

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 06/26/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an assessment for safe self-administration of medication was conducted, for one of one resident reviewed (Resident 44), when two open white plastic containers of topical ointment was found on the overbed table.</p> <p>This facility failure increased the potential for unsafe self-administration of medication.</p> <p>Findings:</p> <p>On June 23, 2025, at 3:08 p.m., during a concurrent observation and interview with Resident 44 in her room, two white plastic containers of topical ointment were observed on top of her over bed table. Resident 44 stated she applied the topical ointment to her lower legs when she felt itchy. Resident 44 further stated she would put more ointment if she wanted to. The two plastic containers were observed to have a label which indicated, .Oxide de Zinc 25% (zinc oxide).</p> <p>On June 23, 2025, Resident 44's admission RECORD, was reviewed. Resident 44 was admitted on [DATE], with diagnoses which included personal history of infectious and parasitic (organism that lives on a host) diseases.</p> <p>A review of Resident 44's HISTORY AND PHYSICAL, dated August 14, 2024, indicated Resident 44 was mentally capable to make decisions.</p> <p>Further review of Resident 44's medical record indicated there was no documented evidence a self-administration assessment was conducted.</p> <p>On June 23, 2025, at 3:14 p.m., a concurrent interview and review of Resident 44's medical record was conducted with Registered Nurse (RN) 1. RN 1 stated Resident 44 had two open white plastic containers of medication on top of the overbed table. RN 1 stated there was no assessment conducted for self-administration of medications for Resident 44. RN 1 stated Resident 44 should not have been allowed to self-administer the ointment without a proper assessment for self-administration. RN 1 further stated it was not safe for Resident 44 to have medications at the bedside, and an assessment for self-administration of medication should have been conducted for Resident 44.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On June 25, 2025, at 9:02 a.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated she expected the licensed nurses to follow the policy and procedure regarding self-administration assessment and administration of medications for all residents. The ADON further stated if the policy and procedures were not followed, there was a potential for the residents to not receive medications according to the physician's order, and to not be monitored for any adverse (negative) effects.</p> <p>A review of the facility's policy and procedure titled, SELF ADMINISTRATION OF MEDICATIONS, dated February 2025, indicated, .It is the policy of this facility to respect the wishes of alert, competent residents to self-administer prescribed medication choosing to and capable of self-administration .To determine the ability of alert residents to participate in self-administration of medications .the interdisciplinary team will assess and periodically re-evaluate .</p> <p>A review of the facility's policy and procedure titled, MEDICATION ADMINISTRATION-GENERAL GUIDELINES, dated November 2021, indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so .Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure provision of pharmacy services to meet the needs of the residents, when:</p> <ol style="list-style-type: none"> Four discontinued bags of large volume fluid for injections containing normal saline (electrolyte supplement in water) 0.45% remained stored in the medication room available for use; One discontinued bag for IV (intravenous, into vein) infusion containing vancomycin (antibiotic for infection) 1 gram in 250 ml (milliliter, unit of measurement) remained stored in the medication refrigerator available for use; One discontinued blister card containing ondansetron (medication for nausea and/or vomiting [N/V]) 4 mg (milligram, a unit of measurement) tablets remained in the medication cart available for use for Resident 55; One discontinued blister card containing generic Norco (hydrocodone/acetaminophen, opioid pain medication) 5-325 mg tablets remained in the medication cart available for use for Resident 62; Midodrine (medication to raise blood pressure) 10 mg (milligram, unit of measurement) doses were not given according to the parameters ordered by the physician for Resident 16; and A laboratory test to measure the effectiveness of diabetes medications was not performed consistently according to the physician order for Resident 15. <p>These failures had the potential for medications errors due to inadvertent administration from discontinued medications and, ineffective medication treatment by not following the physician orders.</p> <p>Findings:</p> <ol style="list-style-type: none"> On June 23, 2025, at 11:30 a.m., during an inspection of the medication room with the Assistant Director of Nursing (ADON), there were four 1-liter bags of 0.45% normal saline for injection without a pharmacy label. The manufacturer labeling of the product indicated it was, Rx (prescription) only. <p>In a concurrent interview, the ADON stated those 1-liter bags were no longer needed for the resident for whom they were ordered and should have been discarded.