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	02/18/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure appropriate treatment and services to restore continence (voluntary control to retain urine or feces until an appropriate time) was provided, for one of five residents (Resident B).This failure resulted in Resident B not receiving the appropriate toileting program to restore or maintain as much normal function of her bladder as possible, and prevent accidents and injuries.Findings:On January 16, 2026, at 9:45 a.m., an unannounced visit was conducted at the facility to investigate a complaint regarding quality of care and treatment.On January 20, 2026, at 12:15 p.m., an interview was conducted with Resident B. Resident B stated care it could take a while for the staff to come and assist her when she calls for assistance. Resident B stated she understands the staff were working with other residents and there were only two to three CNAs on the floor for all the residents, but she wished they could check on her sooner. Resident B stated she tried to take herself to the bathroom, she lost her footing, fell, and soiled herself.On January 20, 2026, at 12:30 p.m., a review of Resident B's medical record was conducted. Resident B was admitted to the facility on [DATE], with diagnoses which included respiratory failure with hypoxia (not enough oxygen reaching the tissue level-causing shortness of breath, confusion, and bluish skin), muscle weakness, and tracheostomy (an opening in the neck, leading into the trachea [windpipe] to establish a secure airway).A review of Resident B's care plans indicated:-dated February 8, 2022, .is on diuretic (water pills-medication to help the body get rid of sodium [salt] and water through increased urination) therapy CHF (congestive heart failure-a condition where the heart cannot pump efficiently and meet the body's needs, blood and fluid buildup in the lungs, legs and abdomen) swelling.interventions. increased risk for falls.monitor for increased risk for falls.-dated September 14, 2022, .has occasional bladder incontinence (involuntary leakage of urine due to loss of bladder control) r/t (related to)-COPD (chronic obstructive pulmonary disease-a lung disease that restricts airflow), respiratory failure has tracheostomy-disease process-impaired mobility-obesity.interventions .brief (diaper) use per pt (patient) request.an unobstructed path to the bathroom.incontinent: check as required.A review of Resident B's History and Physical, dated October 16, 2025, indicated Resident B could make decisions.A review of Resident B's Bowel and Bladder Evaluation, dated October 17, 2025, at 12:41 p.m., indicated; .unlikely candidate for Bowel and Bladder re-training.A review of Resident B's Change in Condition Evaluation, dated December 19, 2025, at 2:08 p.m., indicated; .s/p (status post [after]) fall attempting to go to the bathroom.resident was found in room on the floor lying on her back.neuro-checks (neurological assessment used to evaluate brain and nervous system function) initiated with no abnormalities noted. ROM (range of motion) upper/lower extremities (arms/legs) normal to baseline.resident stated she had pain radiating from her lower back and right wrist.assisted resident back to bed safely. Resident stated she was attempting to go to the bathroom unassisted.lost her balance and landed on (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her backside.no visual injuries noted.encouraged and educated resident to call for assistance utilizing call light and she agreed.pain assessment.acute.back.abrupt onset of severe pain secondary to fall or injury.A review of Resident B's Fall Risk Evaluation, dated December 19, 2025, at 2:08 p.m., indicated; .balance problem while walking.decreased muscular coordination.requires use of assistive devices.A review of Resident B's Minimal Data Set (MDS - a federally mandated resident assessment tool), dated December 26, 2025, indicated Resident B does not have a toileting program and is frequently incontinent with bladder.On January 20, 2025, at 3:30 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident B fell when she went to the bathroom by herself. Resident B should be re-evaluated for a toileting program, she has been here a long time and should be able to be continent as much as she can since she can ambulate and could be a candidate for bowel and bladder toileting program.A review of the facility's policy and procedure titled Toileting Program, dated February 2025, indicated, .bowel and bladder retraining will be provided for residents with the potential to benefit from such a program. When medically appropriate, bowel and bladder toileting is the preferred treatment option for incontinence.helps the resident to attain the highest level of independence on bowel and bladder continence.address toileting program on resident's care plan.reassess the program on quarterly basis and as needed.assessing a resident for toileting program.level of awareness-willingness to cooperate.medications. follow the resident specific toileting program.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care and treatment to manage pain was provided, for one of five residents (Resident A), when:1.Resident A received a pain medication ordered by the physician for pain scale of 4 to 10 for a pain scale of 0/10 (no pain); and2.The physician's order for pain management consult was not scheduled since it was ordered on October 26, 2025. These failures could delay the care and treatment needed to manage Resident A's pain effectively.Findings:On January 16, 2026, at 9:45 a.m., an unannounced visit was conducted at the facility for the investigation of a complaint regarding quality of care and treatment.On January 20, 2026, at 12 p.m., an interview was conducted with Resident A. Resident A stated she hurts all over and it is difficult to move. Resident A stated she was supposed to get her Dilaudid (a potent opioid analgesic medication used to treat moderate to severe pain) every three hours and the nurses did not give it to her as ordered. Resident A stated she had asked to see a pain doctor and it had not happened yet.On January 20, 2026, a review of Resident A's medical record was conducted. Resident A was admitted to the facility on [DATE], with diagnoses which included bilateral osteoarthritis (non-inflammatory, joint disease, cause by breakdown of cartilage, leading to bone-on-bone friction and pain) of hips with artificial hip joints, and fibromyalgia (chronic disorder with widespread musculoskeletal pain).A review of Resident A's Order Summary Report, included the following physician's orders:- Monitor level of pain using 0-10 scale, ordered July 28, 2025;- Dilaudid Oral Tablet 4 (four) MG (milligram - unit of measurement), give 8 (eight) mg by mouth every 3 (three) hours as needed for moderate to severe pain (4-10), ordered September 7, 2025.