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	04/22/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on interview and record review, the facility failed to ensure one on one (1:1) supervision was provided according to the physician's order and plan of care, for one of four residents reviewed (Resident 4) when there was no assigned sitter (staff to supervise the resident's whereabouts) to monitor Resident 4's wandering behavior. This failure had the potential to result in Resident 4 wandering out of the facility, leading to potential physical or psychosocial harm. Findings: On April 22, 2025, at 9:35 a.m., an unannounced visit to the facility was conducted to investigate complaints regarding quality of care. On April 22, 2025, at 12 p.m., during an interview with Certified Nursing Assistant (CNA) 2, CNA 2 stated there were situations where there was not a sitter for Resident 4 which was reflected as blank in the assignment sheet. CNA 2 further stated administration would ask staff to keep an eye on Resident 4 until someone was able to come in and sit with Resident 4. CNA 2 stated keep an eye on a resident meant that Resident 4 would not have a 1:1 sitter, instead, all the nurses and CNAs were responsible for monitoring the resident for any harmful behaviors while attending to their own assigned residents. CNA 2 stated it should not happen because someone should only be responsible for taking care of the one resident who required a sitter, because you do not want something to happen to the resident. On April 22, 2025, at 12:15 p.m., during an interview with CNA 3, CNA 3 stated Resident 4 had a wandering behavior due to dementia (memory loss). CNA 3 stated if the box on the staffing assignment sheet for the assigned sitter for Resident 4 was blank, it would indicate to staff that there was either no assigned sitter and it was everyone ' s job to keep an eye on the resident until they could get a CNA to come in, or a housekeeper was the assigned sitter for the resident. CNA 3 stated she found Resident 4 wandering in the hallway about three weeks ago. CNA 3 stated this incident happened when a housekeeper was assigned to Resident 4. During a concurrent record review with CNA 3 the staff assignment sheet for April 4 to April 6, 2025, indicated a blank box for the assigned sitter for Resident 4 on the staff assignment sheet for those dates. CNA 3 stated the blank on the assignment sheet indicated that either a housekeeper was the assigned sitter for Resident 4, or they were attempting to find a CNA to come in and be the sitter for Resident 4. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 22, 2025, at 3:50 p.m., an interview and concurrent record review with the Director of Staff Development (DSD) was conducted. A review of the facility document titled, Sitter Schedule, for the month of April 2025 was conducted. The DSD stated the assigned sitter signed their name for every hour they monitored Resident 4. The facility document indicated there were no staff signatures for the following date and times: - April 1, 2025, 8 a.m. to 2 p.m., and 11:00 p.m.; - April 2, 2025, 12 a.m. to 6 a.m.; - April 4, 2025, 4 a.m. to 6 a.m.; - April 7, 2025 a.m., 12 a.m.- 5 a.m.; - April 8, 2025, 12 a.m. to 5 a.m.; - April 11, 2025, 7 a.m. to 3 p.m.; - April 12, 2025, 12 a.m. to 6 a.m.; - April 13, 2025, 7 a.m. to 2 p.m.; - April 14, 2025, 1 a.m. to 6 a.m., and 8 a.m. to 9 a.m.; and - April 16, 2025 1 p.m. to 2 p.m., 12 a.m. to 6 a.m. In a concurrent interview with the DSD, she stated there were occasions where there was no assigned sitter for Resident 4, so all the staff would keep an eye on the resident. The DSD confirmed the blank spaces indicated Resident 4 did not have an assigned 1:1 sitter assigned to monitor him. On April 22, 2025, Resident 4 ' s record was reviewed. Resident 4 was admitted to the facility on [DATE], with a diagnoses which included unspecified psychosis (a state where a person's perception of reality becomes distorted, leading to difficulties distinguishing between real and imagined experiences) not due to a substance or known physiological condition, altered mental status unspecified, impulse disorder (mood disorder), and dementia. A review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated April 17, 2025, indicated Resident 4 had a Brief Interview for Mental Status (BIMS) score of 03 out of 15 (severely impaired cognition). A review of Resident 4 ' s care plan indicated, .Focus .Elopement (when a patient leaves a healthcare facility against medical advice) risk/wanderer r/t (related to) Resident wanders aimlessly .Has episodes of wandering around .Goal .Safety will be maintained through the review date .Interventions/Tasks .1:1 sitter as ordered r/t Resident wanders aimlessly ., date Initiated, November 5, 2024 . A review of Resident 4's physician ' s orders, dated November 4, 2024, indicated, 1:1 sitter d/t wandering r/t dementia dx (diagnosis). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 22, 2025, at 5 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 4 should not have gone without a sitter, at any time that the order for a sitter was in place as this could place the resident at risk for wandering. The DON further stated the facility did not have a policy for managing residents who require a sitter. A review of the facility's policy and procedure titled, Elopement/Unsafe Wandering, dated June 2018, indicated, .The facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision and diversional programs to prevent unsafe wandering while maintaining the least restrictive environment for those at risk for elopement .Wandering is defined as random or repetitive locomotion and can be either goal directed or non-goal directed/aimless. Elopement is when a resident leaves the facility premised or a safe area without authorization .and/or any necessary supervision to do so .Residents with high risk factors identified on an elopement/wandering evaluation are considered at risk and will have an individualized care plan developed that includes measurable objectives and time frames .These interventions will address the individualized level of supervision needed to prevent elopement/unsafe wandering .

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based an observation, interview, and record review, the facility failed to ensure trained staff were utilized to provide one on one (1:1) supervision of a resident with wandering behavior, for one of four sampled residents (Resident 4). This failure resulted to untrained staff providing 1:1 supervision to Resident 4 and had the potential for wandering residents to experience physical and psychosocial harm due to lack of training to handle residents with wandering behavior. Findings: On April 22, 2025, at 9:35 a.m., an unannounced visit to the facility was conducted to investigate complaints regarding quality of care. On April 22, 2025, at 12:15 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated the housekeeping staff began to be utilized to provide 1:1 supervision to Resident 4 in April 2025. CNA 3 further stated she believe the housekeeping staff did not have training how to handle at-risk residents or provide 1:1 supervision (sitter) or residents. CNA 3 further stated utilizing the housekeeping staff to be sitters for residents placed both the residents and the housekeepers at harm because they were not trained to handle residents at risk for behaviors. On April 22, 2025, at 3:50 p.m., an interview and concurrent record review was conducted with the Director of Staff Development. The DSD stated housekeepers (HK) were utilized as sitters for Resident 4 in April 2025. During a concurrent review of the hourly sitter log (document where the sitter signs hourly to show they were monitoring the resident), the DSD confirmed that the following housekeepers were utilized throughout April 2025: - HK 1 on April 4, 9, and 15, 2025; - HK 2 on April 4, 5, and 12, 2025; - HK 3 on April 8, 2025; - HK 4 on April 5, and 7, 2025; - HK 5 on April 6, and 14, 2025; and - HK 6 on April 7, 2025. In a concurrent interview with the DSD, she stated housekeeping staff were not trained to manage provide 1:1 supervision for a resident with behaviors prior to being a sitter to Resident 4. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 22, 2025, at 5 p.m., during an interview with the Director of Nursing (DON), the DON stated that housekeeping should have had proper training on one-to-one sitting duties, prior to being utilized as a sitter. The DON further stated the facility did not have a policy for managing residents who required a sitter. On April 22, 2025, Resident 4 ' s record was reviewed. Resident 4 was admitted to the facility on [DATE], with diagnoses which included unspecified psychosis (a state where a person's perception of reality becomes distorted, leading to difficulties distinguishing between real and imagined experiences) not due to a substance or known physiological condition, altered mental status