</p> <p>On June 26, 2025, at 9:30 a.m., during an interview with the ADON, the ADON confirmed the 1-liter bags were not stored in the medication room as house supplies.</p> <p>The facility's policy and procedure titled, Discontinued Medications, last updated, August 2019, was reviewed, and indicated, .If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified and shall be stored in a separate location designated solely for this purpose .Medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration) .</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's policy and procedure titled, House-Supplied (Floor Stock) Medications, last updated, August 2020, was reviewed, and indicated, .The facility maintains a supply of commonly used over-the-counter medications considered as floor stock or house medications (not resident-specific) .Floor stock medications are labeled as floor stock or house supply and kept in the original manufacturer's container .</p> <p>2. On June 23, 2025, at 12:05 a.m., during an inspection of the medication room with the ADON, one IV piggyback (IVPB, a method of administering medication through an existing intravenous line) bag containing vancomycin 1 gram in 250 ml normal saline Resident 85 for a resident labeled with the direction to infuse 1 gram vancomycin every 12 hours for 3 days with the stop date of June 20, 2025.</p> <p>On June 23, 2025, at 1:50 p.m., during an interview with the ADON, the ADON stated Resident 85 completed the IV therapy and the vancomycin bag should have been discarded.</p> <p>The facility's policy and procedure titled, Discontinued Medications, last updated, August 2019, was reviewed, and indicated, .If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified and shall be stored in a separate location designated solely for this purpose .Medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration) .</p> <p>3. On June 23, 2025, at 2:25 p.m., during an inspection of Medication Cart Rx 2 with Licensed Vocational Nurse (LVN) 1, there was one blister card containing ondansetron 4 mg (milligram, a unit of measurement) for Resident 55. In a concurrent interview, LVN 1 stated the medication was discontinued.</p> <p>On June 23, 2025, a review of Resident 55's medical record indicated there was a physician order to discontinue ondansetron 4 mg via PEG (percutaneous endoscopic gastrostomy tube, a feeding tube inserted through the abdominal wall into the stomach stomach) every 8 hours as needed for N/V, on June 3, 2025.</p> <p>The facility's policy and procedure titled, Discontinued Medications, last updated, August 2019, was reviewed, and indicated, .If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified and shall be stored in a separate location designated solely for this purpose .Medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration) .</p> <p>4. On June 23, 2025, at 3 p.m., during an inspection of Medication Cart Rx 2 with LVN 1, there was one blister card containing generic Norco (hydrocodone/acetaminophen, an opioid pain medication) 5-325 mg tablets for Resident 62. In a concurrent interview, LVN 1 stated the medication was discontinued. LVN 1 stated when the blister cards containing controlled substances were discontinued and identified, the blister cards needed to be removed, counted, and given to the DON.</p> <p>On June 23, 2025, a review of Resident 62's medical record indicated there was a physician order to discontinue generic Norco 3-325 mg via G-Tube (gastrostomy tube, feeding tube inserted into stomach) every 8 hours as needed for moderate to severe pain 4-10 for 30 days, on May 5, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's policy and procedure titled, Discontinued Medications, last updated, August 2019, was reviewed, and indicated, .If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified and shall be stored in a separate location designated solely for this purpose .Medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration) .</p> <p>5. On June 25, 2025, Resident 16's medical record was reviewed. Resident 16 was admitted to the facility on [DATE], with diagnoses which included heart failure, severe chronic kidney disease on dialysis (a medical procedure that helps remove waste products and excess fluid from the blood when the kidneys are unable to perform this function naturally), and hypertension (high blood pressure);</p> <p>A review of Resident 16's physician order, dated June 18, 2025, indicated for midodrine (medication to raise blood pressure)10 mg (milligram, unit of measurement) to be given to Resident 16 three times a day for hypotension (low blood pressure) with the parameter to hold the dose if systolic blood pressure (SBP, top number in a blood pressure reading, representing the pressure in your arteries when your heart beats) is greater than 120 mmHg (millimeter Mercury, unit of measurement of pressure).