- Pain consultation d/t (due to) uncontrolled pain management, ordered October 26, 2025; and- Morphine Sulfate ER (extended release) Oral Tablet 15 MG, Give 1 (one) tablet by mouth two times a day for pain management, ordered December 30, 2025.A review of Resident A's care plan, dated December 8, 2025, indicated, .Resident having acute pain.interventions.give medication/treatment as ordered.monitor pain levels. A review of Resident A's Medication Administration Record, for the month of January 2026, indicated Dilaudid 4 mg (to be given as needed for pain rate of 4 to 10) was administered with pain level of 0/10 on the following dates and times:- January 5, 2026, at 7:30 p.m.,- January 7, 2026, at 8:14 a.m.,- January 7, 2026, at 3:13 p.m., and- January 7, 2026, at 6:13 p.m.A review of Resident A's Progress Notes, dated December 1, 2025, at 2:50 p.m., indicated, .Phoned (name of pain clinic) to attempt to schedule pain mgmnt (management) consult and was directed to VM (voicemail).A review of Resident A's Progress Notes, dated December 19, 2025, at 12:12 p.m., indicated, .Contacted (name of pain clinic) to f/u (follow up) on referral.Reached VM.A review of Resident A's Progress Notes, dated January 20, 2026, at 12:20 p.m., indicated; .contacted for new pt (patient) referral/appointment (pain management).reached VM (voicemail).On January 20, 2026, at 3:30 p.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident A takes morphine twice a day, and Dilaudid as needed. The ADON stated Resident A had not seen a pain management specialist yet since the physician ordered for pain management consult on October 26, 2025. The ADON stated there was a delay in getting an appointment with the pain clinic. The ADON stated the licensed staff should be evaluating Resident A's pain before giving her any pain medication and should follow the physician's orders. The ADON stated if Resident A's pain level is 0 out of 10, she should not be getting any as needed pain medication. The ADON stated Resident A's pain management needed to be re-evaluated.A review of the facility's policy and procedure titled Resident Care-Recognition and Management of Pain, dated January 2023, indicated; .ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive person-centered care plan, and the resident' goals and preferences.assists each resident with pain management to maintain or achieve the highest practicable level of well-being and functioning by.evaluating pain.the resident will be evaluated for pain upon admission, quarterly, and with any change in their status.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure patient care equipment was maintained in a safe operating condition, when two of the mechanical lifts (also referred to as Hoyer lifts - devices used to safely transfer mobility impaired patients between beds, chairs, and toilets) remained in use on the floor despite identified problems.This failure could have put residents at risk by allowing the use of unsafe equipment. Findings:On January 16, 2026, at 9:45 a.m., an unannounced visit was conducted at the facility for a complaint on physical environment.On January 16, 2026, at 11a.m., an interview was conducted with the Director of Maintenance (DM). The DM stated the facility uses TELS (The Equipment Lifecycle System-a facility wide building management platform-work order system that creates a work order, tracks it, until completion) to keep track of all patient equipment requesting to be repaired.On January 16, 2026, at 1:30 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 1. CAN 1 stated they would take out from the floor wheelchair or equipment used for the residents that were not working properly, and give it to the maintenance for repair.On January 16, 2026, at 1:40 p.m., an observation and concurrent interview was conducted with CNA 2. CNA 2 observed mechanical lift #7 to have Coban (a self-adherent wrap that is designed to stick to itself rather than skin-used for wound care, to support sprains, strains, and secure dressings) wrapped around the mechanical lift's casing. CNA 2 stated the mechanical lift might be broken and should not be used, as it was not safe to use with the residents.On January 16, 2026, at 1:50 p.m., an observation and concurrent interview was conducted with the Director of Nursing (DON). The DON observed mechanical lift #7 and stated mechanical lift #7 should not be wrapped with Coban and continued to be used in the unit. The DON stated he did not know why there was Coban wrapped on the mechanical lift. The DON further stated the staff should tell their direct supervisor if an item is not working properly, a report should be placed in TELS, and the item should be removed from the floor. The DON stated this is a safety problem and could cause an injury if continued to be used.On January 16, 2026, at 2 p.m., an observation and concurrent interview was conducted with the Maintenance Assistant (MA). The MA observed mechanical lift #7 and stated that when equipment is not working and there is an issue, the staff need to let maintenance know, put in a TELS work order with a description of what is wrong, and take the equipment out of service.On January 16, 2026, at 2:08 p.m., an observation was made on Hallway 300. A second mechanical lift was observed in Hallway 300 with a sign which read not working, and a staff member was observed coming out of room [ROOM NUMBER] with mechanical lift #7 with the Coban wrapped