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	05/13/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control and prevention measures were implemented according to the facility's policy and procedure and national guidelines, of using a dedicated patient-care equipment (e.g. blood pressure [BP] cuff and pump, thermometer, and pulse oximeter) on residents requiring contact and droplet precautions (infection control measures used to prevent the spread of diseases transmitted through large respiratory droplets), for three of three residents (Residents 1, 2 and 3).This failure had the potential to spread known infections to other residents or staff in the facility.Findings:On May 13, 2026, at 9:10 a.m., an unannounced visit was conducted to investigate a facility reported incident regarding infection control and prevention.On May 13, 2026, at 9:35 a.m., Resident 1's room was observed to have a sign at the door indicating droplet isolation precautions. Licensed Vocational Nurse (LVN) 1 was observed coming out of Resident 1's room. In a concurrent interview with LVN 1, LVN 1 stated they use disposable blood pressure (BP) cuff when taking vital signs on the residents placed on isolation precautions. LVN 1 stated he took Resident 1's blood pressure earlier and had thrown the BP cuff away in the medication room. LVN 1 stated he should have disposed the BP cuff used on Resident 1 in the resident's trash bin. LVN 1 went to the medication supply room to look for the disposable BP cuff and observed looking for the disposable BP cuff with Registered Nurse (RN) 1. RN 1 stated she was uncertain of the process of taking vital signs on residents placed on isolation precautions and where they could get the disposable BP cuffs.On May 13, 2026, at 9:51 a.m., during an interview with Certified Nursing Assistant (CNA) 1, AN 1 stated she was the assigned CNA for Resident 1. CNA 1 stated she was not sure if Resident 1 required contact or droplet precautions. CNA 1 stated they do vital signs of residents on isolation precautions by wiping down the BP cuff, thermometer, and pulse oximeter (a small, non-invasive device that clips onto your finger (or other body parts like the earlobe) to rapidly measure your heart rate and the amount of oxygen in your blood) before using on the other residents.A review of Resident 1's Face Sheet, indicated the resident was admitted to the facility on [DATE], with a diagnoses which included chronic respiratory failure (lung failure).A review of Resident 1's Progress Notes, dated May 6, 2026, at 3;47 p.m., indicated, .pt (patient) tested positive for growth of klebsiella pneumoniae (a type of bacterium that normally lives harmlessly in the human gut and respiratory tract. However, if it spreads to other parts of the body (like the lungs, blood, or urinary tract), it can cause serious, sometimes life-threatening infections) with resistance markers of ESBL (Extended-Spectrum Beta-Lactamase - refers to a group of enzymes produced by certain bacteria such as E. coli and Klebsiella pneumoniae that make them resistant to many common antibiotics) and CARBA (a shorthand prefix typically used to refer to carbapenem antibiotics (like in Carba-R assays) or carbapenemases-the drug-resistant enzymes produced by certain superbug bacteria that make them highly resistant to standard treatments). Pt has been placed on droplet precautions at this time.On May 13, 2026, at 10:11 a.m., an interview was conducted with LVN 2, who stated she was the assigned nurse for Resident 2. LVN 2 stated Resident 2 had recently tested positive for C-Diff (Clostridioides Difficile -a highly contagious germ that infects the large intestines causing severe diarrhea), and is on contact isolation (isolation of resident and precautions taken to (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
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevent the spread of infection through direct contact). LVN 2 stated they use the BP stand central supply where vital signs (VS) supplies were being kept. LVN 2 stated she had already taken Resident 2's VS with the multi-resident use BP pump, cuff, and thermometer, then disinfected it with Clorox bleach wipes. LVN 2 stated the VS equipment were being used to other residents as well after disinfecting them. LVN 2 stated residents on isolation precautions do not have dedicated VS equipment for the nursing staff to use. LVN 2 stated they have disposable BP cuffs but uncertain if they supposed to use them for isolation residents.A review of Resident 2's Face Sheet, indicated the resident was admitted to the facility on [DATE], with a diagnosis of respiratory failure and anoxic (lack of oxygen) brain damage. A review of Resident 1's, physician's orders, dated April 27, 2026, indicated, . Contact isolation (due to) c-diff.On May 13, 2026, at 10:27 a.m., LVN 1 stated he was not sure how to take VS on residents placed on isolation precautions. LVN 1 stated he conferred with the Infection Preventionist (IP) on the process of taking VS on isolation residents and indicated use of dedicated VS equipment (BP cuff, thermometer strips, and pulse oximeter).On May 13, 2026, at 11:51 a.m., an interview was conducted with the IP, who stated she each resident on Isolation precautions should have a dedicated BP cuff and pump, stethoscope (listens to lungs, heart beat and bowel sounds), and disposable (one use) thermometer strips located in the resident's room. The IP stated staff should use the dedicated equipment then wipe down and sanitize the equipment and leave in the residents' room for the next use. The IP stated replacement of dedicated equipment is in the central supply room, which can be accessed by all shifts. The IP further stated the multi-resident equipment should not be used on isolation residents. The IP stated Resident 1 required droplet isolation precautions, and Residents 2 and 3 required contact isolation precautions. The IP stated LVNs 1 and 2 did not follow the facility's procedure to use dedicated equipment when taking Residents 1 and 2's VS.A review of Resident 3's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke).A review of Resident 3's physician's order, dated April 23, 2026, indicated, Contact Isolation D/T (due to) C. diff.On May 13, 2026, at 4:38 p.m., an interview was conducted with the Director of Nursing (DON), who stated it is preferred that staff use dedicated equipment on isolation residents.A review of the facility's policy and procedure titled, IPCP (Infection Prevention & Control and Control Program, revised, October 2022, indicated, . Policy: It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . Patient-care equipment (e.g. blood pressure cuffs). It is preferred dedicated or disposable patient-care equipment be used.According to the web article titled, Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, published on November 27, 2023, indicated, .Contact precautions.Patient-care equipment and instruments/devices.In.long-term care and other residential settings, use disposable noncritical patient-care equipment (e.g. blood pressure cuffs) or implement patient-dedicated use of such equipment. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use of another patient.