</p> <p>A review of Resident 16's Medication Administration Record (MAR), indicated midodrine was administered to Resident 16 when the SBP was above 120 on the following dates & times:</p> <ul style="list-style-type: none"> - June 19, 2025, 12 p.m., SBP of 121; and - June 21, 2025, at 12 p.m., SBP of 123. <p>On June 25, 2025, at 11:45 a.m., during an interview with the ADON, the ADON stated the 12 p.m. doses on June 19 and 21, 2025 were not held and should not have been given to Resident 16 due to SBP being above 120.</p> <p>The facility's policy and procedure titled, Medication Administration - General Guidelines, last updated, November 2021, was reviewed, and indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices .Medications are administered in accordance with written orders of the attending physician .</p> <p>6. On June 25, 2025, Resident 15's medical record was reviewed. Resident 15 was admitted to the facility on [DATE], with diagnoses which included, adult-onset diabetes mellitus (T2DM, high blood sugar levels resulting from the body's inability to effectively use the insulin it produces).</p> <p>A review of Resident 15's physician indicated the resident was receiving the following medications for T2DM:</p> <ul style="list-style-type: none"> - Lantus 10 units by injection; - Ozempic 0.5 mg by injection; and - Humulin R by injection per sliding scale parameters. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 15's physician order, date ordered on February 1, 2022, indicated to obtain Hgb A1c (hemoglobin A1c, blood test that provides an average blood sugar level over the past 2 to 3 months, a key tool for managing diabetes) test, every three months; and</p> <p>A review of Resident 15's Hgb A1c test results indicated there was no Hgb A1C test completed between May 2, 2024, and February 5, 2025 (August 2024 and November 2024).</p> <p>On June 25, 2025, at 11:50 a.m., during an interview with the ADON, the ADON stated there were some months that were missed, and the test results were not obtained every three months.</p> <p>The facility's policy and procedure titled, Diagnostic Test Results Notification, last reviewed, February 2025, was reviewed, and indicated, .It is the policy of this facility to obtain laboratory and radiology services when ordered by a Physician .Laboratory .services will be arranged as ordered .Notification of test results will be documented in the resident's clinical record .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and document review, the facility failed to ensure medications were labeled with the name of the resident for whom they were intended to be administered.</p> <p>This failure had the potential for medications to be shared by multiple residents.</p> <p>Findings:</p> <p>On June 23, 2025, at 2:25 p.m., during an inspection of Medication Cart Rx 2 with LVN 1, there was one Saline Nasal Spray, not labeled with the name or room number of the resident. In a concurrent interview with LVN 1, LVN 1 confirmed there was no name or room number on the spray bottle or the spray bottle's manufacturer box. LVN 1 stated the spray bottle needed to be labeled with the resident's name. LVN 1 stated she would not know who the medication was for without the name on the medication box.</p> <p>The facility's policy and procedure titled, Labeling and Storage, last revised, February 2025, was reviewed, and indicated, .Each prescription medication label includes .Resident's name .</p> <p>The facility's polity and procedure titled, Medication Administration - General Guidelines, updated November 2021, was reviewed, and indicated, .Medications supplied for one resident are never administered to another resident .</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow up the dental needs of a resident, for one resident reviewed for dental services (Residents 15) .</p> <p>This failure has the potential to place Resident 15 at high risk for complications related to dental and nutritional needs due to the delay in providing dental services.</p> <p>Findings:</p> <p>On June 24, 2025, at 9:15 a.m., during a concurrent observation and interview with Resident 15 in her room, Resident 15 was observed with missing partial upper teeth. Resident 15 stated she wanted to have dentures so she requested to be seen by the facility dentist, but no one updated her if she would receive the dental service or not.</p> <p>On June 24, 2025, Resident 15's record was reviewed. Resident 15 was admitted to the facility on [DATE], with diagnoses which included tracheostomy status (an opening surgically created through the neck into the trachea [windpipe] to allow air to fill the lungs).</p> <p>A review of Resident 15's Initial admission Record, dated February 2, 2022, the oral assessment indicated Resident 15's natural teeth were missing, and was unable to function without natural teeth and dentures.</p> <p>A review of Resident 15's History and Physical Note, dated January 18, 2025, indicated Resident 15 had the capacity to understand and make decisions.