no problems walking around while the foley catheter was in use. Resident 1 was observed to have a healing scab on the scalp above the left forehead.</p> <p>In a concurrent interview with Resident 1, he stated on the day of the incident, he had asked the Social Service staff for permission to leave the facility and was told he could, and they would arrange it if someone was willing to take him. Resident 1 stated he could not get a hold of his friend who could take him, and since he was desperate that he needed some money to buy some personal items, he decided to leave the facility to go to the bank. Resident 1 stated he walked out of the facility without staff knowledge, and rode the bus on the way to the bank (1.9 miles away from the facility entailing 30 minute travel by bus). On the way back, he stopped for half an hour at the post office (3.8 miles away from the facility) to cool off, then rode the first bus back. When he got off the first bus and was about to board the second bus, was when facility staff caught up with him and brought him back to the facility. Resident 1 stated when the bus stopped, he scraped his head on the pole and sustained a scratch to his head, he also got a scrape on his left shin.</p> <p>(continued on next page)</p>		

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE] with diagnoses which included obstructive uropathy (structural or functional obstruction in the flow of urine), high blood pressure, heart disease, tachycardia (very fast heart rate), and diabetes mellitus (abnormal blood sugars).</p> <p>Resident 1's Minimum Data Set, dated [DATE], indicated Resident 1 had a Brief Interview for Mental Status score of 15, signifying intact cognition.</p> <p>On August 9, 2024, at 4:38 p.m., in a concurrent interview and record review with the Assistant Director of Nursing (ADON), the ADON stated the incident occurred on August 7, 2024, around 10:30 a.m., when Resident 1 was due for a blood sugar check before the lunch meal and staff were not able to locate him inside the facility. This prompted an expanded search for the resident, but he could be found in and around the facility premises. The ADON stated resident was brought back to the facility around 12:30 p.m. from the bus stop by a major highway. Upon the resident ' s return, he had a reddened forehead, had a small abrasion to the upper forehead, and an abrasion on the left shin. The resident stated he had gone to the bank, and had gone to see his friend, but did not specify the location.</p> <p>The ADON stated during the Interdisciplinary Team meeting, they were deliberating between the incident being an elopement versus leaving against medical advise. They eventually concluded it was an elopement incident, could be an unusual occurrence, and they had 24 hours to report the incident to the CDPH. The ADON stated they reported it in the evening of August 8, 2024, but it should have been reported before 11 a. m. or 12 noon.</p> <p>A review of the facility ' s undated policy and procedure titled, Elopement/Unsafe Wandering, indicated, . Elopement is when a resident leaves the facility premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so .</p> <p>A review of the facility ' s policy and procedure titled, Unusual Occurrences ., revised July 2007, indicated, . Unusual occurrences shall be reported by the facility within twenty-four (24) hours either by telephone (and confirmed in writing) or telegraph to the local health officer and the Department . The facility definition of unusual occurrences included .unusual occurrences which threaten the welfare, safety or health of patients .</p>		