unspecified, impulse disorder, unspecified, unspecified dementia (memory loss). A review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated April 17, 2025, indicated Resident 4 had a Brief Interview for Mental Status (BIMS) score of 03 out of 15 (severely impaired cognition). A review of Resident 4's physician ' s orders, dated November 4, 2024, indicated, .1:1 sitter d/t (due to) wandering r/t (related to) dementia dx (diagnosis) . A review of Resident 4 ' s care plan indicated, .Focus .Elopement (when a patient leaves a healthcare facility against medical advice) risk/wanderer r/t (related to) Resident wanders aimlessly .Has episodes of wandering around . Goal .Safety will be maintained through the review date .Interventions/Tasks .1:1 sitter as ordered .r/t Resident wanders aimlessly ., date initiated, November 5, 2024. On May 1, 2025, at 11:57 a.m., a telephone interview was conducted with HK 1. HK 1 stated she was a sitter for Resident 4 for multiple days in April 2025. HK 1 stated she had not received any training on how to provide one-to-one sitter services for a resident with behaviors prior to being a sitter for Resident 4. A review of a facility document titled, Inservice Lesson Plan, dated April 22, 2025, indicated, .Topic: sitter/watcher for dementia patients .Educational Objective At the end of this in-service, the student will be able to: 1. Know what to do when patients trying to leave the building. 2. Know who to call when pt is in danger or trying to hurt themselves. 3. Not try to stop when patient is combative, but yell for help call the CNAs or license nurses who are more experience in handling dementia patients .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were implemented when Certified Nursing Assistant (CNA) 1 did not perform hand hygiene after provision of care to a resident and after touching the linen cart. These failures had the potential to spread infection among the vulnerable residents of the facility. Findings: On April 22, 2025, at 9:35 a.m. an unannounced visit was conducted to investigate a infectious disease outbreak. On April 22, 2025, at 9:50 a.m. CNA 1 was observed exiting room [ROOM NUMBER] (resident's room). CNA 1 was observed to remove her gloves outside of room [ROOM NUMBER], then touched the linen cart in the hallway outside of room [ROOM NUMBER]. CNA 1 did not perform hand hygiene when she exited the resident's room. CNA 1 entered room [ROOM NUMBER] again without performing hand hygiene. In a concurrent interview, CNA 1 stated, Sorry, I should have used the hand sanitizer to prevent spreading germs. On April 22, 2025, at 12:15 p.m., during an interview with CNA 3, she stated it was important to perform hand hygiene before and after entering a resident ' s room. On April 22, 2025, at 3:15 p.m., during an interview with the Infection Prevention Nurse (IP), she stated CNA 1 should have performed hand hygiene before entering and after leaving the resident ' s room and before and after touching anything outside the room, specially they have an infectious disease outbreak. On April 22, 2025, at 5 p.m., during an interview with the Director of Nursing (DON), she stated the staff were supposed to perform hand hygiene before and after entering a resident ' s room. A review of the facility's undated policy and procedure titled, Infection Prevention and Control Program, indicated, .prevention of spread of infections is accomplished by use of Standard Precautions [according to the Centers for Disease Control and Prevention, Standard Precautions include hand hygiene] .The hand hygiene procedures will be followed by staff involved in direct resident contact . According to the web article published by Centers for Disease Prevention and Control, titled Clinical Safety: Hand Hygiene for Healthcare Workers, dated February 27, 2024, indicated, .Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with .Handwashing with water and soap .Antiseptic hand rub (alcohol -based foam or gel hand sanitizer .Cleaning your hands reduces .The potential spread of deadly germs to patients .The spread of germs .The risk of healthcare personnel colonization or infection caused by germs received from the patient .When to clean your hands .Immediately before touching a patient .before performing an aseptic task such as placing an indwelling device or handling invasive medical devices .After touching a patient or patient's surroundings .After contact with blood, body fluids, or contaminated surfaces .Immediately after glove removal .