</p> <p>A review of Resident 15's Nutrition/Hydration Risk Evaluation, dated February 4, 2025, indicated Resident 15 had several missing teeth.</p> <p>A review of Resident 15's Order Summary Report, dated June 25, 2025, included a physician's order for low concentrated sweets diet (a type of diabetic diet), regular consistency.</p> <p>A review of Resident 15's dentist notes titled, Impressions Mobile Dentistry, indicated Resident 15 had multiple upper missing teeth and had recommendations as follows:</p> <ul style="list-style-type: none"> - On October 23, 2024, Resident 15 wanted to have upper dentures, and eligibility for full upper denture (FUD) would be checked; and - On April 10, 2025, Resident 15 wanted to have a dentures on the upper arch and eligibility would be checked for FUD. <p>Further review of Resident 15's medical record indicated there was no documented evidence a follow up was made by the Social Services and Nursing Department regarding Resident 15's eligibility for FUD.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On June 25, 2025, at 7:53 a.m., a concurrent interview and review of Resident 15's record was conducted with Registered Nurse (RN) 2. RN 2 stated Resident 15 had dental consultations on October 23, 2024 and April 10, 2025, with a note from the dentist that Resident 15 expressed she wanted to have an upper denture. RN 2 stated, Resident 15's dental request should have been followed up. RN 2 further stated if Resident 15's dental requests were not followed up, there would be a delay of dental care services which could lead to nutritional health issues such as weight loss due to poor oral intake.</p> <p>On June 25, 2025, at 8:09 a.m., during an interview with the Social Service Director (SSD), the SSD stated she did not do a follow up regarding Resident 15's need for dental services. The SSD stated there should have been a follow up with the dentist for Resident 15 to have dentures. The SSD stated if dental services were not followed up, a delay of dental care could worsen Resident 15's health status.</p> <p>On June 25, 2025, at 8:50 am, during an interview with the Director of Nursing (DON), the DON stated the Social Services Department was responsible for the dental needs of the residents, and Resident 15's dental care should have been followed up. The DON further stated if Resident 15 did not receive dental services, she could not eat food properly and this could lead to weight loss.</p> <p>A review of the facility's policy and procedure titled, Dental Services, dated January 2022, indicated, .It is the policy of this Facility to ensure that its residents who require dental services on a routine or emergency basis have access to such services without barrier .For Medicare and private pay residents, the Facility will ensure that the needed dental services are available .</p> <p>A review of the facility's policy and procedure titled, Social Services, Provision of Medically-Related, dated February 2025, indicated, .It is the policy of this facility to provide medically-related social service to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident .Social service is responsible for providing for medically related social service needs of each resident .Examples of these services may include but are not limited to .Scheduling appointments .</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On June 23, 2025, at 12:10 p.m., Resident 64 was observed eating lunch in his room. Resident 64 was eating one of two burritos served on a separate plate from the main entree, which contained a piece of meat, parsleyed rice, and braised cabbage. When asked if he did not like the main dish served for lunch, Resident 64 stated, I don't like pork, so he asked for burritos instead. Resident 64 further stated he disliked pork, but I get it always.</p> <p>Resident 64's meal ticket was reviewed, which indicated, LCS (low calorie sweeteners) Diet .Regular Consistency .GARLIC HERB PORK CHOP 1-EACH .Dislikes: PORK .</p> <p>On June 23, 2025, at 12:30 p.m., Licensed Vocational Nurse (LVN) 2 was interviewed. LVN 2 stated Resident 64 should not have been served pork since that was his dislike, and kitchen staff should follow what it says on the diet slip.</p> <p>A review of Resident 64's record indicated Resident 64 was admitted to the facility on [DATE], with diagnoses which included end-stage renal disease (a condition in which kidneys cannot filter waste from the blood) and diabetes (abnormal blood sugars).</p> <p>Resident 64's MDS indicated a BIMS score of 15 (cognitively intact).</p> <p>On June 24, 2025, at 10:27 a.m., an interview was conducted with the Registered Dietician (RD). The RD stated the residents were interviewed by the Dietary Supervisor (DS) on admission, quarterly, and as needed for allergies, preferences, and dislikes. The RD stated the preferences, dislikes, and allergies were printed on the dietary meal ticket, which would guide the cook and dietary aides during the process of plating the correct therapeutic diet, preferences, and to avoid the chance of allergy food being included by mistake. The RD stated Residents 64 and 76 should not have been served pork for their meals as they had a dislike for pork. The RD stated the goal was to provide a satisfying, nutrient filled meal that can be enjoyed by the residents. The RD further stated food intake may be inadequate by not making reasonable efforts to adjust to the residents' food plan and preferences.