around the casing.On January 16, 2026, at 2:10 p.m., an interview was conducted with CNA 3. CAN 3 stated she used mechanical lift #7 to put a resident back in bed after he had his lunch and did not notice there was Coban wrapped around part of the equipment. CNA 3 stated she should not have used the mechanical lift #7, it may not have worked properly and caused an accident for the resident, she should have been more caution with the equipment.On January 16, 2026, at 2:20 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated he had helped CNA 3 put a resident back in bed and he did not notice there was Coban wrapped around part of mechanical lift #7. LVN 1 stated he does not know why Coban was there, and the lift should not have been used for resident care. LVN 1 stated he should have questioned why there was Coban wrapped around the mechanical lift, because the equipment could be faulty, and the resident could have fallen and been hurt.On January 16, 2026, at 2:25 p.m., an observation and concurrent interview was conducted with the DON. The DON observed Hallway 300 with both mechanical lifts and stated mechanical lift #7 with the Coban. The DON stated mechanical lift #7 should not have been used for the resident because it was uncertain if it was operation and safe to use. The DON (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the second mechanical lift with the sign not working should have been removed from the floor and a work order to repair the item should have been placed with the maintenance department.On January 16, 2026, at 3:15 p.m., an interview and concurrent record review was conducted with the DM. The DM reviewed his monthly inspection logs, dated November 19, 2025, and December 19, 2025, and stated there are three mechanical lifts in the facility and there was nothing in TELS requesting work to be done on the two mechanical lifts found in the facility. The DM stated there were no work orders put in for either mechanical lift to be repaired.A review of the facility's policy and procedure titled Physical Environment-Equipment Maintenance, dated February 2025, indicated, .routine and non-routine care of equipment and to ensure that equipment remains in good working order for resident and staff safety.electrical and hydraulic equipment will be inspected by the maintenance supervisor or designee prior to initial use and on a routine basis to ensure that equipment is working properly.routine inspections and maintenance will be recorded in the Preventative Maintenance Log or TELS system.in the event that equipment maintenance or servicing is required.Maintenance Request Log will be available at the nursing station.the log will be checked by Maintenance Supervisor or designee daily.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, and sanitary environment for the residents, staff, and the visitors, when:1.The floors in Hallway 100 were deformed with multiple raised areas; and2. The ceiling in room [ROOM NUMBER] had a crack due to water damage.These failures had the potential for residents, staff, and visitors to be harmed from the unsafe environment.Findings:On January 16, 2026, at 9:45 a.m., an unannounced visit was conducted at the facility for the investigation of a complaint regarding physical environment.On January 16, 2026, at 10 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated there was a ceiling leak in the facility at the end of November from the rains in Hallway 100, but there was no mold noted from the leak, and it was repaired after.On January 16, 2026, at 11 a.m., an interview was conducted with the Director of Maintenance (DM). The DM stated there were three leaks in the roof from the rains, one was in November and two in December. The DM stated one of the leaks did affect a resident's room, and a piece of the dry wall was cut and repaired. The DM stated the facility uses TELS (The Equipment Lifecycle System - a facility wide building management platform-work order system that creates a work order, tracks it, until completion) to keep track of work orders and maintenance repairs.On January 16, 2026, at 1:40 p.m., an observation and concurrent interview was conducted with the Certified Nursing Assistant (CNA) 2. The flooring in Hallway 100 was observed to be deformed with multiple raised areas on the floor while walking. CNA 2 stated the floor had bumps on it, and that it was not safe for the residents or staff as someone could trip and fall.On January 16, 2026, at 1:50 p.m., an observation and concurrent interview was conducted with the DON. The DON observed the flooring in Hallway 100 and stated the flooring should not have bumps in it, and that was a safety hazard for residents and staff.On January 16, 2026, at 2 p.m., an observation and concurrent interview was conducted with the Maintenance Assistant (MA). The MA observed the flooring in Hallway 100 and stated the floors are laminate and the bubbles could occur if there was not enough glue used to put them in place. The MA stated that this could be a safety hazard and someone could trip. The MA stated a work order should be placed through TELS, maintenance needs to assess the area, remove the affected tiles, and replace them with new ones. The ceiling in room [ROOM NUMBER] was concurrently observed with the MA. The MA stated there is a crack in the ceiling from the water damage from a leak which they had repaired before. The MA stated the ceiling needs to be repatched. Resident C was observed in his bed and located under the cracked ceiling.On January 20, 2026, at 1:50 p.m., a concurrent interview and observation was conducted with Resident C. Resident C stated the ceiling was fixed and does not drip on him. The ceiling in Resident C's room was observed to be lumpy with possible water damage, and the paint was cracked and chipped.A review of the facility's undated policy and procedure titled Maintenance Department, indicated, .maintain a clean and safe facility and grounds.through.preventative maintenance.corrective maintenance.certify safe status of the physical plant system and all equipment.floor, wall and ceiling surfaces must be smoothy, dry and cleanable. Any cracks may harbor bacteria.