</p> <p>A review of the facility's policy and procedure titled, Alternates on the Menu & Meal Substitution, dated January 2018, indicated, .Patient food preferences shall be adhered .the DFNS keep tray card updated with dislikes .the cook keeps tallies of diets and dislikes .provides alternate menu item as dictated by the resident's food dislikes .</p> <p>Based on observation, interview, and record review, the facility failed to ensure food preferences were honored, for two of 15 sampled residents (Residents 64 and 76), when the residents were served pork during the lunch meal service on June 23, 2025.</p> <p>This failure had the potential for Residents 64 and 76's dietary intake to be inadequate, by not making reasonable efforts to adjust to the residents' food plan and preferences.</p> <p>Findings:</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. On June 23, 2025, at 11:55 a.m., an observation of Resident 76 was conducted in the dining room. Resident 76's plate contained chopped pork meat, parsleyed rice, chopped braised cabbage, cornbread with margarine, peach crisp and a beverage.</p> <p>Resident 76 ate his food without assistance and ate the contents of the plate with only a few bites of the pork meat consumed.</p> <p>A concurrent interview with Resident 76 was conducted. Resident 76 stated he liked most of the food, but had a dislike for pork.</p> <p>A review of Resident 76's lunch ticket indicated REGULAR Diet Mech Soft/Grnd (mechanical soft/ground-food prepared to be easily chewed and swallowed by grinding or chopping) Texture .GARLIC HERB PORK CHOP 1-EACH .Dislikes: PORK .</p> <p>A review of Resident 76's record indicated Resident 76 was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty or discomfort swallowing).</p> <p>A review of Resident 76's Minimum Data Set (MDS- a clinical assessment tool), dated May 16, 2025, indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact).</p>

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NAME OF PROVIDER OR SUPPLIER Desert Mountain Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 47-763 Monroe Avenue Indio, CA 92201	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe, sanitary food preparation and storage practices were followed in the kitchen when wooden storage shelves in the dry supply area were observed to be chipped, splintered and the lacquered varnish peeled off.</p> <p>This failure had the potential to cause food-borne illness in a highly susceptible resident population.</p> <p>Findings:</p> <p>On June 23, 2025, at 9:52 a.m., an observation with the Dietary Supervisor (DS), was conducted in the dry goods supply room. The wooden shelving was observed to have bare chipped, splintered wood, and the lacquered varnish had peeled off in many places.</p> <p>In a concurrent interview with the DS, the DS stated the staff always use gloves before reaching into the shelves for food items, to avoid splinters from the wood. The DS stated the staff safety related to splinters was a risk.</p> <p>On June 23, 2025, at 10:30 a.m., an interview and observation with Plant Director (PD) was conducted. The PD stated the wooden shelves should not be chipped, splintered or unsealed because of possibility of staff injury and cross-contamination of resident food.</p> <p>On June 24, 2025, at 10:27 a.m., an interview with the Registered Dietician (RD) was conducted. The RD stated she was aware of the state of the damaged shelving in the dry goods supply room and had notified both the PD and the Administrator at different times through this year. The RD stated the wooden shelves should not have opened, unsealed, chipped wood as it was possible for staff injury and cross-contamination leading to possible illness in the vulnerable resident population.</p> <p>A review of the facility's policy and procedure titled, Food Storage, dated February 2025, indicated, .All food . items purchased for the Food & Nutrition Services Department should be properly stored .all food items .shall be stored .on shelves .which facilitate thorough cleaning .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented, when:</p> <ol style="list-style-type: none"> 1. For Resident 47, a black stand fan in the resident's room was observed with dust accumulated on the front and back guard covers; and 2. For Resident 287, one used plastic urinal was found inside the resident's personal belonging's storage closet. <p>These failures had the potential to increase the spread of pathogens (germs) and infections to residents which could lead to serious illness.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On June 23, 2025, at 10:55 a.m., during a concurrent observation and interview with Certified Nursing Assistant (CNA) 1 in Resident 47's room, a black stand fan was observed with black and gray debris accumulated on the front and back guard covers. CNA 1 stated it was dust, and the fan should have been cleaned. <p>On June 25, 2025, Resident 47's record was reviewed. Resident 47 was admitted to the facility on [DATE], with diagnoses which included respiratory failure with tracheostomy (trach-an opening in the neck, directly into the trachea [windpipe], to facilitate breathing).</p> <p>A review of Resident 47's HISTORY AND PHYSICAL, dated January 25, 2024, indicated Resident 47 was mentally incapable of understanding.</p> <p>A review of Resident 47's Minimum Data Set (MDS- a resident assessment tool), dated March 31, 2025, indicated Resident 47 had tracheostomy care treatment.</p> <p>A review of Resident 47's Care Plan Report, dated January 30, 2024, indicated, .Tracheostomy care per facility protocol .</p> <p>A review of Resident 47's Order Summary Report, dated June 25, 2025, indicated Resident 47 was on enhanced barrier precaution due to gastric tube (a tube inserted directly into the stomach) and trach.</p> <p>On June 23, 2025, at 11 a.m., during a concurrent observation and interview with the Respiratory Therapist (RT), the RT stated the stand fan was dusty and it should have been cleaned. The RT further stated the dust from the fan could potentially fly through the air and go to Resident 47's mouth or trach site, and could cause respiratory infection.</p> <p>On June 25, 2025, at 2:47 p.m., during an interview with the Infection Preventionist (IP), the IP stated the stand fan and other equipment used for residents must be free from dust. The IP further stated dust accumulated in the fan could cause the spread of germs and result in respiratory infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On June 25, 2025, at 3:10 p.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated she expected the staff to clean equipment surfaces, and these should be free from dust. The ADON further stated any accumulated dust that floats through the air and goes to the resident's trach, could cause respiratory infection.</p> <p>A review of the facility's policy and procedure titled, Rooms, Cleaning Residents, dated February 2025, indicated, .It is the policy of this facility to provide a clean, comfortable, homelike and sanitary living area . Damp wipe surfaces .with germicidal solution .</p> <p>A review of the facility's policy and procedure titled, Infection Control, dated February 2025, indicated, .The infection prevention and control program as a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program .Recognize infection control practices while providing care .Effective cleaning and disinfecting equipment as needed .</p> <p>2. On June 23, 2025, at 10:10 a.m., during a concurrent observation and interview with CNA 1, one used plastic urinal was found inside Resident 287's personal belonging's storage closet. CNA 1 stated it should not be placed on top of the storage closet shelves and should be placed in urinal holder. CNA 1 further stated It should not be placed anywhere.</p> <p>On June 25, 2025, Resident 287's record was reviewed. Resident 287 was admitted to the facility on [DATE], with diagnoses which included kidney failure (kidney disease), malignant melanoma of skin (skin cancer).</p> <p>A review of Resident 287's HISTORY AND PHYSICAL, dated June 19, 2025, indicated Resident 287 was mentally capable of understanding.</p> <p>A review of Resident 287's Order Summary, dated June 19, 2025, indicated Resident 287 had abdominal surgical dehiscence (the separation of a surgical incision in the abdomen, exposing underlying tissues or organs) and had a trach in neck area.</p> <p>On June 23, 2025, at 10:15 a.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 3, LVN 3 stated used urinal should be placed in urinal holder and or should be discarded if Resident 287 did not use it. LVN 3 stated proper storage of urinal should have been implemented to prevent spread of germs. LVN 3 further stated It is infection control issue.</p> <p>On June 25, 2025, at 2:46 p.m., during an interview with the IP, the IP stated plastic urinals should be placed in urinal holder when not in used and should not be stored anywhere. The IP further stated if not properly stored, it would result to surface contamination and would spread of infection.</p> <p>On June 25, 2025, at 3:10 p.m., during an interview with the Director of Nursing (DON), the DON stated she expected the nurses to follow proper storage of urinals and follow the facility's policy and procedure in infection control. The DON further stated if proper storage of urinals would not follow, it would result to cross contamination and would spread infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure titled, Infection Control, dated February 2025, indicated, .The infection prevention and control program is comprehensive in that it addresses detection, prevention and control of infections among residents and personnel .Safe use of disposable and single use supplies and equipment .</p> <p>A review of the facility's policy and procedure titled, Bedpan and Urinal, Cleaning and Storage, dated February 2025, indicated, .It is the policy of this facility to provide clean and sanitary bedpans and urinals as well as store them for residents .urinal will be labeled with resident's name .Place the urinal in the urinal holder by the bed side .</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's wheelchairs were maintained in a safe operating condition, for two of 15 residents (Residents 45 and 70).</p> <p>These failures had the potential to result in injury to the residents.</p> <p>Findings:</p> <p>1. On June 24, 2025, at 1 p.m., a record review for Resident 45 was admitted to the facility on [DATE], with diagnoses which included spinal stenosis (the spaces inside the bone become too small), aftercare following joint replacement surgery and diabetic neuropathy (type of nerve damage that occurs with diabetes).</p> <p>A review of Resident 45's Minimum Data Set (MDS - a resident assessment tool), dated June 3, 2025, included a Brief Interview for Mental Status (BIMS) score of 15 (cognitive intact).</p> <p>On June 24, 2025, at 1:58 p.m., an interview and concurrent observation with Resident 45 was conducted. Resident 45 stated the wheelchair he was using was broken including the left-hand break which does not lock up, the left-hand armrest was loose, and wobbles when the chair was being used, and the right-hand wheel had a metal hand rim which was missing part of the rim leaving sharp edges easily available to the resident's hand. Resident 45 stated this was dangerous and someone could be hurt.</p> <p>On June 24, 2025, at 2 p.m., an interview and concurrent observation with Plant Director (PD) was conducted in Resident 45's room. The PD assessed Resident 45's wheelchair and acknowledged the need for parts replacement. The PD stated he had not known the wheelchairs had broken parts. The PD stated the cracked upholstery was an infection control issue and could cause cross-contamination leading to illness of the residents and the broken metal and inoperative brake were a risk for resident injury.</p> <p>On June 24, 2025, at 2:34 p.m., an interview with Physical Therapy Assistant (PTA) was conducted. The PTA stated he had assisted with Resident 45's wheelchair problem. The PTA stated he had looked for a working/new wheelchair but was unable to find another more appropriate replacement. The PTA stated Resident 45's current wheelchair had a metal piece that needed to be replaced and the resident agreed to be careful and would refused another exchange. The PTA stated he had sent a work request to maintenance for repair of wheelchair in PCC, describing the issue. The PTA stated he had completed the following process for Resident 45's broken wheelchair:</p> <ul style="list-style-type: none"> - Replace the broken equipment for the resident; - Send a work order in the computer system noting the repair needed; and - Remove the broken equipment and place it in the workshop with a note attached documenting the repair needed. <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On June 24, 2025, at 1 p.m., a record review of Resident 70's record indicated Resident 70 was admitted to the facility on [DATE], with diagnoses which included unilateral primary osteo arthritis (occurs when cartilage wears down on joint bone ends), right knee pain, hemiplegia (paralysis or extreme weakness on one side of the body).</p> <p>A review of Resident 70's MDS, dated April 13, 2025, included a BIMS score of 15 (cognitive intact).</p> <p>On June 24, 2025, at 11:50 a.m., an interview and concurrent observation with Resident 70 was conducted. Resident 70 stated his wheelchair had been fixed once though the wheelchair remained shaky and the armrest still had cracked and peeling upholstery.</p> <p>Resident 70 stated the left wheel of the wheelchair was loose and Resident 70 have reported the issue. Resident 70 stated the left armrest's upholstery and padding was cracked and peeling with holes for the padding to stick out.</p> <p>On June 24, 2025, at 2 p.m., and interview and concurrent observation with the PD was conducted. The PD assessed Resident 70's wheelchair and acknowledged the need for parts replacement. The PD stated he had not known the wheelchairs had broken parts.</p> <p>The DP stated the cracked upholstery is a infection control issue and could cause cross-contamination leading to illness of the residents and loose wheel were a risk for resident injury.</p> <p>A review of the facility's policy and procedure titled, Physical Environment - Equipment Maintenance, dated February 2025, indicated, .to ensure equipment remains in good working order for resident and staff safety .</p> <p>A review of the facility's policy and procedure titled, Resident's Rights - Accommodation of Needs, dated February 2025, indicated, .the facility to be aware of the importance of accommodation of needs for each resident .nursing staff will communicate .any specific accommodation of a particular resident .</p>		